Addressing Disparities in Perinatal Care Delivery

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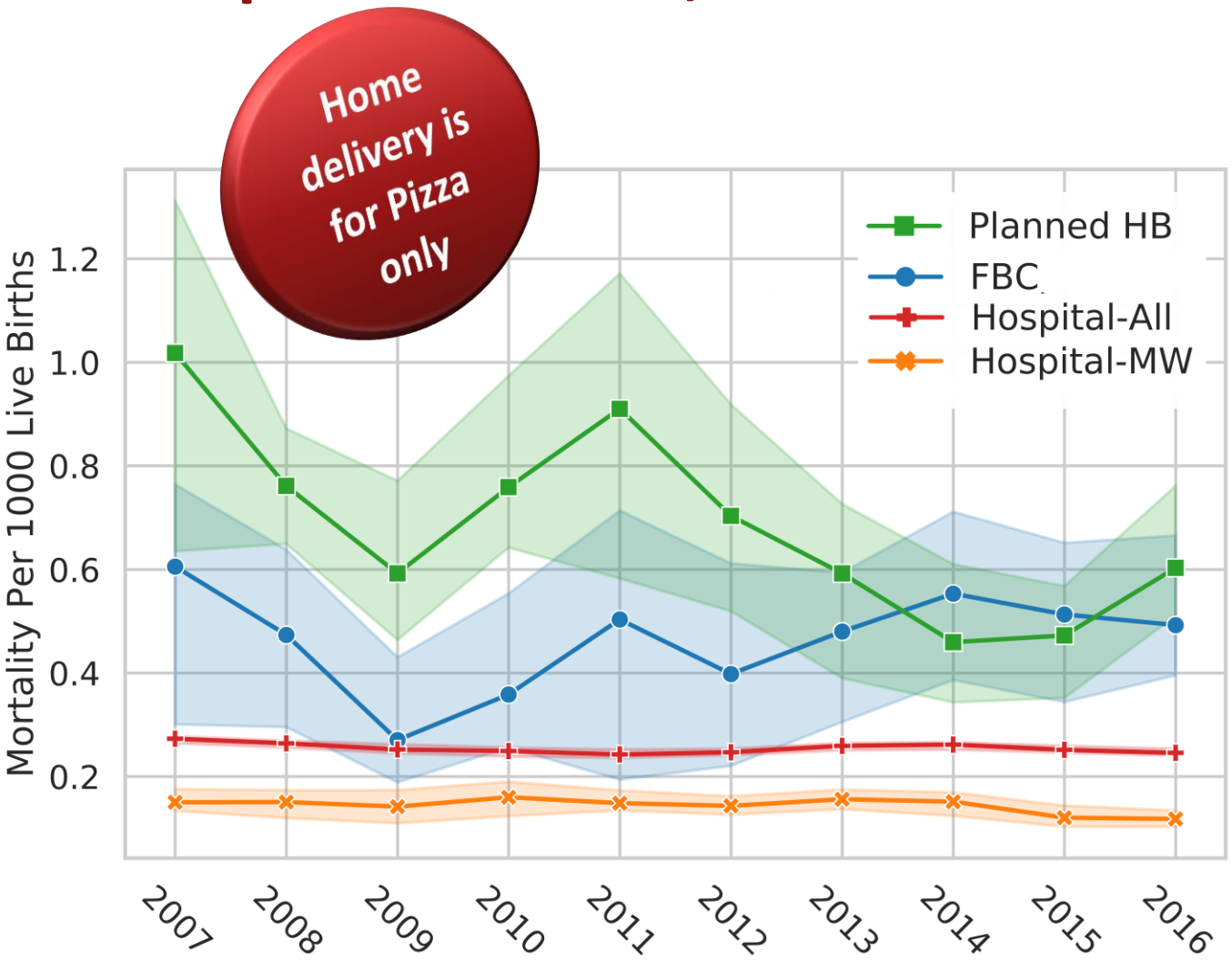


Disclosure

Dr. Profit's equity research has been supported by:

- NICHD R01 - HD083368 (PI: J Profit)
- NICHD R01 - HD084667 (PI: J Profit)
- NICHD R01 - HD094847 (Co-PIs: J Profit, E Main)

Dr. Profit serves as an unpaid Advisory Board Member of the NEC Society

CPQCC

QUALITY IMPROVEMENT IN ACTION

Stanford MEDICINE

california perinatal quality care collaborative

CPQCC

By the numbers

17K

NICU ADMITS

CPQCC

138

MEMBER HOSPITALS

CPQCC

7K

ACUTE NEONATAL TRANSPORTS

CPeTS

9K

HIGH-RISK INFANTS REGISTERED

HRIF

500K

BIRTHS

CMQCC

Live Births	Inborn Admission Percent	NICU Admissions	CPQCC Small Babies	CPQCC Big Babies
28,217	10.35 %	3,307	506	569

Acute Transports-In	TRIPS @ NICU Admit	TRIPS Change Eval to NICU Admit	Out-the-Door Time [AcTrsIn]	With at least 1 Major Surgery
249	9.91	0.13	1 Hour 7 Minutes	126

VON Small Babies

Survival w/out Major Morbidity	Growth Velocity	Median PMA at Home Discharge	ANS (JC) Treatment	ROP Exam at Appropriate PMA
63.78 %	13.50	38 Weeks / 1 Day	99.64 %	97.47 %

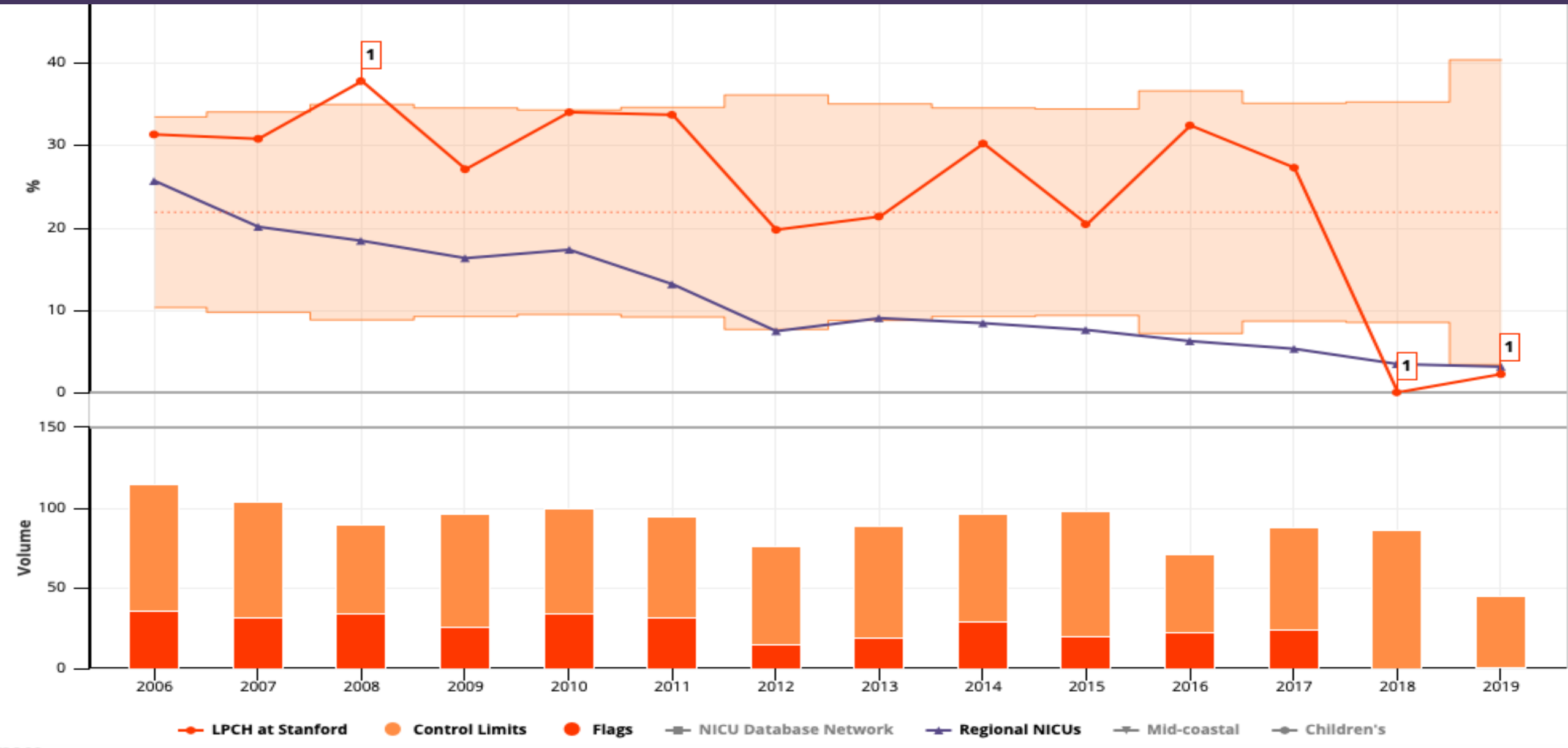
Chronic Lung Disease	NEC	Home on Human Milk Nutrition	Normothermic
24.09 %	3.08 %	76.05 %	70.34 %

Big Babies

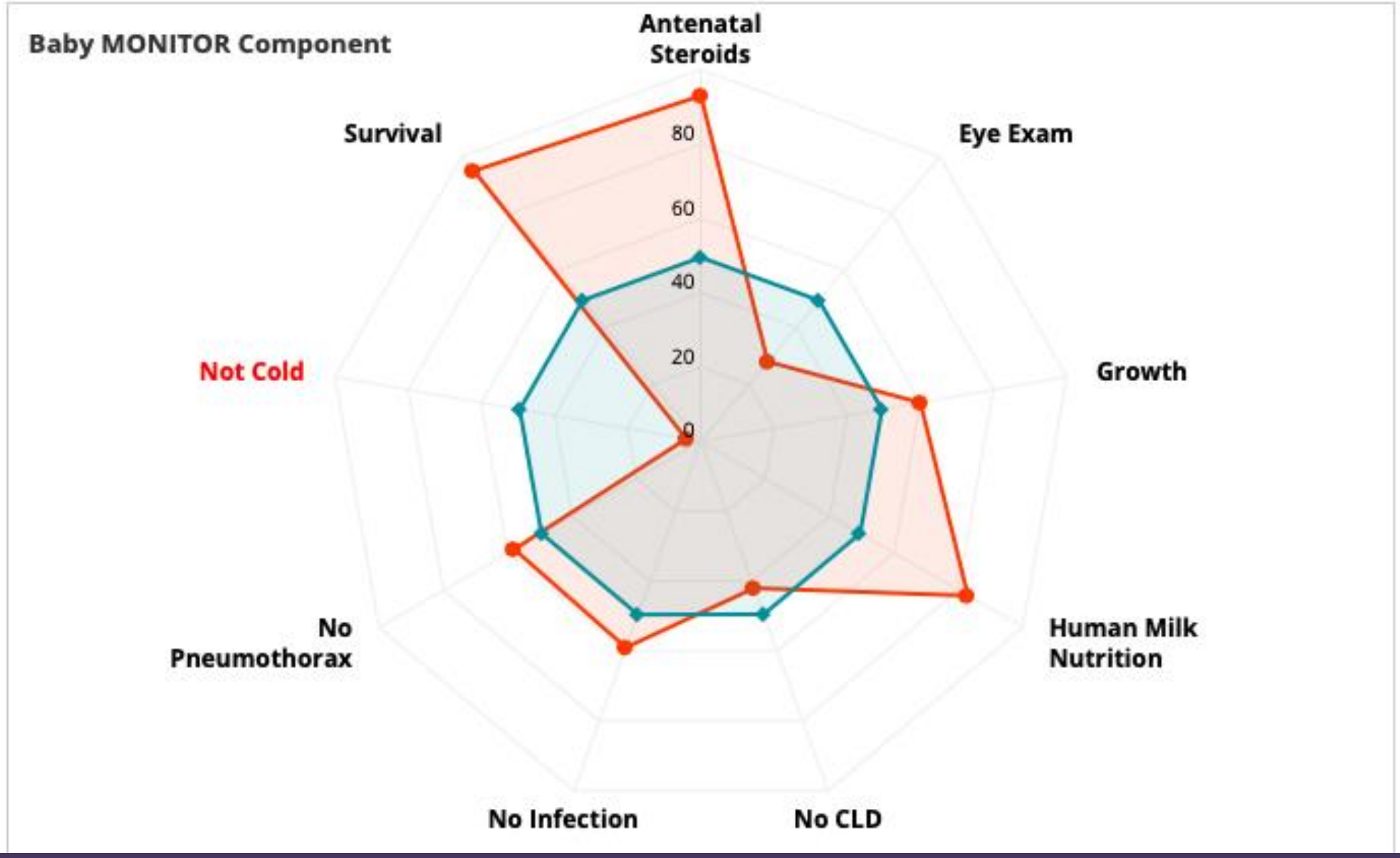
Early Sepsis	Moderate/Severe HIE	Active Therap. Hypothermia Volume	High Acuity
0.11 ‰	1.44 ‰	67	82.95 %

Infection Control

CPQCC SPC CHARTS



Demo NICU: Composite Score: 69



CPQCC BABY-MONITOR

By The Numbers

NICU level improvements between 2008-2017

Member hospitals reduced mortality rates for VLBW infants by

15%

An additional

8.5%

of babies were discharged without major morbidities like severe ROP, NEC, CLD, and severe IVH

And the rate of Necrotizing enterocolitis (NEC) decreased by

45%

By The Numbers

NICU level improvements between 2008-2017

Member hospitals reduced severe intraventricular hemorrhage by

19%

There were

36%

fewer cases of severe retinopathy of prematurity (ROP) or ROP surgery

And the rates of nosocomial infection declined by

44%

Lee, Liu, Profit, Hintz, Gould.
J Perinatol. 2020 Jul;146(1):e20193865

Best Hospitals for Neonatology

Fifty pediatric centers were ranked for care of fragile newborns. Taking breast milk at discharge, the hospital's level of experience taking care of newborns, infection rates in the NICU, availability of ECMO for fragile heart-lung patients, advanced technologies and family support services accounted for most of each hospital's score.

HOW WE RANK AND RATE HOSPITALS »

BEST CHILDREN'S HOSPITALS
U.S.News & WORLD REPORT
RANKINGS

#2 – Children's Hospital Los Angeles

#3 – Lucile Packard Children's Hospital Stanford

#4 – University of California San Francisco

#5 – Racy Children's San Diego

Are there Disparities in Perinatal Care?

She Was Pregnant With Twins During Covid. Why Did Only One Survive?

Why being Black and giving birth in New York during the pandemic is so dangerous.

MEDICAL DISPATCH

THE ESSENTIAL WORKERS FILLING NEW YORK'S CORONAVIRUS WARDS

By Dhruv Khullar
May 1, 2020

Delivery people are among the essential workers who must expose themselves and their families to the virus every day. Photograph by Matt Rourke / AP / Shutterstock

For Latinos and Covid-19, Doctors Are Seeing an 'Alarming' Disparity

The outsized infection rate among Hispanics in some states could hobble efforts to quash the spread of Covid-19, prompting states like Oregon to step up testing and take emergency measures.

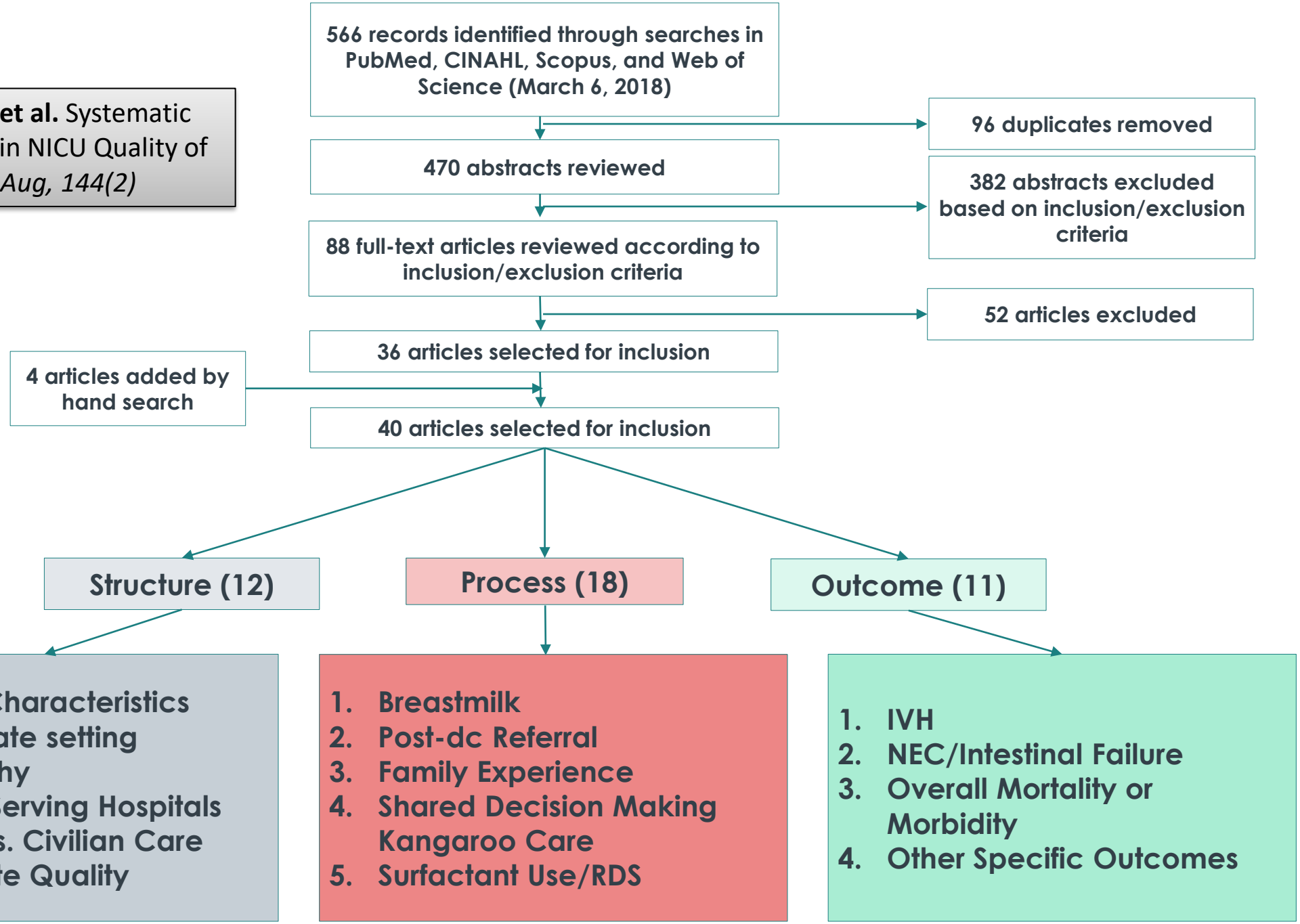
Context matters – always exposed to bias

Origins of disparity

SDH

Following THROUGH

Sigurdson K, Profit J, et al. Systematic Review of Disparities in NICU Quality of Care. *Pediatrics 2019 Aug, 144(2)*



What are the mechanisms for disparities in NICU Care?

Mechanisms for Disparity

Minority mothers and neonates can have worse outcomes than whites because

1. Receive care from facilities that treat patients with poor quality of care *(BETWEEN)*,
2. Receive worse quality of care than white mothers in the same facility *(WITHIN)*

Opinion

EDITORIAL

Racial Segregation and Inequality of Care in Neonatal Intensive Care Units Is Unacceptable

Elizabeth A. Howell, MD, MPP; Paul L. Hebert, PhD; Jennifer Zeitlin, DSc, MA

Related article

Despite significant improvements in the survival of very preterm newborns in neonatal intensive care units (NICUs) over the last decade, significant racial and ethnic disparities exist for very preterm infants.[1-3] While these disparities are rooted in a complex web of factors, a growing body of evidence has documented the role of quality of care in creating disparities. Black and Hispanic very preterm infants are more likely to be born in hospitals with worse outcomes than white infants after adjustment for risk factors, and differences in hospital of birth explain a significant proportion of the black-white and Hispanic-white disparities for these vulnerable infants.[2] Additional research has documented that racial and ethnic disparities in quality exist between and within NICUs for very low-birth-weight infants.[4]

In this issue of *JAMA Pediatrics*, Horbar et al[5] explore the extent of segregation and inequality for very low-birth-weight and very preterm infants in NICUs across the United States. They developed indices at the hospital level to measure segregation (ie, uneven distribution of racial and ethnic groups across NICUs) and inequality (ie, concentration of racial or ethnic groups in lower-quality NICUs). Using data from the Vermont Oxford Network and a cohort of more than 117 000 infants born at 401 g to 1500 g or 22 to 29 weeks' gestation from 2014 to 2016, they measured segregation and inequality at the hospital level for black, Hispanic, and Asian infants relative to white infants. They found significant segregation across NICUs in the United States for all 3 racial and ethnic groups and regional variation in quality of care. Compared with white infants, black infants received care at lower-quality NICUs; Asian and Hispanic infants received care at higher-quality NICUs. Region of residence explained differences for Hispanic but not Asian or black infants.

This article has a number of strengths in relation to previous studies. First, Horbar et al[5] used a comprehensive measure of quality, the composite Baby-MONITOR (Measure of Neonatal Intensive Care Outcomes Research) score, rather than solely relying on risk-adjusted mortality or morbidity to assess hospital performance. The Baby-MONITOR score includes 9 infant-level process and outcome measures (eg, antenatal steroid exposure, hypothermia on admission, health care associated infection, and mortality) that have been used to measure quality in California NICUs.[4,6] Much of the previous literature on the contribution of quality of care to neonatal disparities has relied on measures of risk-adjusted neonatal morbidity and mortality ascertained through the use of administrative data. While morbidity and mortality are direct measures of health and of most importance to families, they are indirect measures of quality, and comparisons between hospitals are more strongly reliant on the ability to carry out risk adjustment than process measures. Furthermore, they do not identify specific areas that can be targeted in the NICU to improve outcomes. While the use of administrative data, such as state discharge abstract data linked with birth certificate data, allow for population-based estimates, these administrative data lack many of the data elements necessary to measure quality more directly (eg, receipt of medications, vital signs, and growth).

Another strength is the use of a national data set that includes nearly 90% of very low-birth-weight and very preterm infants born annually in the United States, making it possible to confirm that previous findings from specific regions apply more broadly to the US population. Horbar et al[5] also propose an interesting index for inequality. In our previous research, we ranked hospitals by risk-adjusted morbidity and mortality and examined where black and Hispanic very preterm infants were born.[2] In this article, Horbar et al[5] rank NICUs by a direct measure of quality and examine the proportion of white infants in those NICUs. Their index of inequality has the potential to be used in future research investigating disparities. Future research would benefit from more granular data on race and ethnicity to measure disparities in care for specific subgroups of black, Hispanic, and Asian infants.

Patient-level quantitative measures of quality, such as those used in the study by Horbar et al,[5] are critical to solving disparities in the NICU because these measures have the potential to illuminate the pathways by which racial disparities in outcomes are realized. Minority mothers and their neonates can have worse outcomes than white mothers because (1) they receive care from facilities that treat all mothers with poor quality of care, (2) they receive worse quality of care than white mothers in the same facility, or (3) they have health and social risks that are beyond the control of the hospital.[7] Without patient-level measures of quality, we cannot distinguish the effects of the latter 2 pathways and therefore cannot say whether the solution lies within the hospital or not. Furthermore, this composite measure builds on previous work to identify evidence-based interventions in neonatology and illustrates the health impact of failure to implement them in current practice. This approach offers an opportunity for future research to identify which components of care contribute most to disparities. Although each component is weighted equally in the score, the authors point out that changing these weights would likely affect estimates of inequalities.

Howell E, et al. *JAMA Pediatr 2019*

Disparities between hospitals – Structural racism

Neonatal mortality by hospital in NYC

JAMA Pediatrics | Original Investigation

Differences in Morbidity and Mortality Rates in Black, White, and Hispanic Very Preterm Infants Among New York City Hospitals

Elizabeth A. Howell, MD, MPP; Teresa Janevic, PhD, MPH; Paul L. Hebert, PhD; Natalia N. Egorova, PhD, MPH; Amy Balbierz, MPH; Jennifer Zeitlin, DSc, MA

IMPORTANCE Substantial quality improvements in neonatal care h… decade yet racial and ethnic disparities in morbidity and mor… whether disparate patterns of care by race and ethnicity c… outcomes.

OBJECTIVES To examine differences in neonatal morbi… non-Hispanic black (black), Hispanic, and non-Hispanic… and to determine whether these differences are explai…

DESIGN, SETTING, AND PARTICIPANTS Population-base… nonanomalous infants born between 24 and 31 comple… City hospitals using linked 2010 to 2014 New York City… data sets. Mixed-effects logistic regression with a rand… used to generate risk-adjusted neonatal morbidity and… infants in each hospital. Hospitals were ranked using th… distribution of black, Hispanic, and white very preterm… hospitals. The statistical analysis was performed in 201…

EXPOSURE Race/ethnicity.

MAIN OUTCOMES AND MEASURES Composite of morta… or severe neonatal morbidity (bronchopulmonary dysp… retinopathy of prematurity stage 3 or greater, or intrav… greater).

RESULTS Among 7177 very preterm births (VPTBs), mo… (28%) and was higher among black (893 [32.2%]) and… [22.5%]) VPTBs (2-tailed $P < .001$). The risk-standardiz… twice as great for VPTB infants born in hospitals in the… (0.40; 95% CI, 0.38-0.41) as for those born in the lowe… 95% CI, 0.14-0.18). Black (1204 of 2775 [43.4%]) and H… infants were more likely than white (325 of 1418 [22.9%… in the highest morbidity and mortality tertile (2-tailed $P <$… 95% CI, 18%-23% and Hispanic-white difference, 11%; 95% … proportion of the explained disparities can be attributed to differ… among black, Hispanic, and white VPTB infants. However, 40% (95% CI, 30%-50%) of the black-white disparity and 30% (95% CI, 10%-49%) of the Hispanic-white disparity was explained by birth hospital.

CONCLUSIONS AND RELEVANCE Black and Hispanic VPTB infants are r… hospitals with higher risk-adjusted neonatal morbidity and… differences contribute to excess morbidity and… and Hispanic infants.

JAMA Pediatr. doi:10.1001/jamapediatrics.2017.4402
Published online January 2, 2018.

Editorial

…liations are listed at the end of this article.

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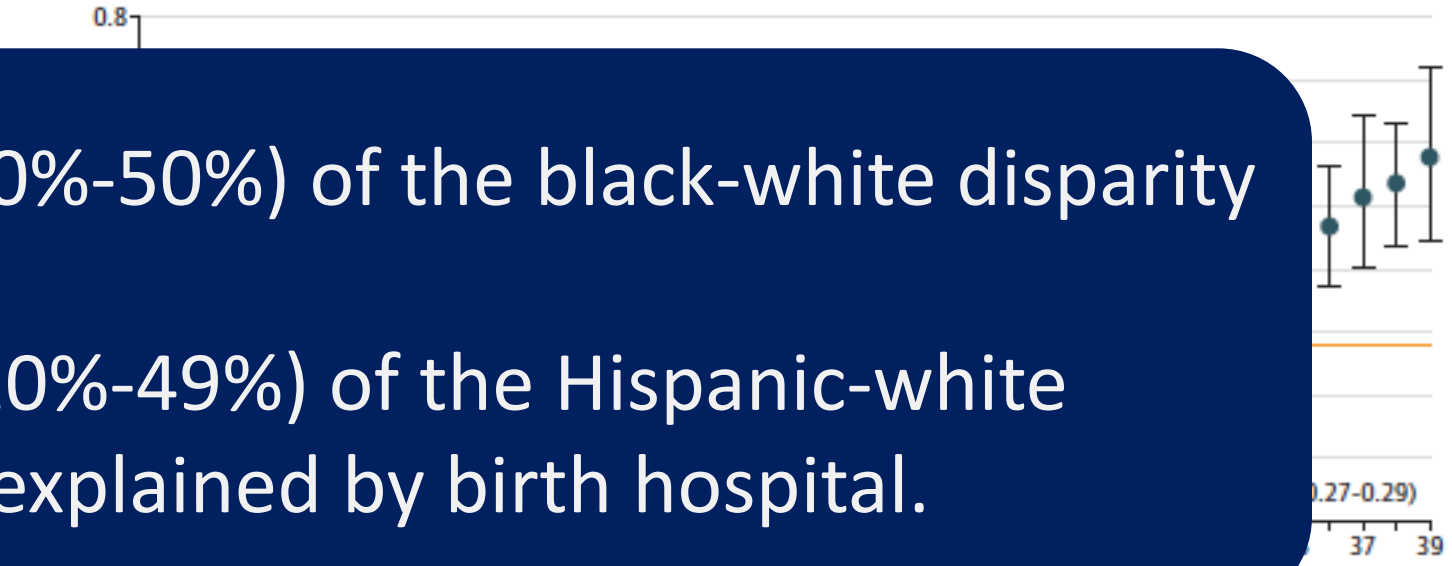
Figure. Hospital Rankings for Risk-Adjusted Neonatal Morbidity and Mortality, New York City, NY, 2010-2014



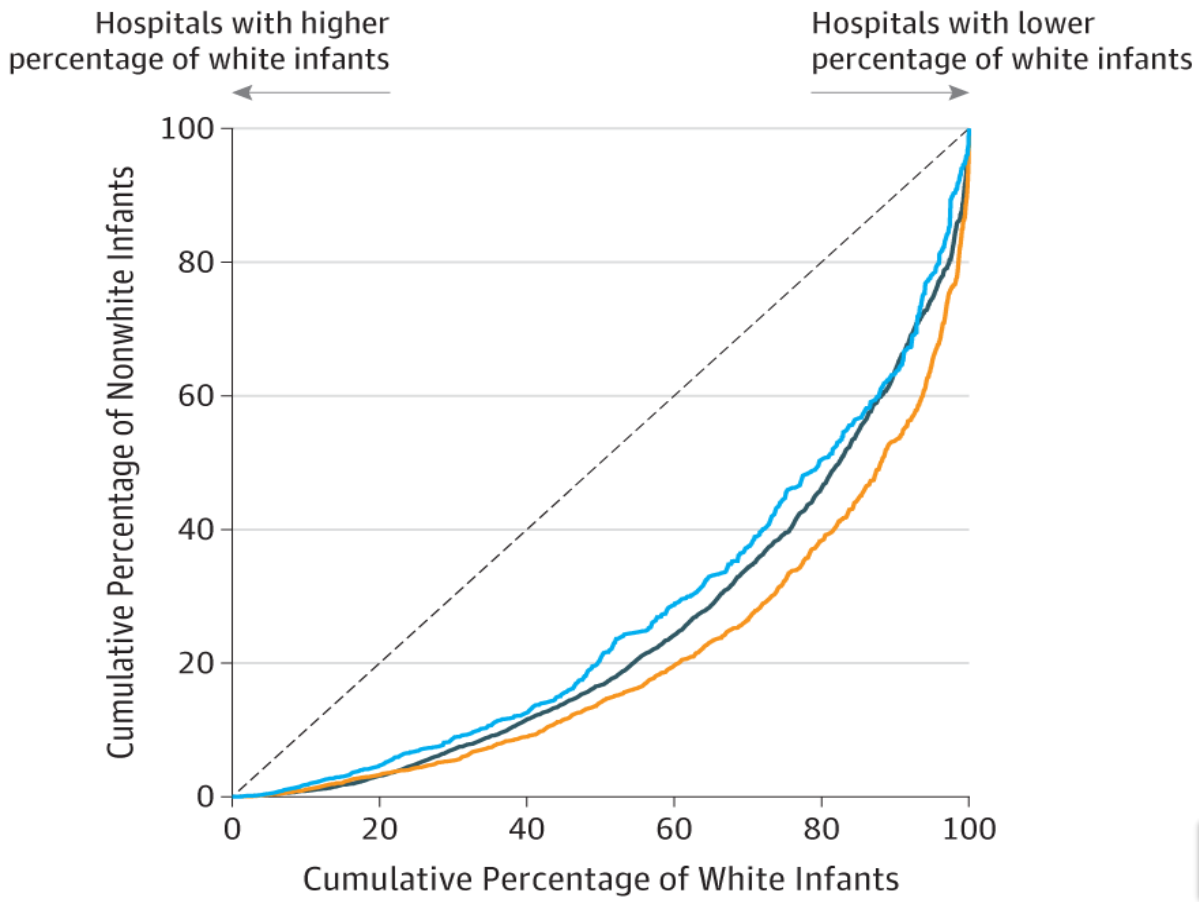
40%(95%CI, 30%-50%) of the black-white disparity and
30% (95%CI, 10%-49%) of the Hispanic-white disparity was explained by birth hospital.

Howell et al. JAMA Pedatr 2018

JAMA Network™

Racial Segregation in the NICU

	NICU Segregation Index (95% CI)
Black	0.50 (0.46-0.53)
Hispanic	0.58 (0.54-0.61)
Asian	0.45 (0.40-0.50)




Research

JAMA Pediatrics | Original Investigation

Racial Segregation and Inequality in the Neonatal Intensive Care Unit for Very Low-Birth-Weight and Very Preterm Infants

Jeffrey D. Horbar, MD; Erika M. Edwards, PhD; Lucy T. Greenberg, MS; Jochen Profit, MD; David Draper, PhD; Daniel Helkey, MS; Scott A. Lorch, MD; Henry C. Lee, MD; Ciaran S. Phibbs, PhD; Jeannette Rogowski, PhD; Jeffrey B. Gould, MD; Glenn Firebaugh, PhD

Editorial
Supplemental content

IMPORTANCE Racial and ethnic minorities receive lower-quality health care than white non-Hispanic individuals in the United States. Where minority infants receive care and the role that may play in the quality of care received is unclear.

OBJECTIVE To determine the extent of segregation and inequality of care of very low-birth-weight and very preterm infants across neonatal intensive care units (NICUs) in the United States.

DESIGN, SETTING, AND PARTICIPANTS This cohort study of 743 NICUs in the Vermont Oxford Network included 117 982 black, Hispanic, Asian, and white infants born at 401 g to 1500 g or 22 to 29 weeks' gestation from January 2014 to December 2016. Analysis began January 2018.

MAIN OUTCOMES AND MEASURES The NICU segregation index and NICU inequality index were calculated at the hospital level as the Gini coefficients associated with the Lorenz curves for black, Hispanic, and Asian infants compared with white infants, with NICUs ranked by proportion of white infants for the NICU segregation index and by composite Baby-MONITOR (Measure of Neonatal Intensive Care Outcomes Research) score for the NICU inequality index.

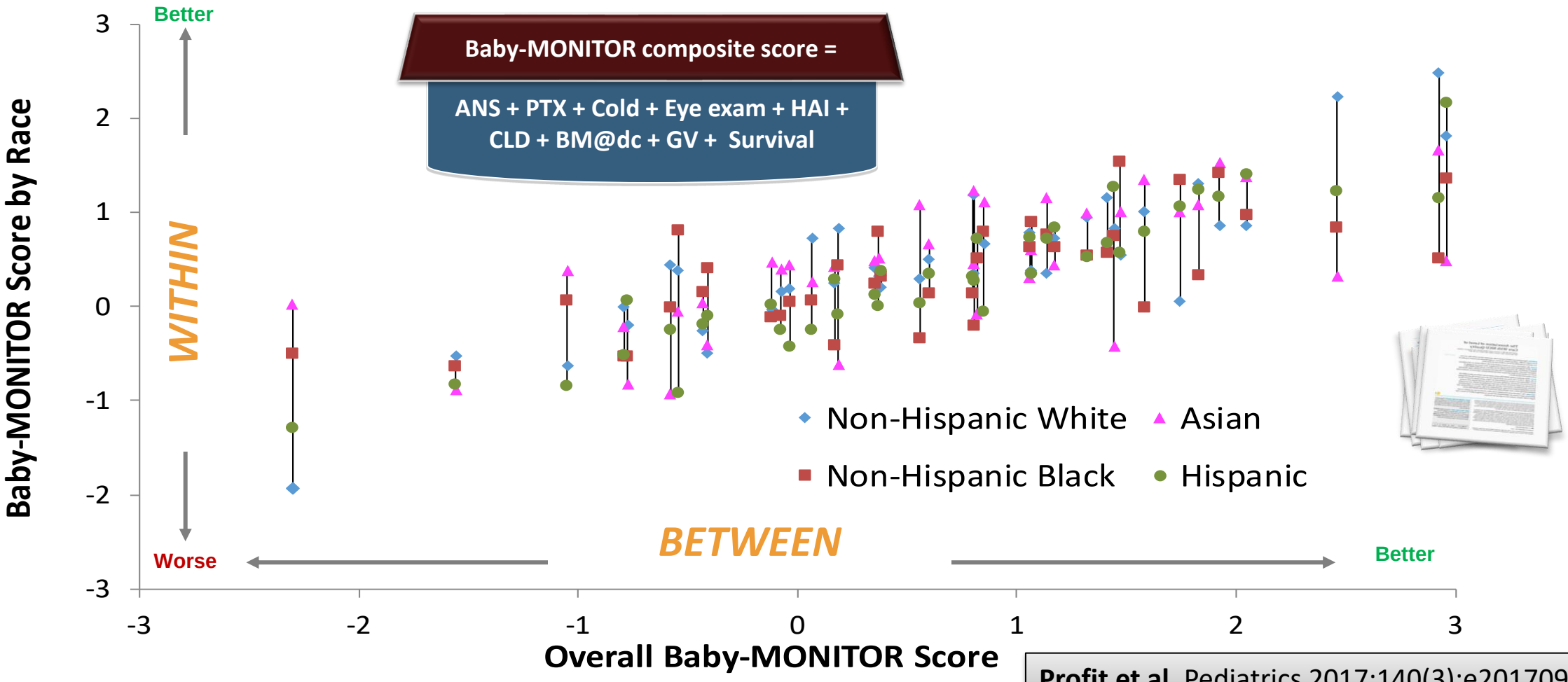
RESULTS Infants (36 359 black [31%], 21 808 Hispanic [18%], 5920 Asian [5%], and 53 895 white [46%]) were segregated among the 743 NICUs by race and ethnicity (NICU segregation index: black: 0.50 [95% CI, 0.46-0.53], Hispanic: 0.58 [95% CI, 0.54-0.61], and Asian: 0.45 [95% CI, 0.40-0.50]). Compared with white infants, black infants were concentrated at NICUs with lower-quality scores, and Hispanic and Asian infants were concentrated at NICUs with higher-quality scores (NICU inequality index: black: 0.07 [95% CI, 0.02-0.13], Hispanic: −0.10 [95% CI, −0.17 to −0.04], and Asian: −0.26 [95% CI, −0.32 to −0.19]). There was marked variation among the census regions in weighted mean NICU quality scores (range: −0.69 to 0.85). Region of residence explained the observed inequality for Hispanic infants but not for black or Asian infants.

CONCLUSIONS AND RELEVANCE Black, Hispanic, and Asian infants were segregated across NICUs, reflecting the racial segregation of minority populations in the United States. There were large differences between geographic regions in NICU quality. After accounting for these differences, compared with white infants, Asian infants [illegible] NICUs and black infants [illegible]

Lorenz Curves for Segregation by Race/Ethnicity in US NICUs ranked by the proportion of white infants from highest to lowest, and the cumulative population percentages of white and minority infants were plotted on the x- and y-axes. If all NICUs had the same racial distribution as the overall population, the curves would fall on the diagonal.

Edwards, Horbar, Profit et al. *JAMA Pediatr 2019*

Variation in Quality of Care by R/E *WITHIN* and *BETWEEN* NICUs



Profit et al. Pediatrics 2017;140(3):e20170918

Original Article

Disparities in Health Care–Associated Infections in the NICU

Jessica Liu, PhD, MPH[1,2] Charlotte Sakarovitch, P
Henry C. Lee, MD, MS[1,2] Jochen Profit, MD, MP

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Medicine, Stanford University, Stanford, California
[4]Medical Data Lab, Université Côte d'Azur, Nice, France

Am J Perinatol

Abstract

Objectives This stud
associated infection (H
race/ethnicity and its
Study Design This i
between 2011 and 2
Results Risk-adjust
units (NICUs), rang
higher odds of HA
Non-Hispanic bla
tertile of infecti
ethnicities suff
Conclusion Hispanic i
variation in infection across
with infection.

Keywords
- infant
- health care–associated infection
- disparity
- risk factors

Health care–associated infection (HAI) is a serious complication among very low birth weight (VLBW; <1,500 g) preterm infants hospitalized in the neonatal intensive care unit (NICU), and infection rates in these infants have ranged from 21 to 30%.[1–4] VLBW infants are especially susceptible to HAI. They are immune-incompetent hosts, require prolonged hospitalization, undergo frequent invasive procedures, and receive prolonged broad-spectrum antibiotics and intravenous nutrition.[1,5–7] In addition, infection risk is conveyed by a combination of maternal health and clinical practice-related factors.[1–3,5,6,8–11]

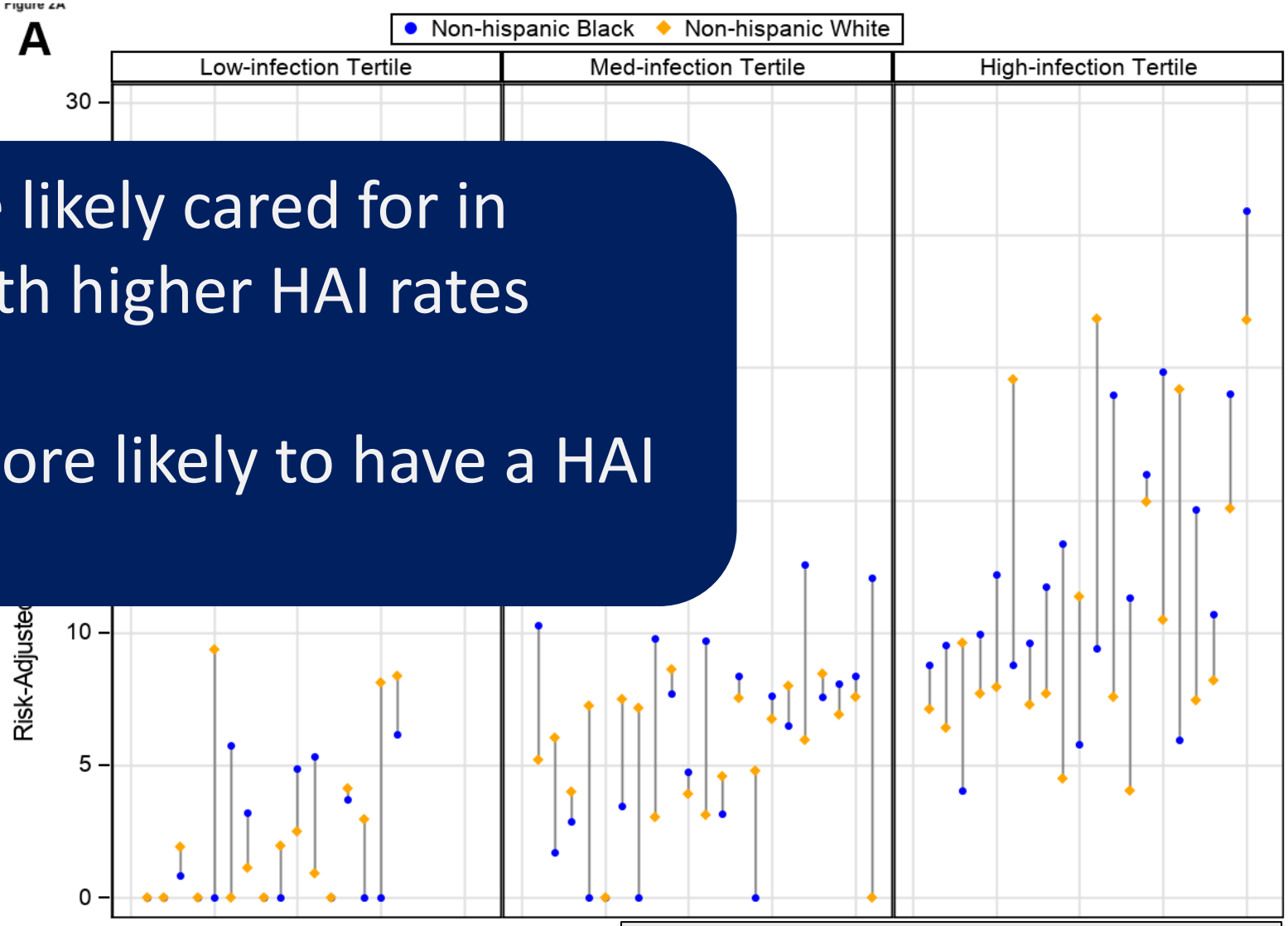
HAIs are associated with increases in neurodevelopmental impairment, mortality, length of stay, and as a result, increased financial costs of care.[3,6,12–17] Payne et al reported that the occurrence of just one single type of HAI would increase costs of treating VLBW infants by $100 million.[12] Reducing HAI has been a priority in recent years, and successful efforts have been reported from individual NICUs and through collaborative networks, such as the Vermont Oxford Network and the California Perinatal Quality Care Collaborative (CPQCC).[7,18–20]

Vulnerable populations may be differentially affected by HAI because they may receive care in challenged hospitals, which provide lower quality of care,[21–23] or differential treatment within hospitals.[24] HAI is more dependent on

[*] At the time of this research, Dr. Sakarovitch was a senior statistician at the quantitative sciences unit.

Blacks more likely cared for in hospitals with higher HAI rates

Hispanics more likely to have a HAI

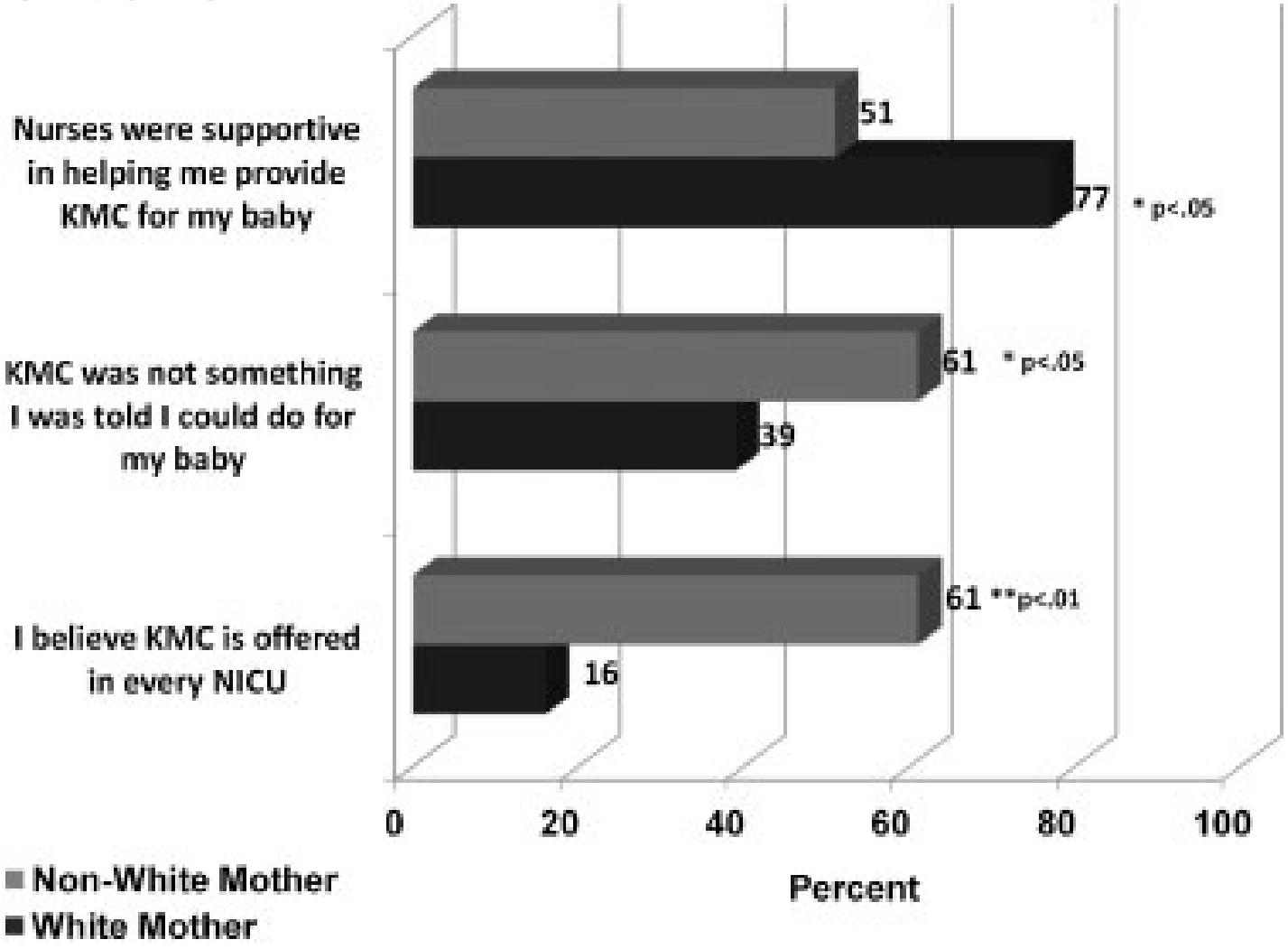


Liu, Profit, et al.
Am J Perinat 2020 Jan;37(2):166-173

Disparities within hospitals – Interpersonal racism

Access to Kangaroo Care

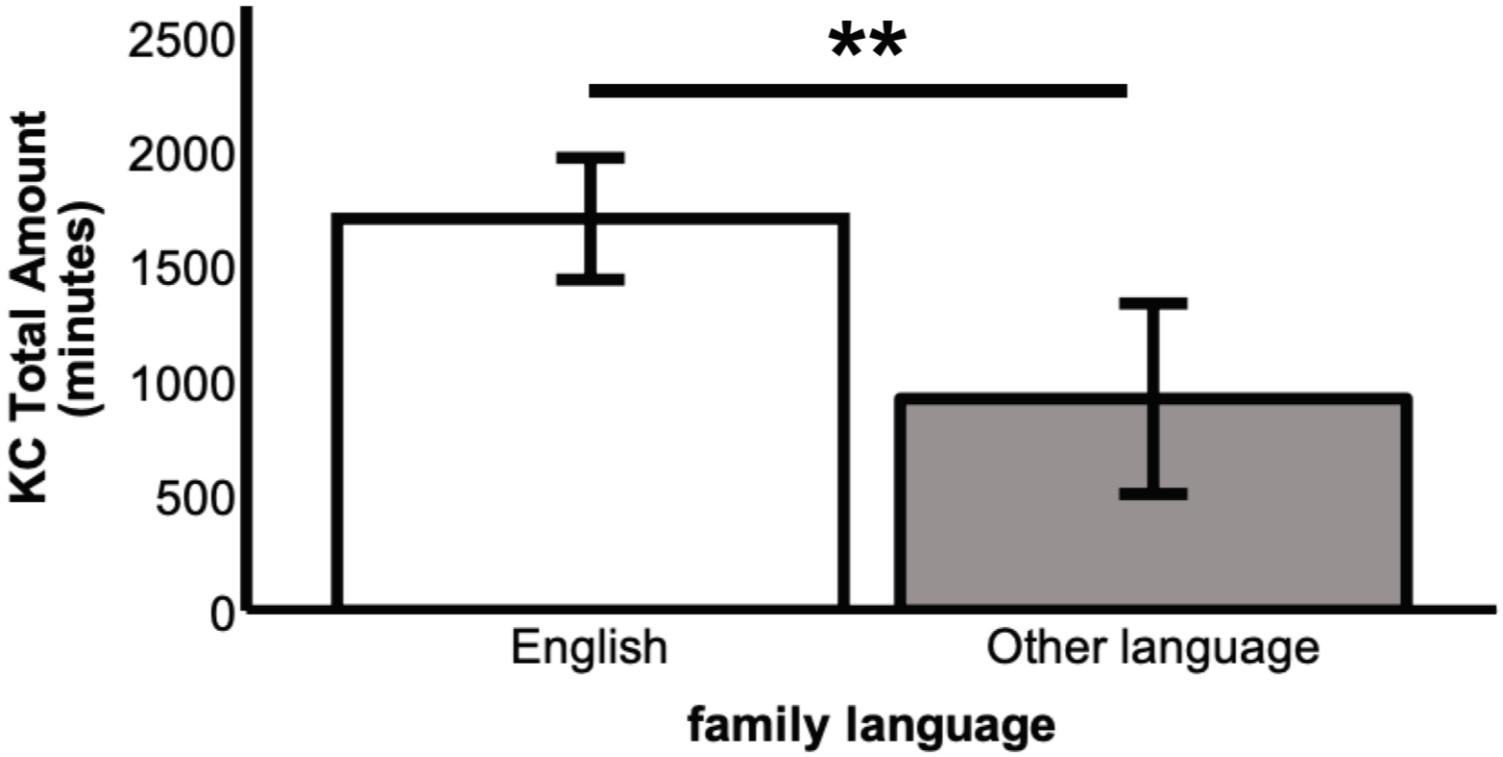
Hendricks-Muñoz et al.
Am J Perinatol 2013



Disparities within hospitals – Interpersonal racism

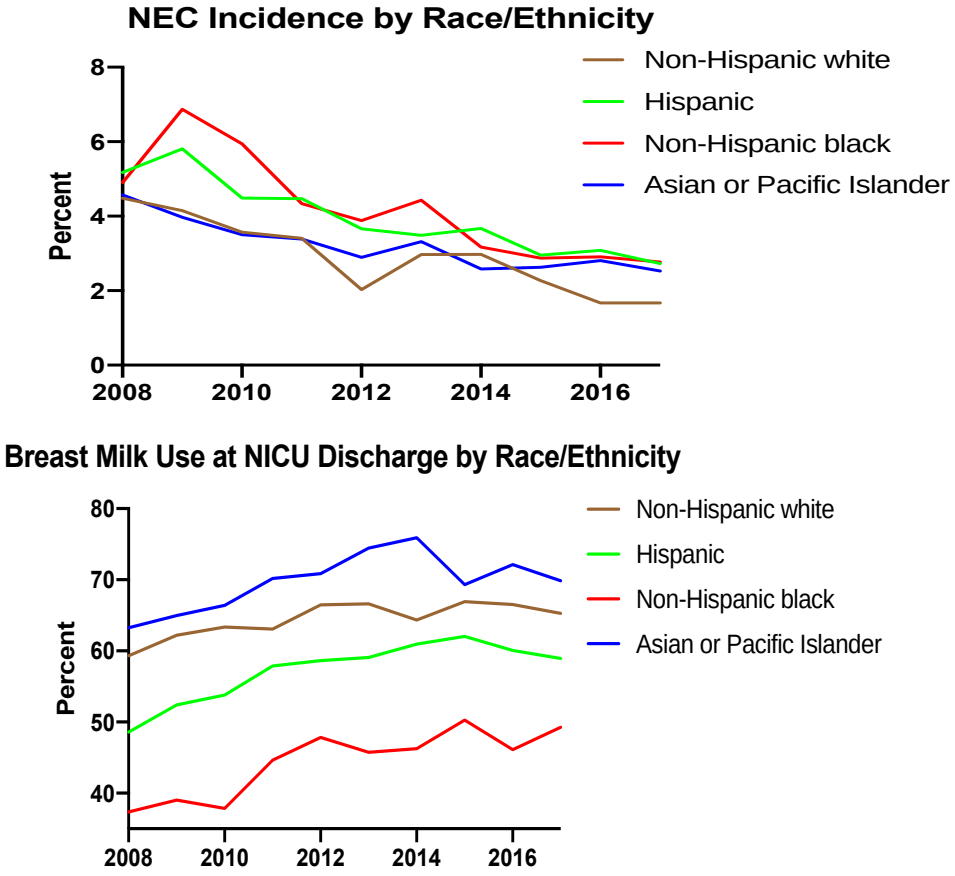
Access to Skin-to-Skin Care

Brignoni-Pérez E et al.
www.medrxiv.org/content/10.1101/2020.11.09.20224766v1

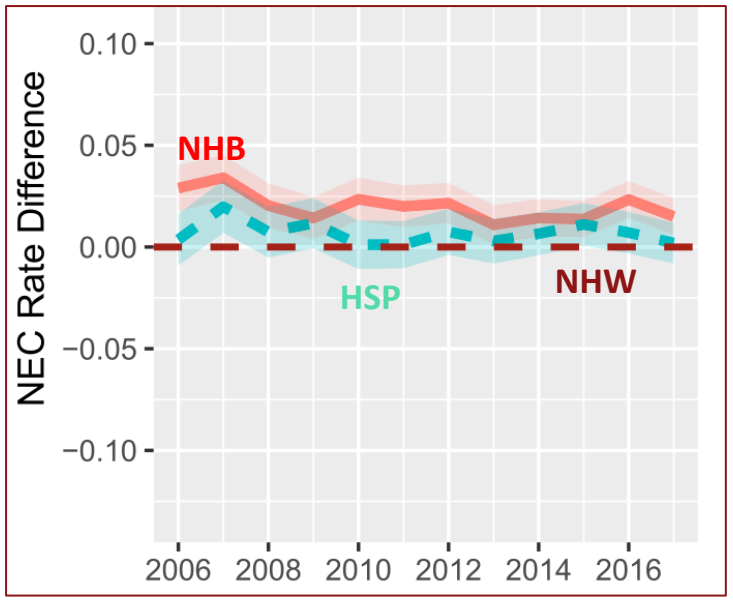


Are disparities improving?

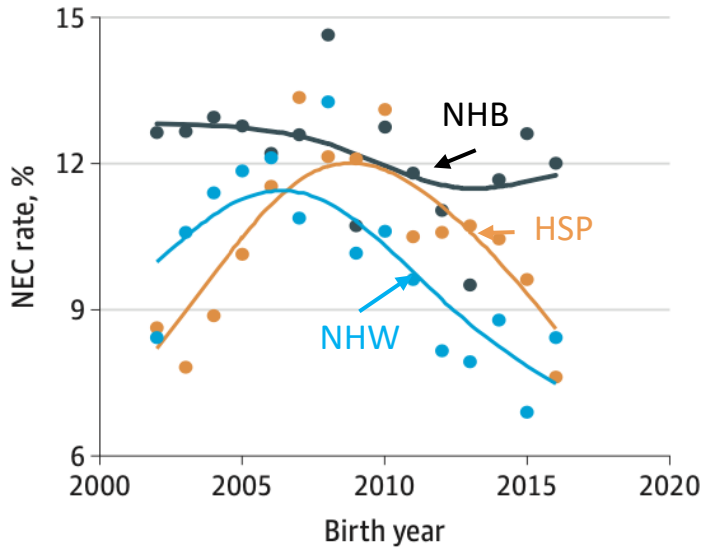
NEC



Goldstein, Profit et al.
Pediatr Res. 2020 Aug;88(Suppl 1):3-9



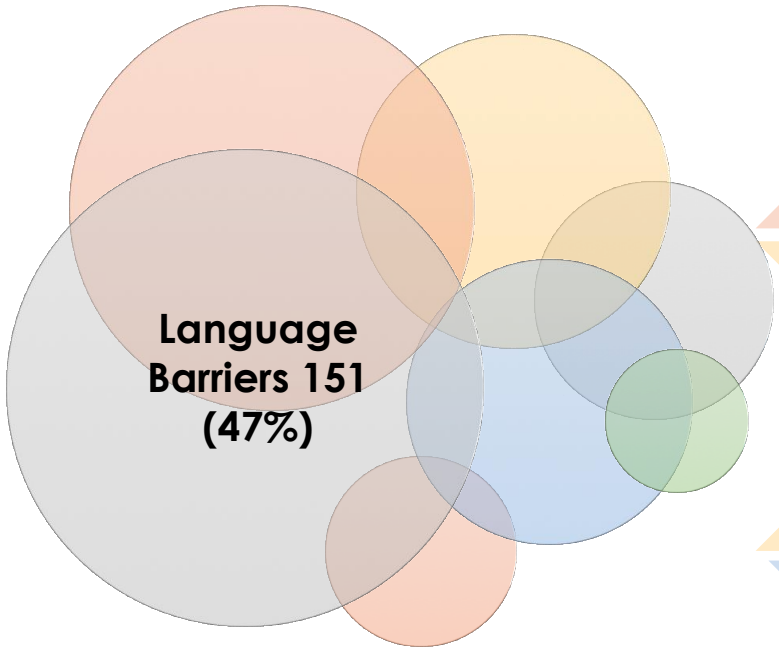
Boghossian et al.
Pediatrics. 2019;
144(3):e20191106



Travers, Profit et al.
JAMA Netw Open.
2020;3(6):e206757

But we treat all patients the same!

Overlapping Dimensions



Types of Disparate Care

Neglectful Care: 83 (26%). NICU staff ignore, avoid or neglect family needs (e.g. breastfeeding support) when considered difficult or unpleasant or when obstacles considered too great to overcome.

Judgmental Care: 82 (26%): Staff evaluate a family's moral status based on race, class or immigration. Circumstances or behaviors judged more harshly. Discrimination occurs through staff attitudes or resource allocation.

Systemic Barriers: 139 (44%): Staff unable or unwilling to address barriers families face such as transportation, child care, housing, employment, translation needs, or religious or cultural needs.

Suboptimal Care: 312 (96%)

Social, Economic or Racial Privilege: 12 (3%)

Priority Treatment and/or Assertive Families: 12 (3%). Families connected to NICU receive priority treatment. Assertive families receive more attention.

Privileged Care: 12(3%)

Sigurdson K, Profit J, et al. Disparities in NICU Quality of Care: A Qualitative Study of Family and Clinician Accounts. *J Perinatol* 2018 May;38(5):600-607

Neglectful care

Just a general observation when I worked as a charge nurse... Nurses tended just to **ignore parents who did not speak their language**. Often the use of a translator didn't occur daily for education and updates. These parents would have to **sit by their baby's bedside and wonder** how they were doing. ...these parents did not get the opportunity to interact and bond with their baby as a result.

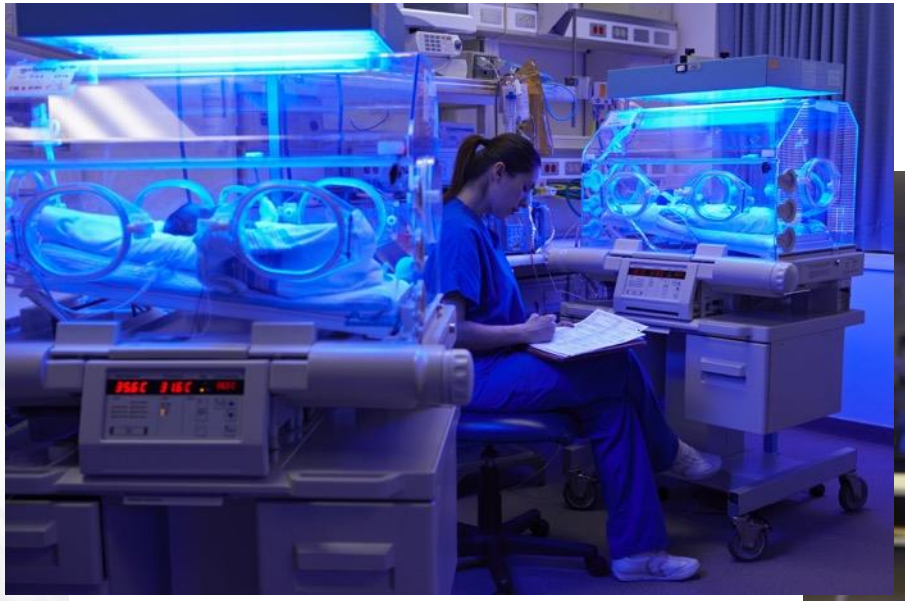
Judgmental care

I see this all the time... the way we treat black moms is definitely different than how we treat white moms. Age plays a factor too - young moms are judged very unfairly. One black mom was judged very harshly for being late for a feeding even though she had a long and challenging transit ride to get to the hospital. A white mother who was late on the same day was greeted with sympathy…

Systemic barriers to care

A hispanic 24 week baby born outside the hospital with young parents with another former 25 weeker. **Parents didn't have transportation and had irregular working conditions. Child Protective Services** was called because the medical team was concerned about **infrequent visits and infants medical needs at discharge.**

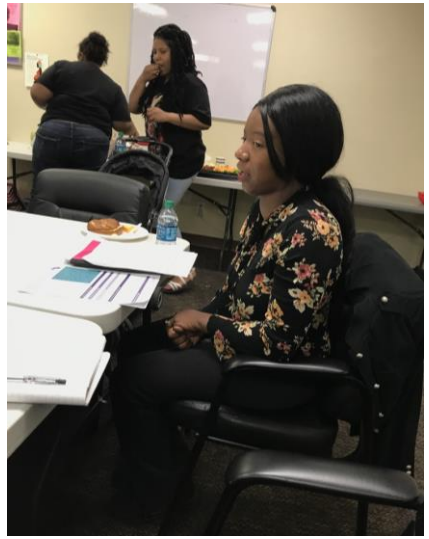
Accounts told of disparate care of families, not strictly infants



CPQCC Equity Action

1. **Audit and Feedback, Benchmarking**
    a. Development of new disparity sensitive metrics (FCC measure pilot)
    b. Equity Dashboard
2. **QI focus**
    a. Health Equity Taskforce – interpersonal racism, structural racism, care transitions
    b. Collaborative of safety net NICUs
    c. Use of disparity aim in QICs
3. **Education**
    a. CPQCC annual meeting focus on equity and anti-racism
    b. Disparity Tip Sheet
4. **Research**
    a. Various efforts and collaborations

1. Audit and Feedback
a. Measuring Family Centered Care



* Expert panel with FAMILY REPRESENTATIVES.
  Focus groups and interviews with minoritized families
* DELPHI METHOD

  Structured method for expert input without need for consensus
  Two rounds of multi-criteria ratings of measures
  SELECTION CRITERIA:
  - Median rating >=7 (scale of 1 (low) – 9 (high)
  - Pass test for agreement (80% of ratings between 7-9)
  - Pass test for disagreement (90% of ratings were between 4-9)
* OVERALL GOAL
  Develop a balanced scorecard of measures across multiple domains

Sigurdson K, Profit J, Dhurjati R, Morton C, Scala M, **Vernon L*, Randolph A*,** Phan JT, Franck LS. **Former NICU Families Describe Gaps in Family-Centered Care.** ***Qual Health Res 2020. *Former NICU moms***

Four Candidate Measures Selected – 30 NICU Pilot started 1/2021

ENGAGING FAMILIES AS PARTNERS

- Family presence at the bedside
- Family not present at the bedside
- **NICU family advisory council (✓)**

FAMILY PARTICIPATION IN HANDS-ON CARE

- **Days to first skin-to-skin care (✓)**
- Frequency of skin-to-skin care
- Days to skin-to-skin by two family members

SUPPORT FOR BREASTFEEDING

- NICU lactation consultant availability
- Time to first lactation consult
- **Time to priming with oral colostrum (✓)**

PROVIDING SERVICES AND SUPPORTS

- NICU social worker availability
- Time to social worker contact
- **Delayed social worker encounter (✓)**
- Frequency of social worker contact

COMMUNICATING WITH FAMILIES

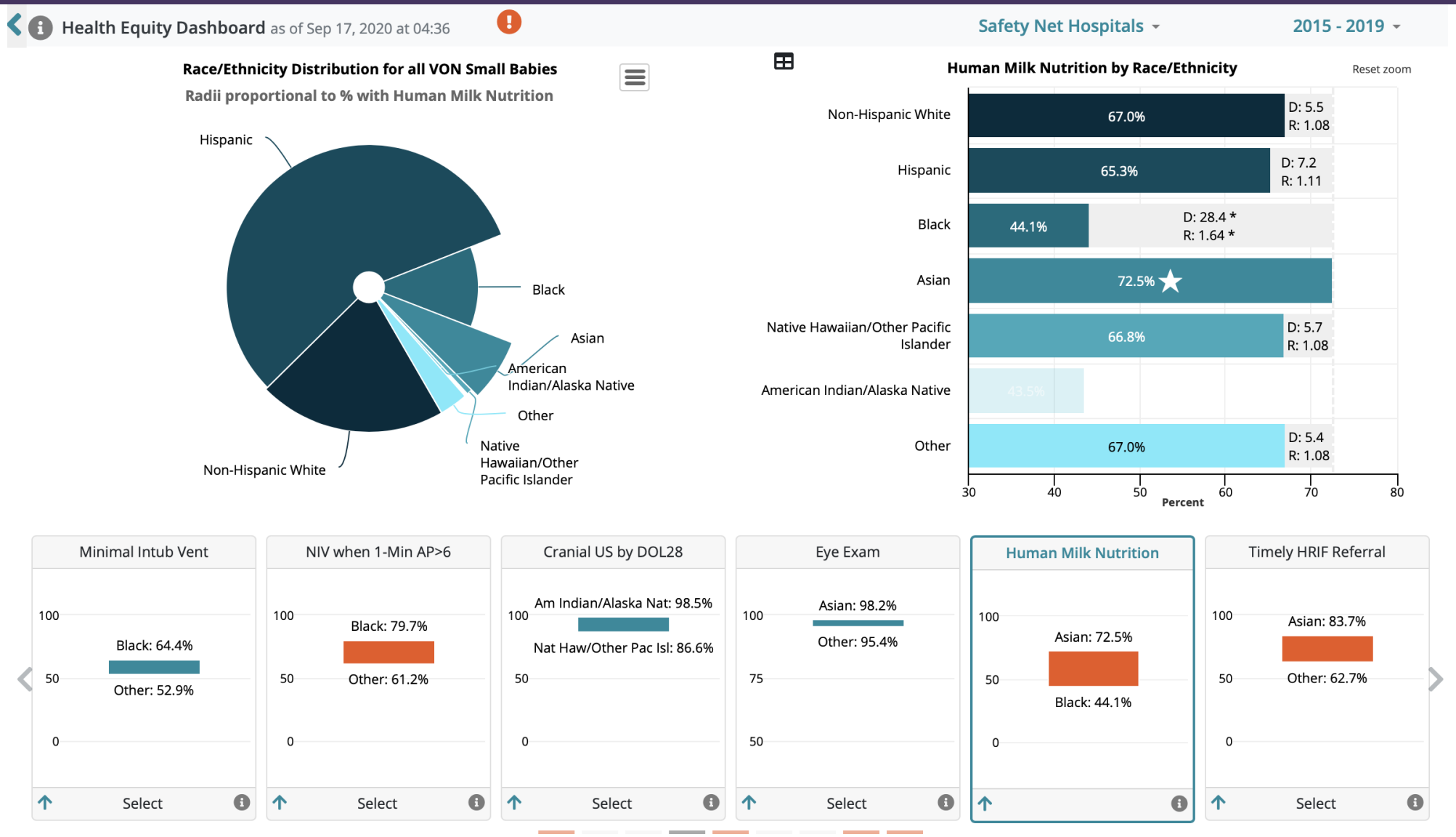
- Frequency of updates to families by MD/NNP/RN
- Frequency of updates to families with limited English proficiency by MD/NNP/RN
- Provision of interpreter services

CARE COORDINATION

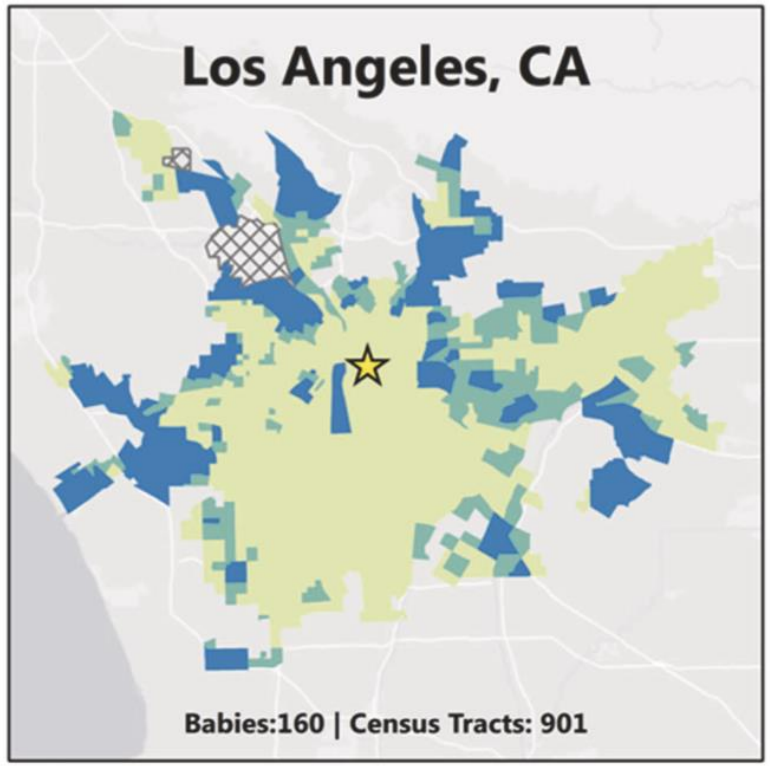
- Post-discharge care coordination*
- Continuity of care by RN*
- Continuity of care by MD*

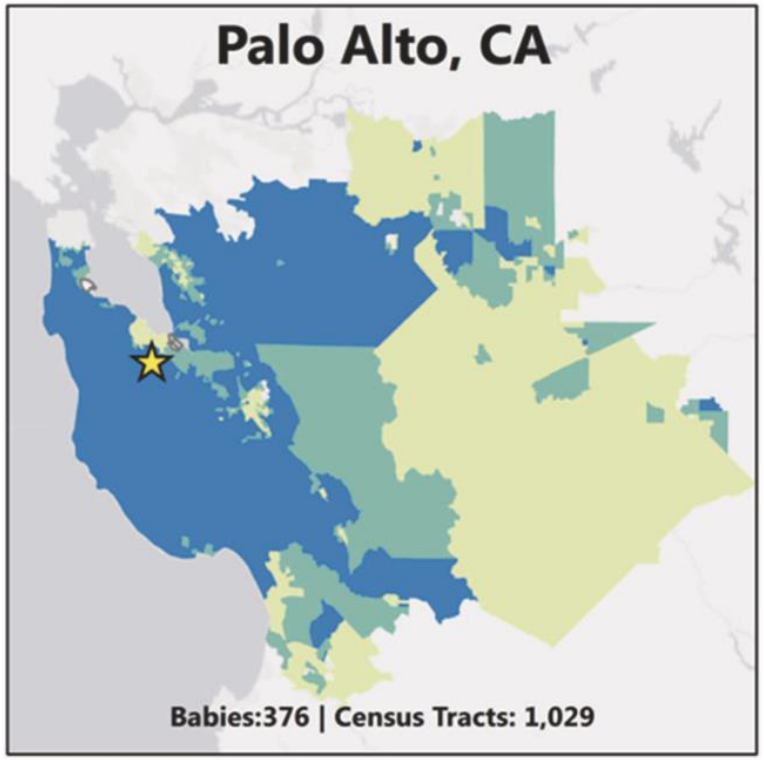
*Care coordination measures to be subjected to additional research- Not selected at this time

1b. CPQCC EQUITY DASHBOARD



NICU catchment areas





Low SES — High SES

Missing Data

2. QI - CPQCC Equity Task Force

Interpersonal and Structural Racism

OB efforts

SDH

HRIF

Transition to home

Following THROUGH

3. Education – Call to Action

Friday, March 5, 2021

2021 CPQCC Improvement Palooza

Advancing Anti-Racism in the NICU Through Teamwork and Family Centeredness

2021 CPQCC Improvement Palooza

8:00 **Opening and Welcome**
Elizabeth Rogers, MD

8:15 **Practicing Anti-Racism to Improve Outcomes for Black Infants**
Moderator: *Carmin Powell, MD*
Rachel R. Hardeman, PhD, MPH &
Tamorah Lewis, MD, PhD

9:25 **How to Build and Make the Most of Your QI Team: CPQCC Leadership**

9:55 **Break**

10:05 **NICU Partnerships: Respect, Trust & Collaboration**
Moderator: *Ashley Randolph*
Jochen Profit, MD, MPH, Necole McRae &
Jenne' Johns, MPH

11:15 **How to use the CPQCC Health Equity Dashboard to Advance Equity in Your NICU: Center Work with PQIP Ambassadors**

12:00 **Lunch (team lunch with personal reflection)**

1:00 **Access, Equity and the California Latinx Experience**
Cristina Gamboa, MD, Ashwini Lakshmanan, MD, MS,
MPH & Marina Persoglia Bell, MA

2:00 **Brave Spaces: Restoring Right Relationships**
Amber McZeal, MA, Elizabeth Rogers, MD,
Cloteal Franklin & Mark Burns

2:45 **Break**

2:55 **QUALITY IMPROVEMENT SUCCESSES FROM CPQCC MEMBERS**

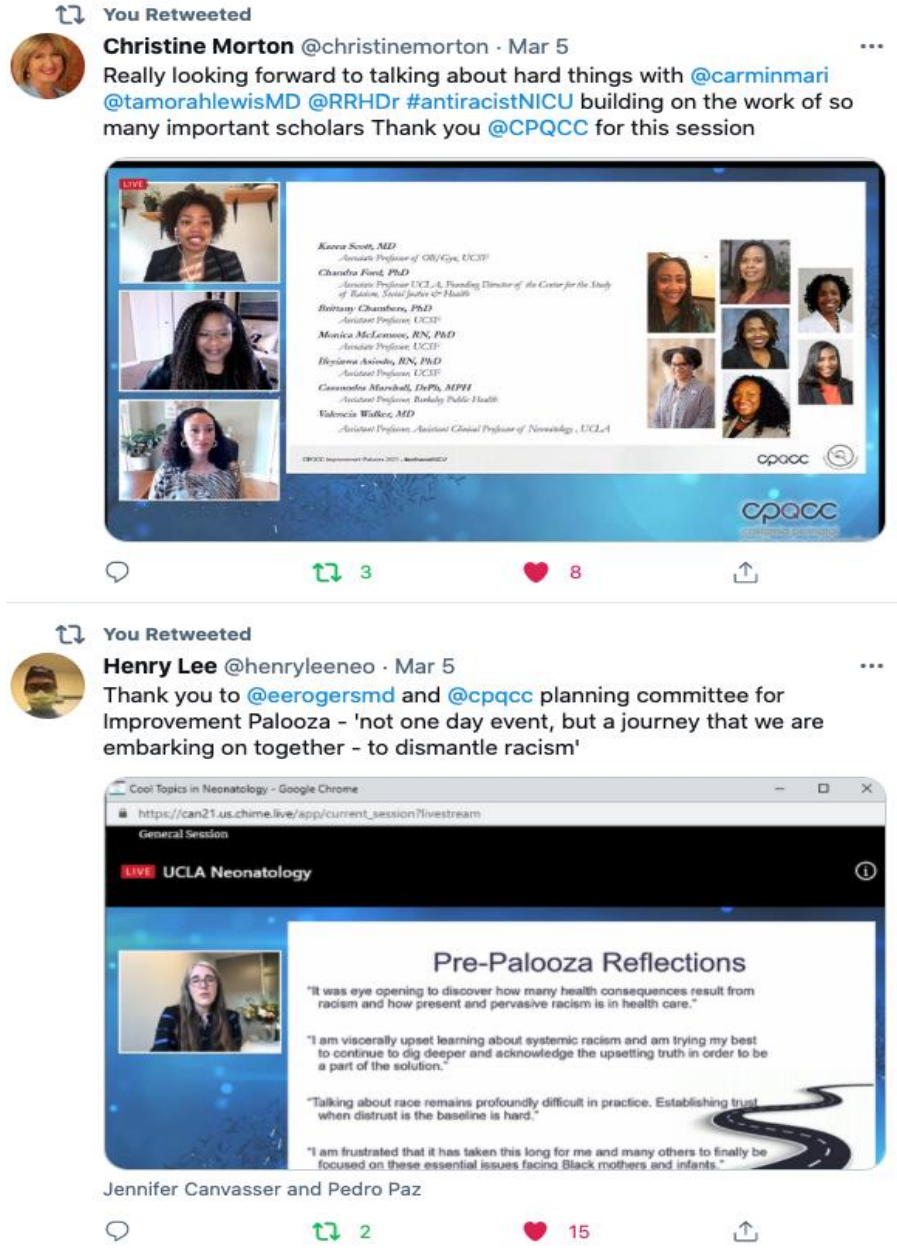
Mother And Baby Substance Exposure Initiative (MBSEI) Collaborative: UC Irvine
Pam Aron-Johnson, RN, Robin Koeppel, DNP, CNS &
Alexandra Iacob, MD

Reducing Hypothermia in ELBW Infants: Kaiser Permanente Fontana
Dilip R. Bhatt MD, FAAP, FACC, FACMQ, Rangasamy
Ramanathan, MD, Nirupa Reddy, MD, V. Reinaldo Ruiz, MD,
FACOG & Sunjeeve Weerasinghe, MSN, NNP-BC, CNS

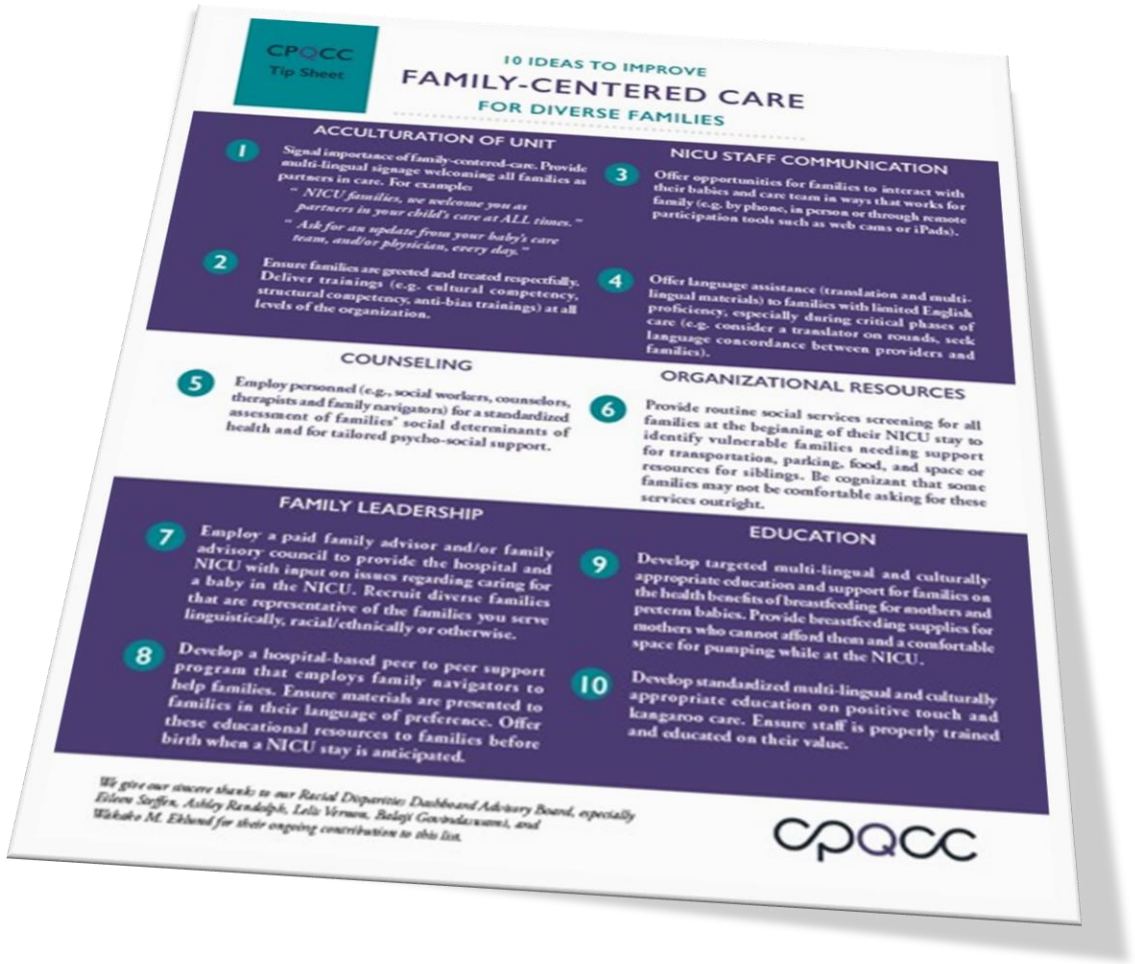
Grow, Babies, Grow: Mercy San Juan Medical Center
Laura Dennis, RD, MAS, Carolyn Getman, MD,
Sofie De Nardi, MD & Gale Schmaltz, NNP

3:50 **Closing Remarks**

4:00 **Adjourn**



3b. Education - Disparity Tip Sheet and Organizational Change Framework



CPQCC Tip Sheet

10 IDEAS TO IMPROVE
FAMILY-CENTERED CARE
FOR DIVERSE FAMILIES

ACCULTURATION OF UNIT

1. Signal importance of family-centered care. Provide multi-lingual signage welcoming all families as partners in care. For example:
   - *" NICU families, we welcome you as partners in your child's care at ALL times. "*
   - *" Ask for an update from your baby's care team, and/or physician, every day. "*
2. Ensure families are greeted and treated respectfully. Deliver trainings (e.g. cultural competency, structural competency, anti-bias trainings) at all levels of the organization.

NICU STAFF COMMUNICATION

3. Offer opportunities for families to interact with their babies and care team in ways that works for family (e.g. by phone, in person or through remote participation tools such as web cams or iPads).
4. Offer language assistance (translation and multi-lingual materials) to families with limited English proficiency, especially during critical phases of care (e.g. consider a translator on rounds, seek language concordance between providers and families).

COUNSELING

5. Employ personnel (e.g., social workers, counselors, therapists and family navigators) for a standardized assessment of families' social determinants of health and for tailored psycho-social support.

ORGANIZATIONAL RESOURCES

6. Provide routine social services screening for all families at the beginning of their NICU stay to identify vulnerable families needing support for transportation, parking, food, and space or resources for siblings. Be cognizant that some families may not be comfortable asking for these services outright.

FAMILY LEADERSHIP

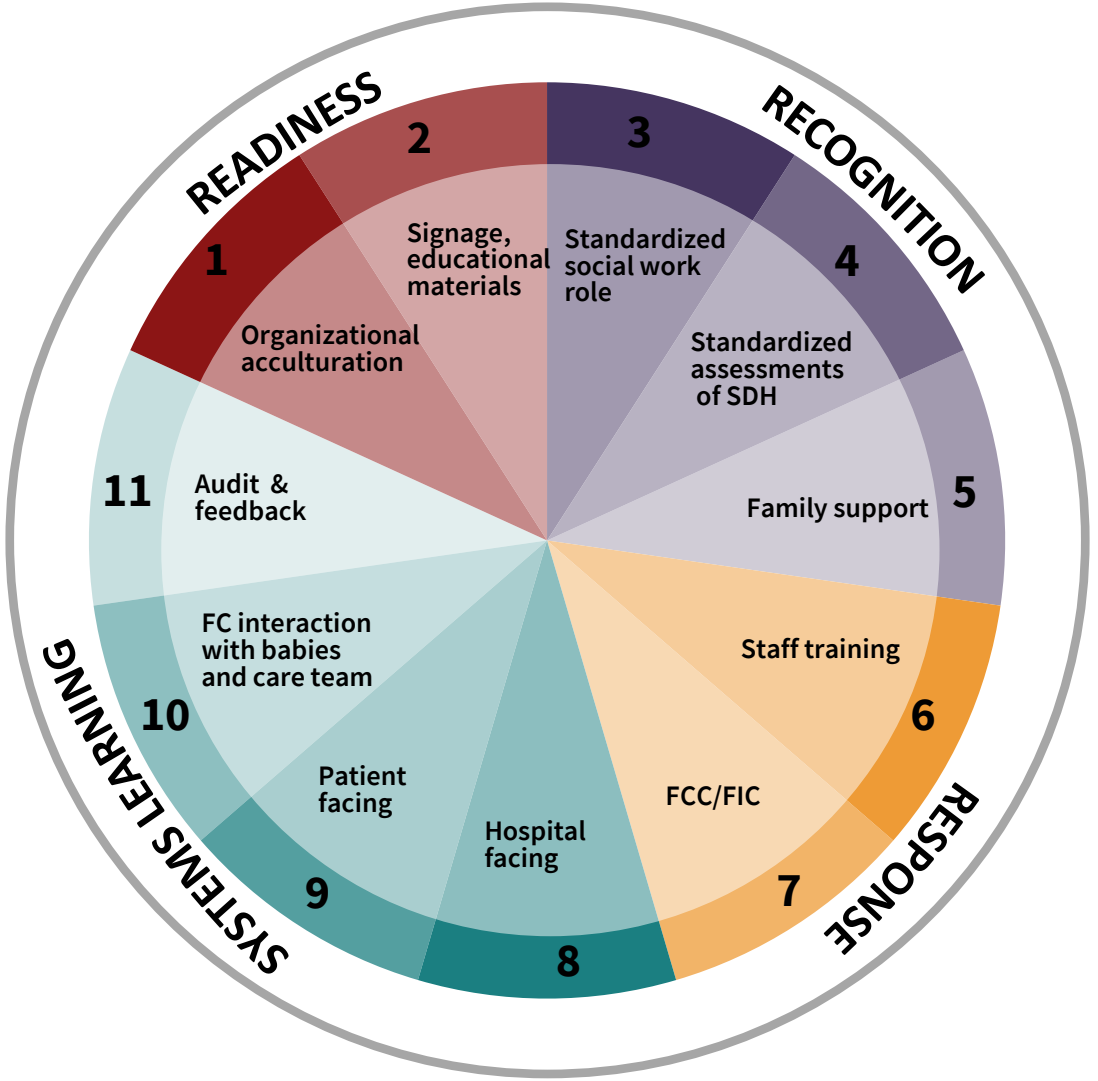
7. Employ a paid family advisor and/or family advisory council to provide the hospital and NICU with input on issues regarding caring for a baby in the NICU. Recruit diverse families that are representative of the families you serve linguistically, racial/ethnically or otherwise.
8. Develop a hospital-based peer to peer support program that employs family navigators to help families. Ensure materials are presented to families in their language of preference. Offer these educational resources to families before birth when a NICU stay is anticipated.

EDUCATION

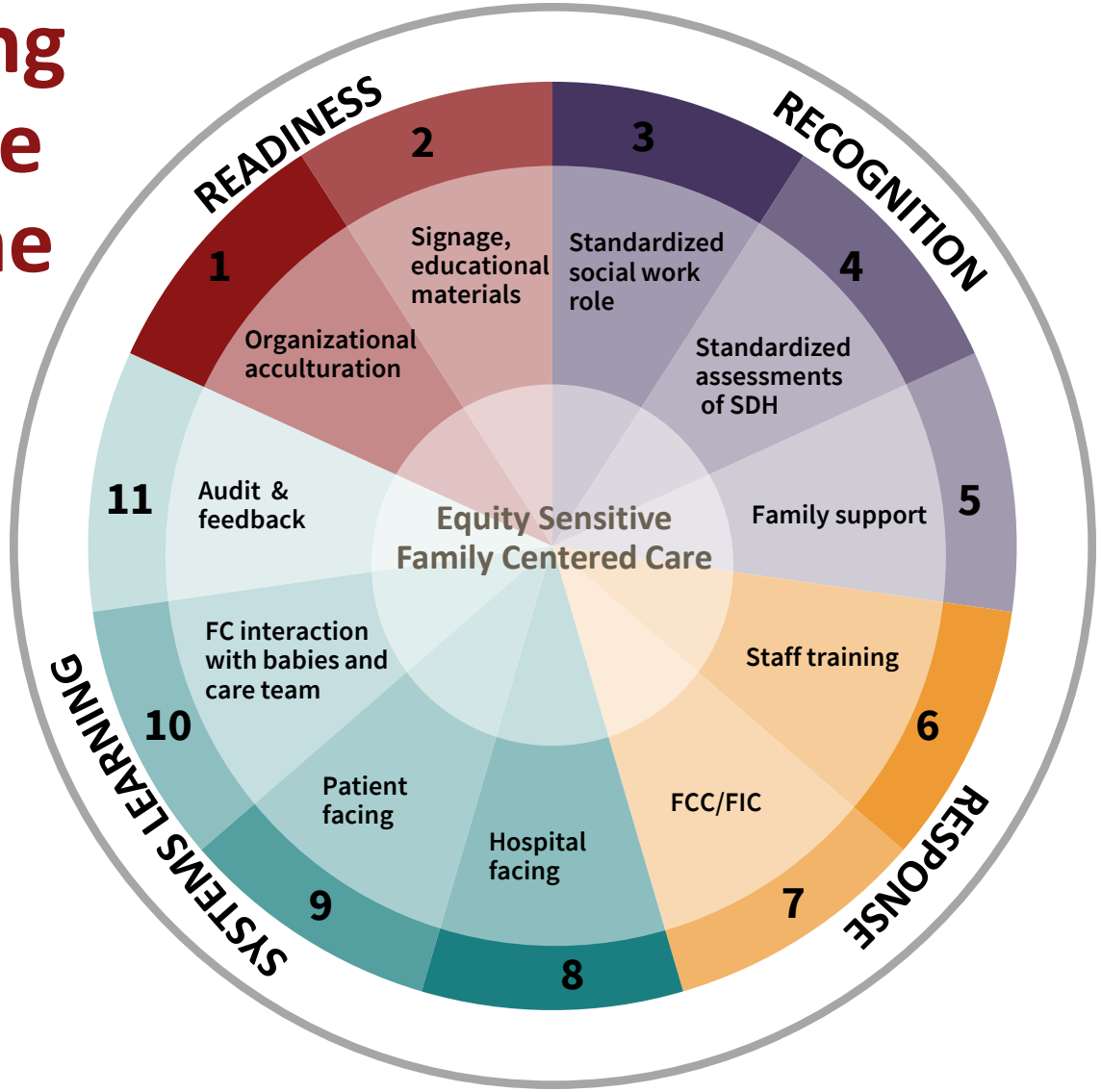
9. Develop targeted multi-lingual and culturally appropriate education and support for families on the health benefits of breastfeeding for mothers and preterm babies. Provide breastfeeding supplies for mothers who cannot afford them and a comfortable space for pumping while at the NICU.
10. Develop standardized multi-lingual and culturally appropriate education on positive touch and kangaroo care. Ensure staff is properly trained and educated on their value.

We give our sincere thanks to our Racial Disparities Dashboard Advisory Board, especially Eileen Siefkin, Ashley Randolph, Lelia Vernon, Balaji Govindaswami, and Wakako M. Ekhoud for their ongoing contribution to this list.

CPQCC



Changing what we do in the NICU



FCC or Family Integrated Care

Audit and feedback of quality measures by race/ethnicity/language and care team in person or over the phone/video

- Language concordance

Pediatric RESEARCH

PEDIATRICS PERSPECTIVES

Our Responsibility to Follow Through for NICU Infants and Their Families

Jeffrey D. Horbar, MD,[a,b] Erika M. Edwards, PhD, MPH,[a,b,c] Yolanda Ogbolu, PhD, CRNP-Neonatal, FAAN[a,d]

REVIEW ARTICLE OPEN

The color of health: how racism, segregation, and inequality affect the health and well-being of preterm infants and their families

Andrew F. Beck[1,2], Erika M. Edwards[3,4,5], Jeffrey D. Horbar[3,4], Elizabeth A. Howell[6,7,8], Marie C. McCormick[9,10,11] and DeWayne M. Pursley[9,11]

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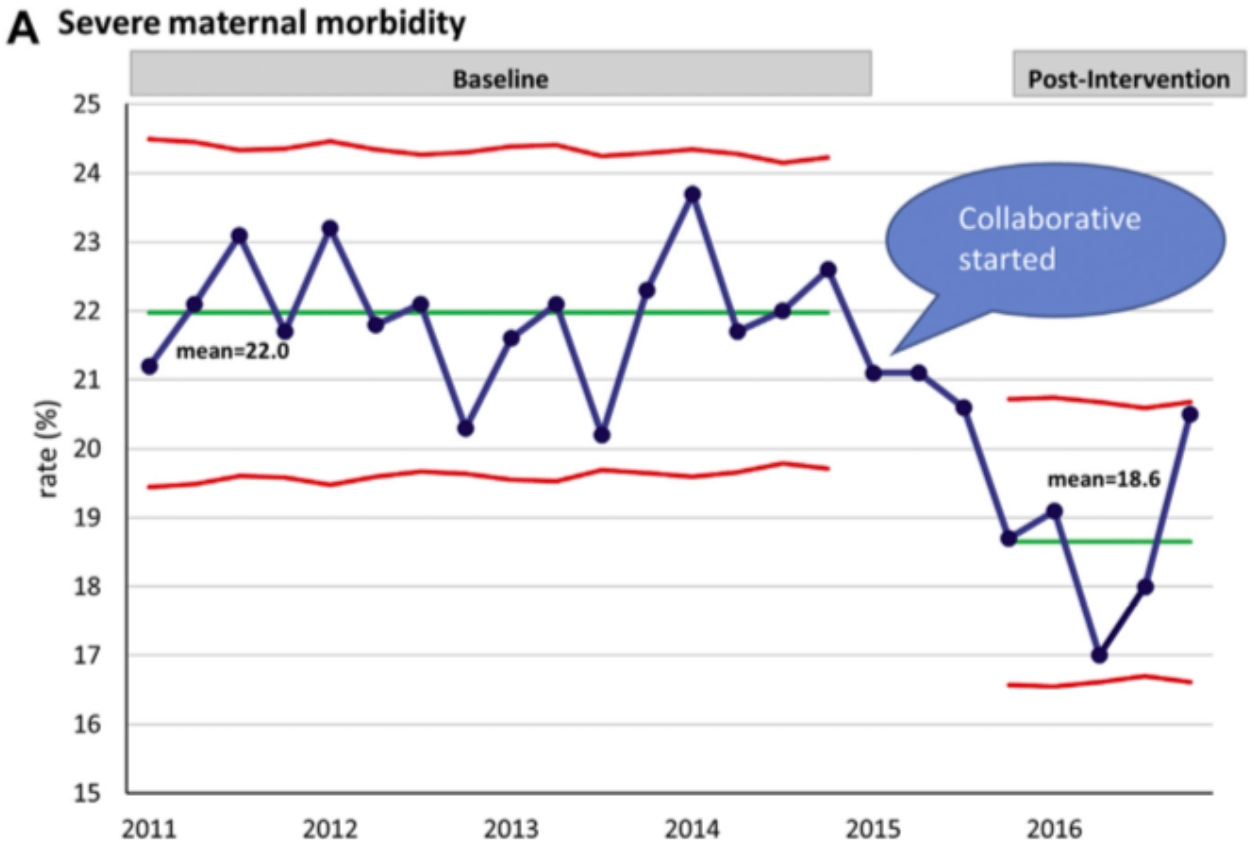
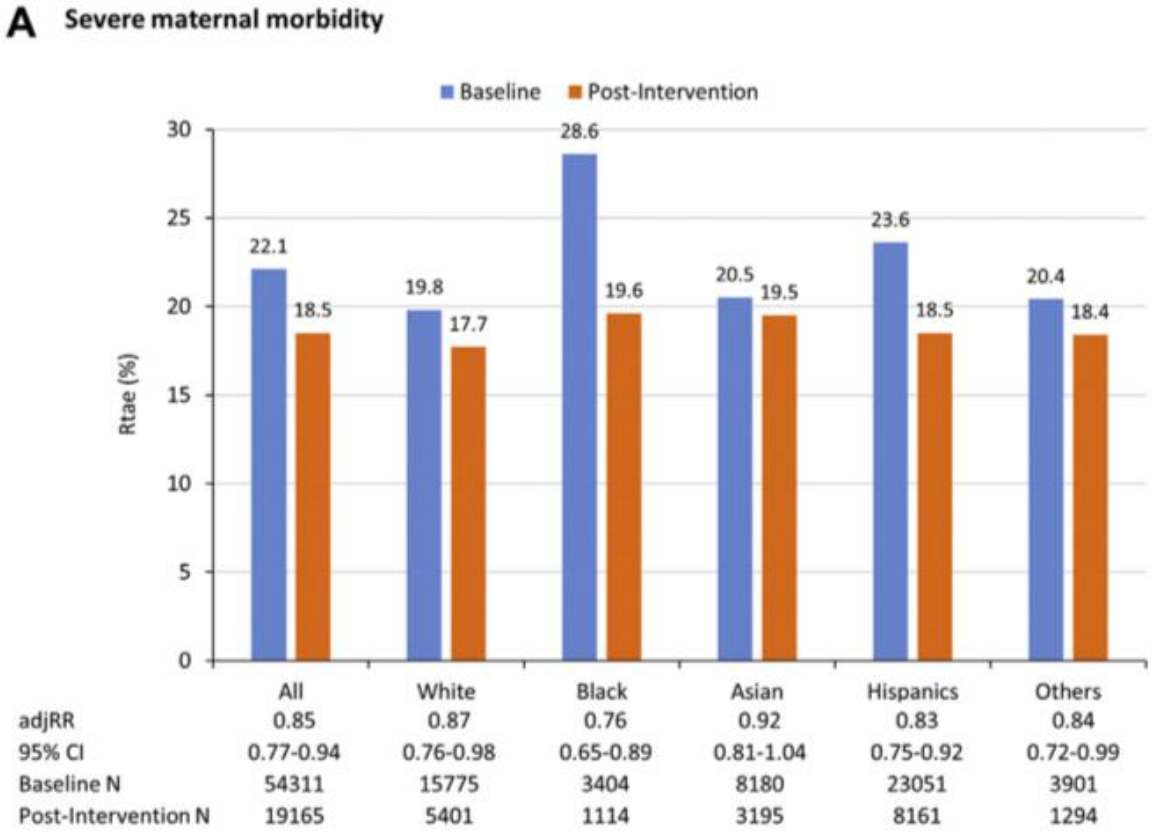
1. Identify, prevent, and mitigate social risks
2. Recognize our responsibility does not end at NICU discharge
3. Develop robust QI efforts to ensure equitable, high-quality NICU care
4. Advocate for social justice at the local, state, and national level

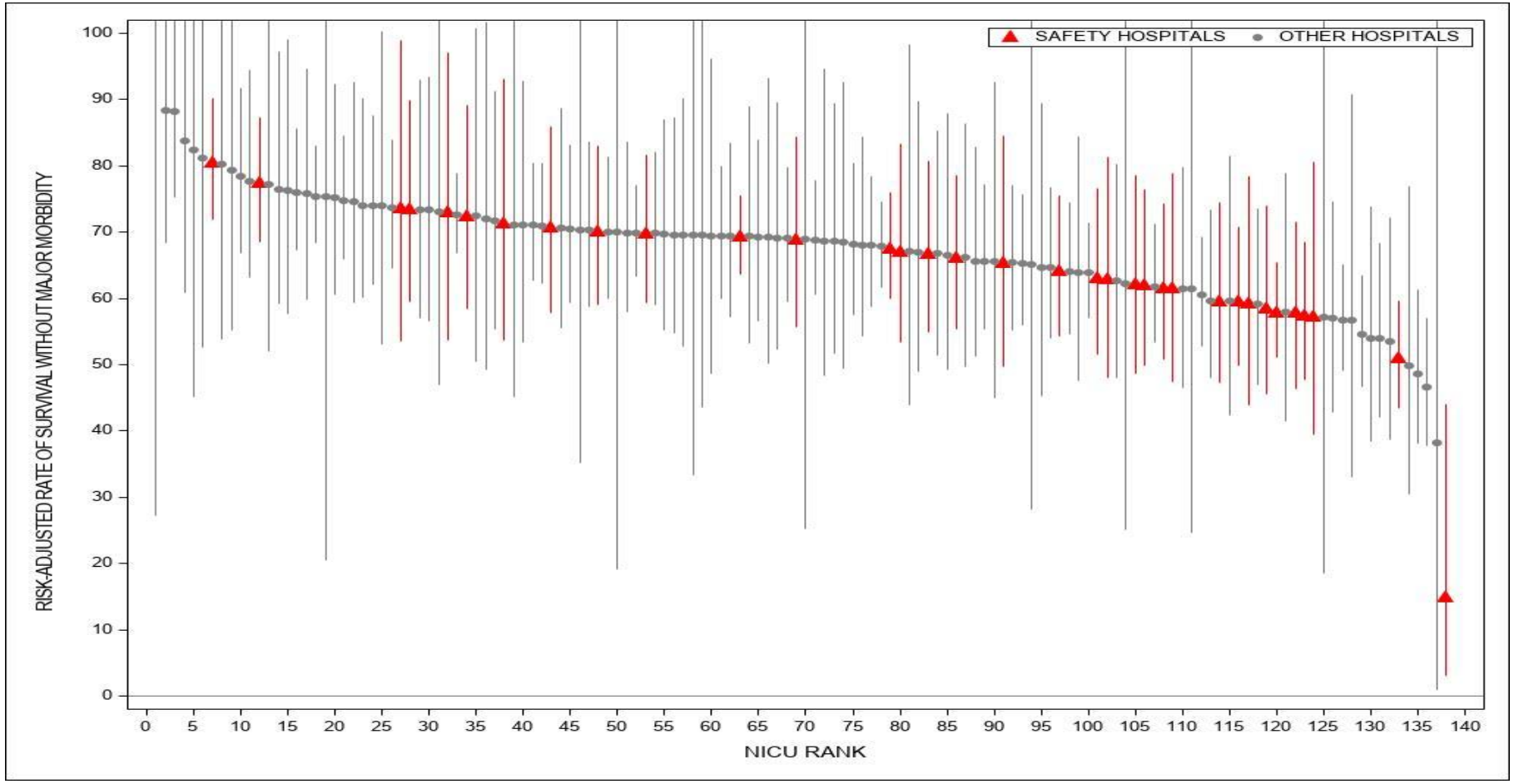
4. Research – Technical Versus Adaptive Disparity Solutions QI





Main, Profit et al. AJOG 2020

4. Research



Liu J, Pang E, Iacob A, Profit J, et al., *under review*

Summary

- **We don’t practice in a social cocoon**
- Institutional and interpersonal racism in the NICU exists and needs to be addressed
- Education is necessary but not sufficient, trust in QI methods
- Families know best
- Try Something Tomorrow!!

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@CPQCC