

The Pandemic Has Increased Demand for Data and Accountability to Decrease Maternal Health Inequity

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The United States is facing a maternal mortality crisis¹ that has been particularly acute for women² of color. Black and indigenous women are two to three times more likely to experience worse maternal health outcomes than white women.³ Increasingly, structural racism is recognized as a key driver of maternal health inequities.⁴ This extends to systems and organizations that provide perinatal care⁵ and wraparound health and social services for pregnant and postpartum women with low incomes,⁶ many of whom are at highest risk of poor maternal health outcomes. These services and supports are funded through a patchwork of public and private sources that are often stretched thin, leaving critical gaps that perpetuate maternal health inequities. And the COVID-19 pandemic has put even more strain on these resources and exacerbated those inequities.

In this brief, part of a larger series on COVID-19 and maternal health equity, we draw on interviews with maternal care stakeholders and available literature and reports (Box 1) to assess if and how our current data systems provide the information needed to track inequities in maternal health outcomes, as well as what data collection efforts must be prioritized to establish accountability and reduce inequities. Our key findings are as follows:

- › Mothers and infants are facing changes in their health care delivery during the pandemic, such as greater reliance on telehealth, greater discontinuities in care during the prenatal period, and shifting birthing and infant separation practices. For Black, Hispanic/Latinx, and American Indian mothers, these changes are compounded by the economic fallout's disproportionate effects on their communities.
- › Existing data systems cannot support maternal health equity. Payers, providers, health departments, and communities lack data on maternal health outcomes and patient satisfaction disaggregated by race and ethnicity. Therefore, they cannot assess whether changes in practices are improving or worsening maternal and infant health outcomes and/or mitigating the spread of the virus, and whether these answers differ by race, ethnicity, and other characteristics. This information is critical for communities and providers identifying policies that can reduce and ultimately eliminate racial and ethnic inequities while mitigating virus spread.
- › Data collection efforts that support improved maternal health equity will require that payers and providers track multiple dimensions of health care practice and policy, including staffing and reimbursement policies and mothers' access to high-quality, culturally effective, respectful, and affordable prenatal and birthing care.

- For data-sharing platforms to improve care quality and outcomes and reduce inequities, they must ensure privacy (e.g., include only deidentified data) and provide information accessible to patients and other community members. Such platforms will also need to be created in partnership with a range of stakeholders.
- Achieving sustained improvements in care quality and reducing inequities in outcomes will require that providers and payers invest in collecting high-quality, reliable data on maternal health care and health outcomes disaggregated by race, ethnicity, and other characteristics. It also requires funding to support (1) needed practice changes and trainings that reduce bias and inequities and (2) community-driven testing and evaluation of changes in service delivery models.

BOX 1. RESEARCH METHODS

In spring and summer 2020, we conducted individual and small-group interviews with 40 maternal health experts, perinatal care providers, consumer advocates, philanthropic funders, and frontline health workers serving pregnant women to identify and examine key concerns about maternal health equity and challenges raised by the pandemic. We also conducted, and periodically updated, a comprehensive scan of publicly available information on maternal health equity during the pandemic from national policy and research organizations, professional and provider trade organizations, and leading maternal and infant health advocacy groups. Our findings primarily reflect insights into and responses to the pandemic that emerged between March and September 2020.

Because of social distancing requirements and the urgency of this topic during the pandemic, this analysis has some limitations. We could not interview mothers directly, and though we interviewed provider and advocate stakeholders, we recognize they do not represent mothers' viewpoints. In addition, our interviewees were predominantly on the East Coast, but we acknowledge community needs and realities differ by location and understand the importance of authentic community voice, partnership, and engagement as solutions are developed, implemented, and evaluated.

We center this work, part of the Urban Institute's larger Transforming Health and Health Care Systems project, around the Center for Social Inclusion's definition of racial equity:* when "people, including people of color, are owners, planners, and decisionmakers in the systems that govern their lives" and society "[acknowledges and accounts for] past and current inequities and provides all people, particularly those most impacted by racial inequities, the infrastructure needed to thrive."

* What is racial equity? Center for Social Inclusion website. <https://www.centerforsocialinclusion.org/our-work/what-is-racial-equity/>. Accessed October 19, 2020.

Before the pandemic, U.S. maternal health outcomes were worse than those of other wealthy countries, and declining.⁷ The maternal mortality rate doubled to almost 24 deaths in 100,000 live births from 1991 to 2014.¹ This tragic outcome has affected women of color most acutely; data show that Black women's and American Indian women's maternal mortality rates are four to five times that of white women.³

As data began highlighting the United States' poor maternal health outcomes in the 2000s, states focused on improving maternal mortality and morbidity for all populations. These efforts included establishing quality committees of experts that analyzed data and identified ways to address services and quality; almost every state created fetal and infant mortality review boards, maternal quality review committees, perinatal quality review committees, and/or other oversight committees. The data also moved states to make practice and policy

changes:⁸ some states used pay-for-performance packages to incentivize health and social service partnerships that could improve outcomes, and some used maternal care practice bundles, which identified quality care tools for improving outcomes (e.g., the American College of Obstetricians and Gynecologists' Alliance for the Improvement of Maternal Health program).⁹ These efforts raised awareness that improving maternal outcomes does not decrease long-standing racial and ethnic inequities.

In response to the data, California was among the first states to create a targeted equity effort, developing its Birth Equity Collaborative to promote implicit bias training and other equity-focused measures.¹⁰ Other states passed legislation or created guidelines requiring implicit bias training for perinatal teams. Key advocacy organizations, like Black Mamas Matter,¹¹ the Center for Law and Social Policy, and Movement for Family

Power, consistently reminded state and federal policymakers of the importance of authentically including those affected by inequities not only in developing solutions but in defining success measures. And data groups, like Race for Equity,¹² have called for the “use of data-driven decisionmaking to achieve outcomes that center upon the lived experiences of community members.” But to date, few states have systematically monitored relevant outcomes by race and ethnicity or embedded accountability for equitable outcomes in their programs (i.e., used financial or other tools to require programming and practices that decrease inequities). However, the pandemic has focused attention on maternal health inequities and is leading to budgetary, clinical, and system changes that could spur programmatic innovation, payment reform, and community partnerships that will help eliminate inequities.

In the following section, we describe how maternal health care has been changing during the pandemic, whether maternal health inequities have been exacerbated, and how well our data systems allow us to track those measures. We then identify key health care practices and policies and maternal health measures to be tracked and assessed by race and ethnicity. Finally, we describe what it will take to build a data system that supports achieving maternal health equity through incentives or other quality measures.

Maternal Care During the Pandemic

COVID-19, the disease caused by the novel coronavirus, has led to rapid changes in the way health systems and providers¹ care for pregnant and postpartum women². These changes have been necessary to protect both staff and patients. However, the evidence is limited regarding the quality of care provided, how maternal health outcomes and racial inequities in such outcomes are changing, or whether new rules, regulations, and practices are protecting providers and patients or exacerbating long-standing inequities.

When the pandemic began, interviewees noted that attention and funding shifted away from maternal health efforts. Health, public health, social service, and other systems were unprepared and could not rely on experiences from prior epidemics. Attention and resources shifted to virus treatment, control, and, eventually, prevention. Because of a constantly changing knowledge base and lack of adequate testing supplies, hospital leadership made rapid decisions that were often implemented chaotically (e.g., isolation and visitor protocols implemented for people in labor with suspected COVID-19). Even before news reports exposing racial and ethnic inequities in COVID-19 outcomes, stakeholders worried the pandemic’s rapid onset was exacerbating long-standing maternal health disparities. Over time, federal, state, and local policymakers and provider organizations began to more coherently address maternal and child health concerns related to COVID-19.

Though more data are needed to fully understand how the pandemic and U.S. responses to it have affected maternal care and outcomes, our interviews and scans of the evidence suggest they may be worsening maternal inequities. Society lacks a full picture of maternal and infant outcomes associated with COVID-19, in part because of the rapidity of the response. This incomplete picture also owes to inadequacies in our data collection efforts and a lack of health system accountability for inequities in maternal outcomes by race, ethnicity, and other characteristics. Dartmouth College’s COVID and Reproductive Effects (CARE) study,¹³ which seeks to understand how COVID-19 is affecting pregnant women’s well-being and health care experiences, is a beginning, but more is needed. Ideally, future efforts would include more community-based participatory research to expose the breadth of the pandemic’s effects on maternal morbidity and mortality.

The pandemic has led to changes in clinical practice, hospital policies, social service access, and patient realities. Understanding these changes allows stakeholders, including community members, to assess the links between current practices and outcomes for different women and identify successes, solutions, and concerns. Both qualitative and quantitative data are needed to understand how to create a culturally and linguistically effective and equitable maternal and child health care system. Such work would be incomplete without community members, including Black and indigenous mothers, providing input on the questions asked, context for results, and ideas for outcome measures and solutions.

Clinical Practice

We interviewed providers who feared that existing inequities have worsened during the pandemic, because of systemic and individual biases and barriers predating the crisis. Concerns about changes in clinical practice loomed large. Interviewees acknowledged that, even before the pandemic, many women saw a different provider each time they sought care, especially those who are uninsured or enrolled in Medicaid. Though new providers have access to a new patient’s chart, those charts can lack important health and social indicators. And if women assume their chart captures their full history, they may not bring up past concerns. During the pandemic, staffing shortages¹⁴ have increased the likelihood that patients will see different providers each visit. The usage of telehealth, though important, also worried many key informants; they reported difficulty reading nonverbal cues, struggling to fully bond with new patients, and, along with lack of continuity, feeling or knowing they may not fully understand women’s overall health, which could lead to worse outcomes for mothers and infants. Some providers noted the pandemic has disrupted access to on-site translators, and video coordination can be challenging because of timing and technology issues. Finally, providers and patients lacked equitable access to telehealth or telemonitoring technology because of cost, limited data plans, and lack of internet access.

Often, these bonding and continuity gaps have disproportionately affected Medicaid-enrolled or uninsured patients, those in rural areas, and those in other marginalized populations. However, the pace of the pandemic meant few providers were collecting outcome data, disaggregated or not, when we spoke with them in the summer. On a more positive side, providers felt teleservices increased care access for some mothers, especially with postpartum visits, because mothers no longer had to find transportation or babysitters for a short appointment.

Hospital Practice Changes

The pandemic has also caused myriad hospital policy and practice changes. Initially, hospitals prohibited advocates, doulas, or family members from being present during prenatal visits and birth. Without this support, many women feel vulnerable and isolated. Before the pandemic, doulas were shown to improve maternal health outcomes and decrease maternal health inequities.¹⁵ We spoke with service providers who noted that their Black participants, other participants of color, and participants with behavioral health concerns appreciated the doula support, even though hospitals may not fully embrace their efforts. Though barring such supports from visits and delivery can help control infection, it is also likely associated with worse outcomes. Further, we heard often that these restrictions contributed to patient stress. As states and hospitals balanced maternal health and disease spread, many began to ease restrictions. Only hospitals in some states, like New York, now allow one support person in the birthing room; elsewhere, some mothers must still choose between having a doula or family member present.

Unfortunately, stark examples of implicit bias have come to light during the crisis. A New Mexico hospital used American Indian/indigenous race as a proxy for COVID-19 risk among mothers,¹⁶ leading to American Indian/indigenous mothers and infants being separated at a higher rate than other mothers and infants. Concerned whistleblowers exposed this policy, but, as one informant noted, separating a mother from her infant based on race or ethnicity has been a long-standing practice in the U.S. child welfare system.¹⁷ Though data have not been collected to assess the extent of separations based on race and ethnicity, the New Mexico example is chilling and highlights the work hospitals must do to develop trusting relationships with Black and indigenous mothers. A continued lack of bias education makes it unlikely that the pandemic will change these discriminatory practices. And policies leading to separation have deleterious effects on mothers and their children, such as decreased maternal-infant bonding and decreased initiation of breastfeeding.¹⁸

Finally, ever-changing hospital and provider policies and a lack of standardization or rules have reportedly led some mothers and their families to mistrust both the health care system and their providers, further affecting a relationship already changed by limited in-person visits. Hospitals' and providers'

policies will likely continue changing as the epidemic and their understanding of the virus evolve. Collecting disaggregated outcome data and patient satisfaction surveys will help them understand which efforts may worsen inequities and need to be altered. These data, in conjunction with patient surveys and interviews, can help identify policies that can ultimately eliminate racial and ethnic inequities while mitigating virus spread.

Social and Economic Concerns

Finally, broader social and economic concerns could increase inequities during the pandemic. Interviewees feared, and studies are beginning to show, that required postpartum isolation during the pandemic is leading to increased anxiety and depression.¹⁹ Mothers and their infants may not be able to access family or community support because of quarantining and physical distancing. Few patient surveys, claims data, or provider data are catching the number of patients who need, can access, and are receiving care—much less disaggregated by race. Unmet behavioral health needs already contributed to maternal and infant morbidity before the pandemic,²⁰ and stakeholders felt pandemic-induced isolation is likely worsening this. Stakeholders also noted patients are struggling to access basic needs, like diapers, food, and clothing, because of supply issues and shopping restrictions related to the pandemic. Though these restrictions have eased in some localities, they may be restored in anticipation of a second wave of infections this fall. Because the pandemic has required some providers' offices to close, uncertainty regarding the availability and accessibility of supports has grown. Key informants described confusion over whether WIC offices are open and whether, and if so which, behavioral and physical health providers are operating. In addition, people are facing increased stress because of the virus, such as unemployment or employment in risky environments, financial stressors, and lack of child care. Before the crisis, public and private health and social systems were beginning to talk about and work with communities to address societal and social determinants of health; with the pandemic, new and heightened needs—from losses of employment, health insurance, and child care to other social distancing realities—are being revealed.

Inadequacies in Available Perinatal Care and Maternal Outcome Data

Before the crisis, many data collection systems failed to monitor maternal outcomes across race and ethnicity.²¹ Given the inadequacies in data collection and existing information on the pandemic and related recession's disproportionate effects on Black, Hispanic/Latinx, and indigenous populations, inequities in maternal health and morbidity and mortality are likely growing. Key informants shared that data collection has taken a back seat to keeping systems running as efficiently as possible. Now that systems are stabilizing and policies and practices have adapted, collecting disaggregated outcome

and patient satisfaction data at all service levels is critical. Doing so helps researchers, policymakers, practitioners, and community members understand how the pandemic may be disproportionately affecting some communities and, in turn, provide care and engagement that supports equitable maternal and child health outcomes. This should extend to provider practices of all types, hospitals, public and private payers, health departments' maternal child health programs, and social service providers. In turn, stakeholders can assess whether COVID-19 practices and policies, in conjunction with previous practices, are improving or worsening patient care.

Despite key informants' consistent concerns that maternal health inequities are worsening during the pandemic, our existing data systems do not provide the information necessary to assess how health care practices and policies and maternal outcomes are changing according to race, ethnicity, or other relevant maternal characteristics. Payers, providers, health departments, and communities lack outcome data that could show how changes have affected maternal and infant health outcomes and/or mitigated spread of the virus. Moreover, they cannot distinguish whether these answers differ by race, ethnicity, and other intersections, so they can begin addressing inequities. With disaggregated outcome data and patient satisfaction surveys, payers, providers, and communities will better understand which efforts may be worsening inequities and need to be altered and which are working and should be expanded.

Designing Data Collection Systems to Improve Maternal Care Outcomes and Equity

High-quality, stratified data including race and ethnicity identifiers, at a minimum, can help reveal how pregnant and parenting women of color are faring during the pandemic and track efforts to advance equity in their care. Care and outcomes can be optimized, for example, if providers, hospitals, health departments, and private and public payers systematically collect data on depression, anxiety, social needs, postpartum attachment, prenatal and postpartum visit attendance, patient perceptions and trust, and other measures that capture access to and use of culturally and linguistically effective services. Effectively stratified health care data on other outcomes, such as blood pressure trends and diabetes control, would also contribute to improved understanding of health and health care inequities.

Additionally, patient perspectives can identify areas of success and failure, which can then inform care models that improve care and outcomes. Each time a patient interacts with the health care system is an opportunity to collect data to improve equitable outcomes; collecting data during different health care engagements can not only lead to more equitable outcomes but spur innovation and increase knowledge about effective solutions. Further, equitable partnerships with community members can identify additional outcome measures, ensure

the right domains are targeted, and contextualize results as solutions are developed. This approach is endorsed by the Maternal Child Equity Collaborative,²² which promotes Black maternal and child health equity and seeks to ultimately eliminate the Black infant mortality disparity.

With appropriate high-quality data collection, health systems can analyze how changes in policies, programs, and practices during the pandemic have affected selected outcomes. Providers and payers will need to pair data collection with critical assessments of (1) policies, practices, and supports that may improve or worsen inequities and (2) access to culturally and linguistically effective care. It will be critical to understand and track the following health care practices, policies, and measures, as well as their effects by race, ethnicity, and other characteristics:

- › **Prenatal care staffing:** What is the provider team's composition? Who are the new reimbursable staff and providers (e.g., doulas)? Is the number of currently reimbursable providers (e.g., midwives) adequate? Are they offering culturally and linguistically appropriate care?
- › **Access to prenatal and postpartum services:** What access and barriers to obstetric/gynecological services do mothers face? To what extent are women experiencing continuity of care during their pregnancies? To what extent are women screened for other health needs and referred to and engaged with appropriate supports? Did patients have consistent access to telehealth and telemonitoring services and, if not, what barriers prevented use of those services? If so, were the services effective? Were providers able to assess and respond to emerging health needs?
- › **Adequate financing:** To what extent have financing of and reimbursement rates for services changed? Can available reimbursements support provision of culturally effective care and equitable outcomes?
- › **Birthing facilities:** What birthing facilities are available? Where are they located, and are they accessible to everyone? Are they providing culturally and linguistically appropriate services? If not, why not? Do they conduct risk assessments to determine clientele?
- › **Health care coverage:** What does health insurance coverage for pregnant women look like overall and for different populations? What health care services are health insurance plans actually covering for pregnant women (e.g., COVID-19 testing, antibody testing, telehealth, behavioral telehealth, medication, and medication delivery)? Do providers and patients know about and understand coverage changes?
- › **Access to respectful care:** What share of women report having positive birth experiences? How much does the care

received differ from what is recommended? Does this answer vary across populations? What level of trust do women have in their providers and the staff they interact with in the health care system? What are patients' and providers' perceptions of care, bias, mistreatment,²³ access to needed care, and system challenges/improvements?

- › **Access to social services:** Did providers complete screenings for social determinants of health? Did they make referrals in response to screening results? What health care engagement resulted from such referrals? Did access to needed services differ? If so, why?
- › **Birth policies:** At what rates have mothers and babies been separated at birth and subsequently reunited? Why, when, and for how long were birthing persons separated from their infants?

In addition to assessing whether and how these prenatal and delivery practices and policies have changed during the pandemic and whether they have disproportionately affected certain women, it will be important to examine these practices' effects on outcomes. Future analyses should assess whether and how racial and ethnic inequities in maternal and birth outcomes have been affected or, as feared, increased as the pandemic has unfolded.

Longer-Term Investments in Data Collection and Practice Change to Support Maternal Health Equity

Creating appropriate training, infrastructure support, and incentivizing payment policies and enhancing community members' abilities to use and understand data, and act based on that information, could promote high-quality maternity and child health outcomes for Black, Hispanic/Latinx, and indigenous women, as well as women at higher risk of poor outcomes.

One such change is providing care to Black and indigenous women using the existing, culturally responsive and effective care approaches in their respective communities, which predate the pandemic and have been historically underfunded or ignored. Of course, any past and new programming must be continually evaluated using stratified data to see if it should be altered to ensure equitable outcomes.

States are well positioned to work with public and private payers, hospitals, providers, and communities to (1) ensure they are collecting necessary maternal health care data and (2) create a data-sharing platform that allows stakeholders to identify, understand, and remedy deficiencies and inequities in the health care system. Data systems will be imperfect at first but can be improved and effective with leadership and support. Such a process has already occurred within the California Maternal Quality Care Collaborative, which ultimately

created a California Birth Equity Collaborative¹⁰ and could serve as a template for other states. Successful models exist in other health areas, too: the Ryan White CARE Act developed planning councils²⁴ that brought together diverse community stakeholders, proactively including those with lived experience to use the data effectively and distribute resources to improve outcomes. Such efforts require leadership, innovation, funding, and commitment to eliminate inequities, and relying on past practices will not suffice. To succeed, data collecting and sharing efforts must account for several issues:

- › **Privacy:** These platforms must contain deidentified data, so they do not invade consumer privacy and/or lead to punitive actions in systems with racially disparate outcomes (e.g., child welfare and criminal justice).
- › **Transparency:** Information provided via these platforms should be accessible, allowing consumers to easily choose providers, alternative birthing locations, hospitals, and payers that have demonstrated high-quality, equitable outcomes.
- › **Community partnership:** To identify affected subgroups and add context to data analyses, states could immediately develop an advisory board of diverse stakeholders representing their unique community make-up and needs, including currently or recently pregnant women. This group could monitor data in their community and provide guidance on how to improve metrics and hold systems accountable.
- › **Cross-sector collaboration:** States can ensure maternal and child health and social service providers systematically collect, share, and stratify robust deidentified data on outcomes related to health, social services, patient satisfaction, and more. Shared data can identify areas where policies could be developed and enacted to improve outcomes for all people.

Improved data collection must be paired with—and will in turn be improved by—greater investments by providers and payers in the development and sustainability of culturally effective care, including the following:

- › **Funding, training, and infrastructure support for data collection:** Such support can ensure providers, payers, and administrators collect high-quality, reliable data that include patients' races, ethnicities, and other intersectional data.
- › **Funding practice changes for providers with limited resources:** Many providers need time and funding to change how they provide care. This may require changing engagement practice, clinical workflow, staffing, and follow-up approaches. This type of introspection and restructuring, especially among clinics serving the underinsured, is rarely funded and impossible with limited profit margins.

› **Funding for trainings to reduce bias and inequities:**

Providers, alternative birthing locations, hospitals, and state health departments must engage in bias training, educate themselves on culturally and linguistically effective care practices, and learn about, implement, and evaluate promising practices to decrease inequities (e.g., virtual or in-person doulas).

› **Supporting community-based interventions and evaluations:**

The evidence base regarding culturally and linguistically effective maternal health practices across communities is sorely lacking. Many communities have developed effective, culturally relevant services that have not been evaluated. In other areas, supposedly evidence-based solutions have not been evaluated to see if they are effective within Black, indigenous, or other diverse populations, and they often exclude cultural context. Supporting evidence-informed interventions will depend on supporting community-based evaluations by researchers working together with communities.

With strong leadership, commitment, community partnership, and changes in priorities and financing, equitable maternal child health outcomes can become a reality. The pandemic has laid bare existing structural deficits but also showed our systems can quickly adapt. To reduce maternal health inequities, we must use the current moment to create a new future. During and after the pandemic, providers, public and private payers, and governmental entities will first need to collect and analyze information on maternal health care and outcomes disaggregated by race and ethnicity to identify areas of inequitable mortality and morbidity. Next, federal, state, and local governments must work with communities to identify health, social, and economic practices, programming, and policies that improve equity. This will require conducting needs assessments and gathering in-depth information from women in groups who experience inequities, addressing implicit and explicit biases in delivery of health care and social services, and developing innovative and/or scaling up existing culturally effective services. Though some of this work started before the crisis, continuing stark racial inequities in maternal outcomes in 2019³ showed more work can be done and commitments made at the federal, state, and local levels.

Leadership will be needed to try new policy, practice, and programming ideas—whether they already exist in the community, exist in other health or social fields, or must be developed. Such practices must be evaluated to assess the effects of improving

equitable maternal health outcomes on both health systems and communities. Finally, tying programming and data to payment establishes the importance of equity within a system and ultimately ensures more accountability. States have already begun using maternal and child value-based purchasing²⁵ for maternal and child health outcomes and adding indicators aimed at eliminating inequities is a crucial next step. Other incentives that might also be considered include

- › Medicaid managed-care organization contracts that assign more patients to payers achieving high-quality, equitable outcomes or incentivize payers in other ways;
- › private-insurer adjustments that create narrow networks with lower costs, based on high-quality, culturally effective services and equitable outcomes across diverse intersections; and
- › adjustments to private insurers' network panels to reward providers demonstrating more equitable outcomes.

These efforts can build on existing maternal and child health improvement practices and benefit from lessons learned during the pandemic. Understanding what has worked well during the crisis, especially for Black, Hispanic/Latinx, indigenous, and other marginalized populations, can help the health system combat the currently overlapping maternal health and COVID-19 crises in ways that will also be effective after the crisis.

The pandemic has shown that the U.S. health system can change and innovate on short notice and tackle important problems. To eliminate inequities in maternal health care, federal, state, and local health authorities, public and private payers, hospitals, and providers can collect and analyze maternal and child outcomes data stratified by race and ethnicity (at a minimum). Such authorities must also examine the effects of sexual orientation, class, gender identity, and other factors—as well as these factors' intersections—to eliminate inequities. Payers, providers, and community stakeholders must agree on shared outcome metrics and work together to develop new or scale existing effective responses, using disaggregated data to identify areas of success or for improvement. Finally, payment reform or other incentives will be needed to hold systems accountable to community stakeholders for ultimately eliminating racial, ethnic, and other inequities in maternal care.

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