SEMPQIC Coalition Meeting

January 15, 2019
Review of 2018 Accomplishments and Final Report

Vern Anthony, BSN, MPH, VDA
Health Connect
#1. Healthy Baby @ Home

Goal: Increase the utilization of home visiting services by 10%

## HB@H Project Data (percentage of home visits)

<table>
<thead>
<tr>
<th>Quarter</th>
<th>Health Plans</th>
<th>Clinic</th>
<th>NICU</th>
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<tbody>
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<tr>
<td>3rd Quarter</td>
<td>51</td>
<td>65</td>
<td>15</td>
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</tbody>
</table>
Key Findings:

- Women of childbearing age have knowledge of home visiting services.
- Home visitors should be consistent (different providers are not preferred) and the same person.
- Providers should be compassionate, mindful, non-judgmental, and knowledgeable.
- Clients like bonding, learning, support shown and interaction of the social worker.
- Clients do not like frequent rescheduling, short (2-3 minute) visits, non-professionalism, and uncaring approach.
- Improvements in appointment expectations, meeting settings, family cultural practices noted
- Communication via texting and email was preferred over telephone calls or social media.
#3. SEMPQIC Coalition Meetings

**Objectives:**

- Strengthen a southeast Michigan community based perinatal system of care consistent with the State of Michigan recommendations issued in 2009 and 2013
- **Create a coordinated network for the delivery of home visiting services and other supports for mothers and babies, building on existing services and addressing social determinants of health for those who are high-risk**
- Establish operating policies, procedures, and agreements for Southeast Michigan
- Create a data repository of data elements related to birth outcomes for both mother and baby
#3. SEMPQIC Coalition Meetings

Coalition focused recommendations:

- Providing home visiting agencies space at prenatal clinic sites affords a “safe and endorsed” environment for connecting women in urban areas with home visiting services, and offers an opportunity for positive engagement of HV services with perinatal women.

- Home visiting agency staff may benefit from meeting with prenatal clinic providers to share the objectives and process of MIHP, and the benefits to women who receive services.

- Medicaid Health Plans have varying levels of membership from the high risk target zip codes and focused efforts requiring extra MHP staff effort may not benefit the objective of increasing home visiting services.

- Recognize that word of mouth is the main method of marketing home visiting and increase the accurate information widely available about the service, its benefits and its structure.
#4. Learnings related to impacts of racism on quality of care and disparities

**Recommendations for organizational policies and interventions:**

- Focus on developing and fostering open, non-judgmental communications strategies
- Create a culture of self-reflection
- Identify needed areas for training: implicit biases, communication, leadership
- Use a “trauma-informed lens” in approaching clients and patients
- Create Diversity, Equity, and Inclusion committees
- Survey staff to establish the organizational baseline understanding of health equity and how to measure progress
- Incorporate “equity zones”
- Implement progressive rounding
- Ask patients about their experience of care to determine equity in care treatment
- Incorporate health equity into required staff meetings
#5. Successful Conference on Impact of Racism on the quality of care

**Objectives:**

- Understand the impact of social determinants of health, including racism on the quality of care for women and families
- Identify quality improvement opportunities to integrate community resources or referrals into existing perinatal services in Region 10
- Learn current research and data trends related to health care disparities that impact perinatal health and promote networking for impact

**Attendance:**

- 102 conference attendees
- 72 survey responses
#5. Successful Conference on Impact of Racism on the quality of care

**Objective 1:**
- Met: 94.4%
- Not Met: 1.4%
- No Answer/Other: 4.2%

**Objective 2:**
- Met: 90.3%
- Not Met: 2.7%
- No Answer/Other: 6.9%

**Objective 3:**
- Met: 90.3%
- Not Met: 5.6%
- No Answer/Other: 4.2%
MIHEIP Update

Dawn Shanafelt, MPA, BSN, RN, MDHHS
Vision

Zero preventable deaths.

Zero health disparities.
Key Objectives

- Explicitly address disparities
- Align public and private sector work
- Integrate interventions across the maternal infant dyad
Improvement Plan Timeline

**Important dates in 2019**

- **January 2019**: Maternal Infant Health Summit
- **March 12-13, 2019**: Community of Practice Webinar
- **March 20, 2019**: Regional Implementation Summits
- **April-July 2019**: Ongoing alignment and implementation
- **Ongoing**: Plan is open for public comment
Why is the Improvement Plan needed?
Why is the Improvement Plan needed?

Maternal mortality

From 2011-2015, Michigan’s pregnancy-related mortality rate was **11.6 maternal deaths per 100,000 live births**.

In 2016, approximately 80 women in Michigan died during pregnancy, at delivery, or within a year after the end of her pregnancy.

A recent analysis by the Michigan Maternal Mortality Surveillance (MMMS) Committee determined that **44%** of pregnancy-related deaths were **preventable**.
Why is the Improvement Plan needed?

Infant mortality

In 2017, more than 760 babies in Michigan did not live to their first birthday.

Michigan’s infant mortality rate overall (6.4 infant deaths per 1,000 live births) was higher than the nation’s rate (5.9 infant deaths per 1,000 live births).

The state has not yet met the Healthy People 2020 target of 6.0 infant deaths per 1,000 live births.
Health disparities

Why is the Improvement Plan needed?

Women of color and infants born to women of color face a higher risk of dying.

Three-Year Average Infant Mortality Rate per 1,000 Live Births by Maternal Race/Ethnicity, Michigan, 2010-2017

Infant mortality is defined as a death of a baby before his or her first birthday and is expressed as a rate per 1,000 live births.

Data source: Michigan resident live birth files, and infant mortality files, Division for Vital Records and Health Statistics, MDHHS
Infant Mortality Rate: Michigan, 2000-2017
(rate per 1,000 live births)

Infant mortality is defined as a death of a baby before his or her first birthday and is expressed as a rate per 1,000 live births.

Data source: Michigan resident live birth files and infant mortality files, Division for Vital Records and Health Statistics, MDHHS
Infant Mortality Rate, Prosperity Region 10, 2000-2017
(rate per 1,000 live births)

Data source: Michigan resident live birth files and infant mortality files, Division for Vital Records and Health Statistics, MDHHS

Infant mortality is defined as a death of a baby before his or her first birthday and is expressed as a rate per 1,000 live births.
Infant Mortality Rates by Maternal Race/Ethnicity, Prosperity Region 10, 2017 (rate per 1,000 live births)

Infant mortality is defined as a death of a baby before his or her first birthday and is expressed as a rate per 1,000 live births.

Data source: Michigan resident live birth files and infant mortality files, Division for Vital Records and Health Statistics, MDHHS

2/5/2019
Infant Mortality Rate by Selected County of Residence at Birth, Prosperity Region 10, 2017 (rate per 1,000 live births)

Infant mortality is defined as a death of a baby before his or her first birthday and is expressed as a rate per 1,000 live births.

Data source: Michigan resident live birth files and infant mortality files, Division for Vital Records and Health Statistics, MDHHS

Infant Mortality Rates by County of Residence, Prosperity Region 10, 2017

- Wayne: 10.5 per 1,000 live births
- Macomb: 7.3 per 1,000 live births
- Oakland: 5.4 per 1,000 live births
Infant Mortality Rate by Selected City of Residence at Birth, Prosperity Region 10, 2017 (rate per 1,000 live births)

Data source: Michigan resident live birth files and infant mortality files, Division for Vital Records and Health Statistics, MDHHS

Selected city has more than 5 infant deaths.

Infant mortality is defined as a death of a baby before his or her first birthday and is expressed as a rate per 1,000 live births.

Infant Mortality Rates by Selected City of Residence, Prosperity Region 10, 2017

- Detroit: 14.2
- Taylor: 11.1
- Pontiac: 10.3

Infant mortality is defined as a death of a baby before his or her first birthday and is expressed as a rate per 1,000 live births. Selected city has more than 5 infant deaths.

Data source: Michigan resident live birth files and infant mortality files, Division for Vital Records and Health Statistics, MDHHS

2/5/2019
Infant Mortality Rate by Maternal Characteristics, Prosperity Region 10, 2017

Infant Mortality Rate by Maternal Age, Prosperity Region 10, 2017

Infant mortality is defined as a death of a baby before his or her first birthday and is expressed as a rate per 1,000 live births.

Data source: Michigan resident live birth files and infant mortality files, Division for Vital Records and Health Statistics, MDHHS
Infant mortality is defined as a death of a baby before his or her first birthday and is expressed as a rate per 1,000 live births.

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Data source: Michigan resident live birth files and infant mortality files, Division for Vital Records and Health Statistics, MDHHS
Infant Mortality Rate by Maternal Characteristics, Prosperity Region 10, 2017

Infant Mortality Rate by Other in Household Smoke, Prosperity Region 10, 2017

Infant mortality is defined as a death of a baby before his or her first birthday and is expressed as a rate per 1,000 live births.

Data source: Michigan resident live birth files and infant mortality files, Division for Vital Records and Health Statistics, MDHHS
Infant mortality is defined as a death of a baby before his or her first birthday and is expressed as a rate per 1,000 live births.

Data source: Michigan resident live birth files and infant mortality files, Division for Vital Records and Health Statistics, MDHHS
Preterm birth rate is defined as number of births delivered before 37 completed weeks of gestation per 100 live births. Gestational age is based on the obstetric estimate of gestation.

Data source: Michigan resident live birth files, Division for Vital Records and Health Statistics, MDHHS
Percent Low Birthweight (Birthweight <2,500 Grams), Prosperity Region 10, 2010-2017

Low birthweight rate is defined as number of births with baby birthweight < 2,500 grams per 100 live births.

Data source: Michigan resident live birth files, Division for Vital Records and Health Statistics, MDHHS
Why are moms and babies dying?

*Primary causes of death*

- Health inequities and unjust treatment
- Low birth weight and preterm birth
- Unsafe sleeping practices
- Exacerbation of pre-existing conditions and obstetric emergencies
- Unplanned pregnancies
- Onset of mental/behavioral health conditions
Strategic Focus Areas

- Reducing disparities
- Addressing the primary causes of preventable maternal deaths
- Addressing the primary causes of preventable infant deaths
Commitment to the Community

Grassroots approach

Town Hall Meetings

Ambassador Program

Voice of the Community

MOTHER INFANT HEALTH & EQUITY IMPROVEMENT PLAN
MIHEIP Ambassador Program

The MIHEIP Ambassador Program will continue to collect feedback from the community through community workshops and surveys.

To apply to be a MIHEIP Ambassador, please visit: http://www.surveymonkey.com/r/MIHEIPAmbassador

MIEHIP Town Hall Meetings

From June through September of 2018, five town hall meetings were held throughout Michigan. The primary objective of the town hall meetings was to introduce the Improvement Plan and collect feedback from the community that was integrated into the Plan.
Call to Action for Health Equity

Four action steps starting in Year 1 and moving down the road towards Year 3

2019

- Data-informed interventions
- Identification of systemic inequities
- Inclusive decision-making
- Continued Stakeholder engagement and feedback from families
Where is this work being done?
Together, Saving Lives
Together, Saving Lives

Regional Perinatal Quality Collaboratives: Implementation

RPQCs implement a quality improvement project utilizing the Population Health Model; convene diverse regional stakeholders; and authentically engage families.

Internal Alignment
Population Health and Medicaid programs align their work with the population health model, other program areas, and the RPQCs.

Internal Alignment
Bureau of Family Health Services
MDHHS Program Areas
Medicaid
Title V

Regional Perinatal Quality Collaboratives
Seven RPQCs representing eight of Michigan's prosperity regions

Regional Perinatal Quality Collaboratives
Local Public Health
FQHCs
Home visiting programs
Maternal infant health care providers
Faith-based organizations

External Alignment
Community partners that provide services to moms and babies align their work with the Improvement Plan.

External Alignment

Mother Infant Health & Equity Improvement Plan
Each RPQC will provide support and resources to clinical and community partners to implement selected interventions.

The RPQC is meant to be a cross-sector collaboration.

Implementation of interventions relies on the alignment of efforts between clinical and community services, as well as maternal and infant health sectors.
Regional Perinatal Quality Collaboratives

Backbone organization of the Improvement Plan

• There are currently eight RPQCs, representing nine of Michigan’s prosperity regions

• MDHHS is dedicated to establishing an RPQC in every region by FY2020
Population Health Model


**Measurement**
Measure outcomes to determine the impact.

**Implementation**
Clinical and community alignment of interventions using a quality improvement framework.

**Interventions**
Selection of evidence-based interventions tailored to the community's needs.

**Data-Informed**
Use qualitative and quantitative data to identify needs in each community.

**Population Identification**
Identify vulnerable populations.

**Stratification**
Tier the population into high, moderate, and low groups based on the likelihood of adverse outcomes.
Data-Informed

Use qualitative and quantitative data to identify strategic focus areas of each community.

• The MIHEIP implementation framework is data-informed
• Data will come from various places including MDHHS Vital Records, the Pregnancy Risk Assessment Monitoring System (PRAMS), local health departments, qualitative assessments, and community needs assessments
• Data meetings will be held between MDHHS and each region to report and analyze data
• Ensuring data is regularly updated will provide insight into the specific needs of each region, allow for the selection of appropriate, tailored interventions, and improve the health of the overall population
Population Identification

Identify vulnerable populations.

• Population identification is the process of systematically assessing a population for significant characteristics and needs to identify subpopulations in the member population, based on selected characteristics and needs (NCQA, 2018)

• Though the Improvement Plan will be implemented throughout the state, identifying populations that have the highest opportunity for reducing health disparities will advance health equity
Stratification

Tier identified populations into high, moderate, and low groups based on the likelihood of adverse outcomes.

- Identified populations are stratified based on the likelihood of adverse outcomes to determine which populations and interventions have the potential for the greatest impact.

- To ensure that implementation prioritizes equity, strategies will address barriers and health disparities that exist for the most vulnerable populations identified through the stratification process.

- Vulnerable populations are defined as women and infants whose risk for negative birth outcomes are complicated by multiple disparate factors (i.e. institutions, social, and economic).
Interventions

Selection of evidence-based interventions tailored to each tiered population.
Interventions

Selection of evidence-based interventions tailored to the community’s needs.

- The strategic focus areas provide a driving force for the selection of evidence-based interventions
- Communities select one to three interventions based on stratification & resources
- Interventions are tailored to meet the needs of vulnerable populations
- Home visiting as an overarching resource to implement various interventions
Key Interventions

Achieve zero preventable maternal deaths:

- Improve maternal health
  Address pre-existing conditions and increase screening and treatment for substance use disorder.

- Improve the rate of intended pregnancies
  Improve birth spacing

- Implement MI AIM Safety Bundles
  Hemorrhage and Hypertension safety bundles implemented in all birthing hospitals.
Key Interventions

Achieve zero preventable infant deaths:

- Improve the rate of intended pregnancies
  Improve birth spacing

- Safe sleep practices

- Reduce the rate of low birth weight and preterm birth with cervical screening and treatment and smoking cessation
Supporting Interventions

Additional interventions that contribute to maternal and infant vitality and reductions in disparities:

- Prenatal care
- Mental health services
- Breastfeeding
- Well child checks (including immunizations)
- Home visiting
Measurement

Quality Improvement methods to measure outcomes to determine impact.
Goals

Regional goals and statewide goals

- Short-term: Within one quarter (3 months)
- Intermediate: Within a year
- Long-term: Within three years
- Statewide: Long-term statewide goals
MOTHER INFANT HEALTH & EQUITY IMPROVEMENT PLAN

Next Steps
Call to Action

What you can do

01. Sign up for the newsletter

02. Attend the Maternal Infant Health Summit
   March 12-13, 2019

03. Attend the MIHEC
   February 21, 2019
   More information about the population health model in February

04. Connect with your RPQC
Q & A
MCH Legislative Update

Amy Zaagman, MPA, Michigan Council for Maternal and Child Health
Healthy Baby @ Home Project Update

Alethia Carr, RD, MBA & Dr. Iris Taylor, VDA Health Connect
Healthy Baby@Home

SEMPQIC
The aim of the Healthy Baby at Home (HB@H) Project was to increase the number of healthy birth outcomes and infants experiencing healthy development for the highest risk populations in Region 10 through increased utilization of quality, evidence-based home visiting services.

1. Home visiting referrals from a Medicaid Health Plan to a MIHP Agency, (examine the completeness of demographic data (e.g. telephone number, etc.)) for clients in zip codes 48221 and 48238.

2. Home visiting referral process for newly enrolled clients for prenatal care

3. Home visiting Referral process for moms whose infants were admitted to either the NICU or Special Care Nursery
The following table summarizes the percentage of home visits.

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<tr>
<th>Quarter</th>
<th>Referrals to MHPS, (Percentage)</th>
<th>1ST QUARTER</th>
<th>2ND QUARTER</th>
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<tr>
<td></td>
<td>NICU</td>
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**HB@H Project Data**
Health Baby@Home Update
2018-2019

- Continuing Home Visiting focus
  - NICU/ Special Care Nursery Hutzel Hospital
  - Discontinued focus with health plan referrals
  - Added third MIHP and a FQHC Detroit Community Health Connection

Continuing Advisory Committee Meetings to provide oversight
Q & A
Social Determinants of Health
Exercise and Discussion

Dr. Cheryl Gibson-Fountain, Beaumont Health & Immediate Past President, Michigan State Medical Society
Southeast Michigan Perinatal Care System Quality Improvement Coalition

Cheryl Gibson Fountain, MD, FACOG
Immediate Past President
Michigan State Medical Society

JANUARY 15, 2019
Cheryl Gibson Fountain, MD, FACOG, has no relevant financial relationships.
Current state

• Improving, but still a long way to go
• Need to fully close racial and ethnic disparities
• Lives of African-Americans have been and continue to be complex
• Specific demands may have changed over time, but the PRESSURE remains the same
“THEY WOULDN’T LISTEN TO ME.”
Health Disparities
A health disparity is a health difference that is closely linked with social, economic or environmental disadvantage.
Example - Flint

- Water supply switched to Flint river water in 2014
- Women and their unborn children were exposed to high levels of lead in their drinking water
- Flint saw fewer pregnancies and a higher number of fetal deaths
- Study by economist David Susky from the University of Kansas
  - Fertility rates decreased by 12% among Flint women
  - Fetal death rates increased by 58%
    - Represents 200 fewer children being born than otherwise would have been born
Chlamydia and gonorrhea
• Rates are 5.7 times and 10.6 times higher for African-American women than for white women

Human papilloma virus
• African-American women have higher rates of HPV and cervical cancer
• Mortality rates double those of white women

AIDS
• African-American women represent 65% of new AIDS diagnoses among women
Birth rates

• Although the rates for teenage African-American women (ages 15-19) have decreased by 7%, they still remain higher than those for white women

Premature births

• African-American women have the highest rates
• More likely to have infants with low or very low birth weights
• African-American infants are 2.4 times more likely as white infants to die in their first year of life
Unintended pregnancies

- African-American women experience at three times the rate of white women

Deaths

- African-American women are four times more likely to die from pregnancy-related causes than women of any other race
  - Embolism
  - Postpartum hemorrhage
  - Pregnancy-related hypertension
Requirement to Report Maternal Deaths

STATE OF MICHIGAN
98TH LEGISLATURE
REGULAR SESSION OF 2016


ENROLLED HOUSE BILL No. 4235

AN ACT to amend 1978 PA 98, entitled “An act to protect and promote the public health; to codify, revise, consolidate, classify, and add to the laws relating to public health; to provide for the prevention and control of diseases and disabilities; to provide for the classification, administration, regulation, financing, and maintenance of personal, environmental, and other health services and activities to create or continue, and prescribe the powers and duties of, departments, boards, commissions, councils, committees, task forces, and other agencies; to prescribe the powers and duties of governmental entities and officials to regulate occupations, facilities, and agencies affecting the public health; to regulate health facilities; certain organizations and insurers; to provide for the imposition of a regulatory fee; to provide for the levy of taxes against certain health facilities or agencies; to promote the efficient and economical delivery of health care services, to provide for the appropriate utilization of health care facilities and services, and to provide for the closure of hospitals or consolidation of hospitals or services; to provide for the collection and use of data and information; to provide for the transfer of property; to provide certain immunity from liability; to regulate and prohibit the sale and offering for sale of drug paraphernalia under certain circumstances; to provide for the implementation of federal law; to provide for penalties and remedies; to provide for sanctions for violations of this act and local ordinances; to provide for an appropriation and supplements; to repeal certain acts and parts of acts; to repeal certain parts of this act; and to repeal certain parts of this act on specific dates,” (MCL 333.1101 to 333.2811) by adding section 2017a.

The People of the State of Michigan enact:

Sec. 2017a. A physician or an individual in charge of a health facility who is present for or is aware of a maternal death shall submit information regarding that death at the time and in the manner specified or approved by the department for inclusion in the health information system established under section 2016. As used in this section:

(a) “Health facility” means a hospital, freestanding surgical outpatient facility, or other outpatient facility that is licensed or otherwise authorized to operate in this state under article 17.

(b) “Maternal death” means the death of a woman who was pregnant at the time of her death or within 1 year before her death.

(c) “Physician” means an individual who is licensed or otherwise authorized to engage in the practice of medicine or practice of osteopathic medicine and surgery under article 15.

Enacting section 1. This amendatory act takes effect 90 days after the date it is enacted into law.
Breast Cancer

- White women are more likely to have breast cancer
- African-American women with breast cancer are 40% more likely to die from it
- Every year, over 1,700 African-American women die of breast cancer (an average of five women per day)
- Young African-American women are diagnosed with a higher rate of triple negative breast cancer, which is aggressive and difficult to treat
- Early detection and quick diagnosis are key to eliminating this disparity
Screenings

• Not screened at the level of white women
• Not getting their mammograms
  o Only 35% of African-American lesbian and bisexual women have had a mammogram in the past two years compared to 60% of white lesbian and bisexual women
• Not going to a primary care physician as frequently as are white women
• Lack of screening and necessary medical attention
  o Diagnoses at later stages
  o More difficult to cure
HYPERTENSION

Prevalence

• More prevalent among African-American women than any other group of women
• 46% of African-American women 20 years of age and older have hypertension
• 31% of white women and 29% of Hispanic women 20 years of age and older have hypertension
Impacts on African-American women

- Develop at a younger age
- More complications
- Resultant kidney failure and dialysis
Occurrence

- Approximately four out of every ten non-Hispanic black women (43.7%) have been a victim of rape, physical violence and/or stalking by an intimate partner in their lifetime.
Frequency

• Women tend to develop Alzheimer’s more frequently than men
  
  o Hypothesis - because women live on average five to ten years longer than men, they are more likely to present with the disease
Health Status

- 82% of African-American women are either overweight or obese
- Michigan ranks within the uppermost quartile of states shouldering the highest obesity prevalence in the U.S. (2014 Gallup-Healthways Report)
Exercise avoidance

• Hair care more frequently identified as a barrier to exercise in African-American women
• Often cited as a way to overcome hairstyle challenges related to physical activity
  o In a survey of overweight African-American women (BMI ≥ 27.3), nearly half of the respondents stated that hair care issues affected when and for how long they exercised
Exercise avoidance (continued)

- Similar findings in other analyses and studies
  - Hair style management and maintenance (i.e., flat irons, perms/relaxers, frequent salon visits) are a motivating factor to avoid or limit exercise
  - Compelled to make a conscious decision to sacrifice hairstyle for the sake of physical activity or to schedule salon visits around exercise
  - 40% of African-American women have avoided exercise secondary to hair concerns
- Hair maintenance concerns (i.e., cost, time, etc.) are real and the impact on limiting exercise is a public health concern that cannot be minimized
WEIGHT/OBESITY

Nutrition

• Access barriers to healthy foods
  o High cost and poor availability in inner-city stores
  o Limited transportation

• Access facilitators
  o Giveaways
  o Sharing by family and friends
  o Convenient transportation options

Prayer and meditation
Health care policies to improve the lives of African-American women

• Access to health care coverage
• Access to preventive screenings and follow-up care
• Reasonable sick leave policies
Core Partners

American College of Nurse-Midwives (ACNM)
American College of Obstetricians and Gynecologists (ACOG)
Association of Maternal and Child Health Programs (AMCHP)
Association of State and Territorial Health Officials (ASTHO)
Association of Women’s Health, Obstetric, and Neonatal Nurses (AWHONN)
California Maternal Quality Care Collaborative (CMQCC)
Health Resources and Services Administration Maternal and Child Health Bureau (HRSA-MCHB)
Society of Maternal-Fetal Medicine (SMFM)

Associate Partners

American Association of Blood Banks (AABB)
American Association of Birth Centers (AABC)
American Academy of Family Practitioners (AAFP)
American Hospital Association (AHA)
National Governor’s Association (NGA)
Nurse Practitioners in Women’s Health (NPWH)
The Joint Commission (TJC)
Society for Obstetric Anesthesia and Perinatology (SOAP)
Voluntary Hospital Association (VHA)

Patient Advocacy Groups: Amniotic Embolus Foundation, March of Dimes, Preeclampsia Foundation
Government agencies including; Agency for Health Care Quality and Research (AHCQ), Centers for Disease Control (CDC), Centers for Medicare and Medicaid Services (CMS), Department of Defense (DOD), Indian Health Service (IHS)
Where we’ve been
Early Years following the Civil War

- AMA declined to embrace a policy of nondiscrimination
- Excluded an integrated local medical society through selective enforcement of membership standards

1870s-1960s

- AMA failed to take action against AMA-affiliated state and local medical associations that openly practiced racial exclusion in their memberships
- Such practices functionally excluded most African-American physicians from membership in the AMA
Early Decades of the 20th Century

• AMA listed African-American physicians as “colored” in its national physician directory
• AMA was slow to remove the designation in response to NMA protests

Late 1950s and 1960s

• AMA was silent in debates over the Civil Rights Act of 1964
• Put off repeated NMA requests to support efforts to amend the Hill-Burton Act’s “separate but equal” provision, which allowed construction of segregated hospital facilities with federal funds
Some Effects of This Legacy

• In 2006, African-Americans made up…
  o 12.3% of US population
  o 2.2% of physicians & medical students
  o 1.8% of AMA members
  o 5.0% of AMA committee members and section leaders

• Underrepresentation in American medicine

• Underrepresentation in organized medicine

• Ongoing segregation, and mistrust of medicine, are key drivers of disparities
Some Effects of This Legacy (continued)

• Organized medicine emerged from a society deeply divided over slavery, but largely accepting of racial inequities and theories espousing black inferiority.

• Emblematic of existing societal values and practices, medical schools, residency programs, hospital staffs, and professional societies largely excluded African-Americans.

• For >100 years, many medical societies, including the AMA, actively reinforced or passively accepted this exclusion.
Some Effects of This Legacy (continued)

• Throughout this history, vocal groups of physicians – black and white, and within and outside these associations – challenged segregation and racism.

• The AMA, and American Medicine, have suffered for lack of diversity.

• The history is still being written…
AMERICAN MEDICAL ASSOCIATION

AMA Policies on Discrimination in State and Local Societies from 1940-1964

- Many attempts to change discriminatory membership policies were rebuffed

<table>
<thead>
<tr>
<th>Policy Proposal</th>
<th>AMA Action</th>
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<tbody>
<tr>
<td>1944 – NMA members requested “associate membership” in AMA</td>
<td>Denied</td>
</tr>
<tr>
<td>1952 – Old North State Medical Society requested to be a “constituent association” of AMA</td>
<td>Denied</td>
</tr>
<tr>
<td>1963 – Exclude societies with discriminatory policies</td>
<td>Denied</td>
</tr>
</tbody>
</table>
AMERICAN MEDICAL ASSOCIATION

Reasons given for AMA Inaction

• “Progress” is being made in integrating Southern societies
• The AMA has many “Negro” members
• Many “Negro members of state medical societies…have not chosen to become members of the [AMA]”
• Membership in state/local societies “is outside the jurisdiction of the [AMA]”
Positive Steps since 1968

- 1968 – AMA expressed need to increase number of African-American physicians
- 1992 – AMA Minority Affairs Consortium created
- 1994 – Lonnie Bristow, MD, becomes first African-American AMA President
- 2004-present – minority medical student scholarships (AMA Foundation)
  - $10,000 each
  - 12 scholarships in 2008
Positive Steps since 1968 (continued)

• 2004 – Commission to End Health Care Disparities was created by NMA, NHMA, and AMA
  o Co-chaired by NMA and AMA
  o >50 health organizations are members
Positive Steps since 1968 (continued)

- Commission’s areas of focus
  - Influencing government actions to curtail disparities
  - Engaging health professionals and organizations in efforts to eliminate disparities
  - Improving the practice environment to foster effective efforts to eliminate disparities
  - Promoting collaboration between medicine and private industry on strategies to eliminate disparities
  - Increasing diversity in the health professional workforce
Where we’re going
July 30, 2008

- Ronald M. Davis, MD, (Immediate Past President of AMA) made a formal apology to the National Medical Association on behalf of the American Medical Association for their past behavior and pledged to do everything in their power to right the wrongs done by the AMA to African-American physicians and to their families and patients.
2017-2018

• Leadership of the Detroit Medical Society, Wolverine State Medical Society, and Michigan State Medical Society meet to formulate future collaborative efforts to decrease health care disparities

• Bobby Mukkamala, MD, Chair of the MSMS Board of Trustees, makes a formal apology to the Detroit Medical Society and Wolverine State Medical Society on behalf of the Michigan State Medical Society (March 28, 2018)
June 2019

• Patrice A. Harris, MD, MA, to be installed as the first African-American female President of the American Medical Association
American College of Obstetricians and Gynecologists Appointment

August 14, 2018

Cheryl Gibson, MD
Beaumont Health System
Dept. of Obstetrics and Gynecology
21400 E 11 Mile Rd
Saint Clair Shores, MI 48080
1-888

Dear Dr. Gibson,

I am pleased to confirm that you have been appointed to be a Delegate for the American College of Obstetricians and Gynecologists (ACOG) during the American Medical Association (AMA) House of Delegates (HOD) meetings. We receive many requests for this opportunity from Fellows and your extensive set of qualifications helped you stand out during the selection process. This appointment will begin with the next AMA-HOD meeting which is scheduled for November 13-17, 2018.

As a Delegate, you will be expected to attend each year the AMA’s annual and interim HOD meetings. The dates for these meetings are set many months in advance to allow scheduling of your time to avoid conflicts. If you are unable to attend a HOD meeting, it is very important that you notify Dr. Barbara Levy in advance.

While a member of the ACOG Delegation, your discussions, activities and reports are confidential and should not be discussed outside the closed Delegate meetings. One of your duties as a Delegate will be to recommend positions that ACOG should take on issues in the HOD. Please remember that you cannot speak on behalf of ACOG unless you are asked to do so by the appropriate ACOG authority. This may seem self-evident, but colleagues, media and attorneys may find out you are a volunteer member and ask you about an issue that the delegation is considering and request that you give them your opinion or advice.

Every ACOG volunteer must sign a volunteer agreement annually. By signing this agreement, you agree to abide by several ACOG policies, including the conflict of interest discreditable policy. This agreement and additional information about your role will be provided separately.

Thank you for your willingness to be part of this vital service to ACOG that has such an important impact on women’s health and our specialty. We look forward to working with you soon.

Sincerely,

Hal C. Lawrence, III, MD, FACOG
Executive Vice President and Chief Executive Officer
“The first wealth is health.”

~Ralph Waldo Emerson
“They wouldn’t listen to me.”
Thank you!
Review of 2019 Strategy

Vern Anthony, BSN, MPH, VDA Health Connect
Program Strategy

A: Convene the SEMPQIC at a minimum of 4 meetings in FY2019; ensure Coalition membership is diverse and provides representation of cross-sector community partner

B: Participate in the Regional Perinatal Learning Collaborative with Michigan State University Institute for Health Policy (MSU IHP) and Mike Hindmarsh

C: Apply health equity and the social determinants of health lens to all quality improvement projects implemented in FY2019; access current organizational policies that address the social determinants of health and explore processes for improvement

D: Mother Infant Health Improvement Plan Regional Effort to address Preterm Birth and Low Birth Weight via the strategy of evidence-based home visiting
Q & A
Upcoming Events

- **SEMPQIC Coalition Meeting Dates**
  - April 16
  - June 18
  - September 10

- **Maternal Infant Health Summit:** March 12-13 at the Kellogg Hotel and Conference Center, East Lansing

- **MI-AIHM Biennial Conference:** May 5-7 at the Ann Arbor Marriott at Eagle Crest Resort

- **MIHIP Community of Practice Webinars**
  - March 13 at 10 AM
  - June 19 at 10 AM
  - September 5 at 10 AM
  - October 23 at 10 AM
Thank you for attending!

Next meeting: April 16

www.gdahc.org/SEMPQIC