

Health Equity Column: Addressing Social Disparities in Perinatal and Neonatal Care

Jenné Johns, MPH, Margaret Parker, MD, MPH



In this month's Health Equity Column, I've interviewed Dr. Margaret Parker, Associate Professor of Pediatrics and Director of Newborn Research at Boston Medical Center. Dr. Parker offers her personal and professional experiences with supporting Black and Brown women during the prenatal and neonatal periods. She also pushes the healthcare community to place social and cultural realities of receiving

healthcare for multicultural families. As you read this column, I encourage you to reflect on your social, racial, and ethnic solutions to driving disparities down in perinatal and neonatal care within your respective institutions.

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What is your definition of health equity?

It means that everybody has the potential to reach their optimal health regardless of their social status or their social advantage.

What are your organizational priorities for addressing health and racial equity in perinatal and neonatal care?

One of my first priorities is to make sure that people recognize that social disparities in perinatal care delivery occur. It's not just that the health outcomes differ by social factors. It's that the actual care we deliver varies by these social factors. It's important for providers to understand this and acknowledge it. A key way that that needs to happen is that we need to track our health outcomes in our care and process measures about how we deliver care. These need to be tracked by social factors and that does not currently happen very much. For example, we need to be tracking our delivery methods by language and insurance status and by race and ethnicity. To me, a really important component is to make sure that we're tracking these measures and that people recognize the value of that.

Another priority is making sure that people recognize that, in order to address disparities and perinatal care delivery, we need to have both standardized and non-standardized approaches. For the standardized approaches, we need to make sure that the evidence-based practices that we know can change health outcomes are being delivered uniformly regardless of someone's social status. For example, in breastfeeding, which is an area that I do a lot in, we need to make sure that all mothers have access to the

right kinds of breast pumps that can help them maximally make milk. There are some things that really do need to be standardized across different social strata, which are currently not. I think the second tier of that is that there do have to be non-standardized, culturally appropriate, and tailored approaches to socially disadvantaged groups. I'll again use the breastfeeding example. Not only do women that are of low-income need to have the same kind of breast pump as someone who is of high income, but they may also need additional support with child care, food, and transportation. They might need a more tailored approach that fits the cultural needs of that group. I think that that's another really important factor for addressing social disparities in perinatal care delivery. Number one is acknowledgment, and number two is that to address it, we have to acknowledge we need both standardized approaches that occur equally among groups and non-standardized, culturally tailored approaches.

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Third is the importance of recognizing the implicit and explicit biases that occur within the healthcare system. We are increasingly having studies showing this, and it has been great to see that an increasing amount of people are embracing this topic and acknowledging that it's true. I think that to address this. There are a few things that have to happen. One is leadership buy-in and modeling behaviors by our leaders that this is true and apparent and addressing it openly. I think the second is really trying to bring family voices to the table when we're making decisions about our

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improvement processes. That is so crucial, and it's so basic, yet it's so hard for people to do. It just doesn't happen that much, and that's an area we really need to change.

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What personal and professional experiences led you to focus on health equity in perinatal and neonatal care?

From a personal perspective, I've always been very drawn to socially disadvantaged populations. This is probably stemming from my mom, who was a school principal and then the head of special education in low-income school districts in the East Bay in California, where I grew up. I heard a lot of stories from her growing up. My dad traveled internationally, so I had some experiences very young visiting countries with significant amounts of poverty. I think the combo of those two things made me very focused on the importance of improving experiences for this population and the social justice aspects of it. I think I always had some interest there. I went to med school in the Bronx, and then I was a resident at Oakland Children's, so those experiences also just made me very aware of the adverse social determinants of health that impacted the way that health outcomes occurred in these populations.

In terms of neonatology, I remember that as a resident at Oakland Children's, I was doing my NICU rotation, and I kept seeing all these black women with preeclampsia giving birth to growth-restricted babies. These mothers also had obesity, and I learned that because of the mothers' conditions at birth and what they experienced during pregnancy, that these kids have all these adverse health trajectories in their future. I found this really unfair, and I was also so drawn to this time period. I learned how all the things that happen during pregnancy and in the NICU have such important consequences for future life. I became very drawn to this time period and was intrigued by the Developmental Origins of Health and Disease Hypothesis, more broadly. Those experiences together solidified my choice to go into neonatology because I felt like this was such an opportune time to potentially change the life trajectory for these babies.

What is your call to action for the industry as we seek to eliminate health and racial inequities in perinatal and neonatal care?

First and foremost, we have to be tracking our outcome and process measures by social factors. It's currently not done very much, and if it is done, it's done by race and ethnicity only. But that is just a social construct and only hits the tip of the iceberg. Embedded under racial and ethnic disparities are so many other

social factors. We need to have metrics that track these things, so we know how to improve.

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The second call to action is making a very concerted effort when we do develop improvements and interventions that we ensure that in the appropriate circumstances that equal distribution of these interventions are occurring. When there is a need to provide a culturally tailored approach, we must ensure that happens, that that's acknowledged, and that there's prospective planning for that.

Lastly is the call for action for us to recognize and address implicit bias in our interactions with families in the NICU from a leadership level and making sure that the family voices are coming to the table with decision making about improvement. This means including non-English speaking families, for example, and going farther than the ways we currently do things. We also really need to improve the pipeline of healthcare providers that are underrepresented minorities themselves because that shared experience and background that patients feel when they see that their providers look like them is so critical and gives them so much more trust in the system.

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Final Remarks

These issues aren't new. This has been going on for decades and decades, and many of them are rooted in historical events in the US, and there are lots of political groups in this as well. I continue to be inspired by the work people are doing and the change that I do see, and I think it's an uphill battle that we have to all go in on together. I encourage people to keep up the hard work. I am constantly inspired by my colleagues across the US and in my own local environment and I just hope that folks feel

like they can make a difference, because they can. Every single interaction you have with somebody is important. We're not going to change things overnight, and this has been an ongoing long stretch. People should just remember that every little interaction and step that we have to move forward is really important on this long trajectory of work that we have ahead.

I've seen more enthusiasm in the perinatal space for health equity and care delivery in the last one to two years after COVID and George Floyd's death than I've ever seen in my career, even though I've been doing this for a long time. That is really exciting for me to see and I'm very enthusiastic for what the future is going to bring. Obviously it will be hard but I hope that this momentum continues.

Disclosure: The authors have no disclosures.

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Jenné Johns, MPH is President of Once Upon A Premie, Founder of Once Upon A Premie Academy, mother of a micropreemie, author, speaker, advocate, and national senior health equity leader. Once Upon A Premie is a non-profit organization with a two-part mission: 1.) to donate Once Upon A Premie books to NICU families in under resourced communities, and 2.) lead virtual health and racial ethnic training programs and solutions to the neonatal and perinatal community through the Once Upon A Premie Academy. Jenné provides speaking, strategic planning and consultation services for fortune 500 companies focused on preemie parent needs from a cultural lens and reading as a tool for growth, development, and bonding. Jenné is also a national senior health equity thought leader and has led solutions-oriented health equity and quality improvement portfolios for the nations' largest health insurance and managed care companies.

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Bio: Dr. Parker is an Associate Professor of Pediatrics and Director of Newborn Research at Boston Medical Center (BMC), Boston University School of Medicine. Dr. Parker is a neonatal health services researcher and holds several federal and foundation grants in social disparities in preterm birth outcomes; she has a particular interest in safe sleep and breastfeeding. Dr. Parker is also an expert in multi-site implementation science and is the Co-Chair of the Neonatal Quality Improvement Collaborative of Massachusetts and an Improvement Advisor from the Institute of Healthcare Improvement. She has led multi-site NICU quality improvements focused on breastfeeding and family engagement. Dr. Parker applies a health equity lens to her local and multi-site quality improvement projects and is a member of the American Academy of Pediatrics Committee of Fetus and Newborn.