MAP to Action: Workforce Session
Breakout Room Summary
February 13, 2023

Theme 1: Workforce Training on DEIB and Antiracism to improve the culture of health care settings	**Theme 2: Supporting the growth and availability of a diverse MIH workforce that improve birth equity and quality**
What messages/ideas/information from the presentations resonated with you?	
• Further discussion on specific ways to introduce the issue and anti-racism training into hospitals and academic setting. • There is a generational divide and differing awareness and comfort levels on the topic so leadership across the institutions had to be trained because they were less comfortable with the topic than their own students. • Resource suggestions: 1619 podcast episode 4 "How the Bad Blood Started". Why emancipated slaves didn't have access to care. This isn't something that is new. This is something that has been worked on and the historical context hasn't been there. People will sit in a training but how do you get them interested in being a part of the change. • Interest in how to get people to be emotionally invested in the work? People will go to trainings and be uncomfortable. Are there resources that get people to emotionally commit beyond being required to participate? • Just last week one of a nurses said this is unacceptable and we must do better. We have many nurses that are unaware of this as an issue.	• Providers who have caused harm in birth places are not being held accountable. Should they continue to be board certified or by what means should they be held accountable? What are we doing when we hear women and families talk about being traumatized by a particular provider or hospital? While improving the diversity of the workforce is an important component, we can't continue to allow/pay providers causing harm. • An activation of the law and evidence-based policies to pursue remedies, to react and protect harms that occur. There has been a failure of law to this point. A lot of room for opportunity here. • No proactive enforcement of regulations. We rely on parent/birthing person to be aware of and act on them. Often, people who have been harmed don't know how to report or that they can report. • What does patient engagement look like? Do we provide a safe environment for birthing people to share that the care they received was not safe? • Often times it is not that mothers are afraid to fill out the surveys but it is in knowing nothing is going to be done about the experiences they share. • Birthing people do not share their experiences because their voice isn't heard. Many institutions are not willing to ask the questions because if they get the answers, then what are they going to do/they'll need to act on it, and they aren't ready to do that. How do we change the culture?
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In your own work/industry/sector, are you engaged in a project or pilot that relates to this work? If not, where do you see potential to engage in the projects or priorities we're discussing today?	
• One hospital shared: 2019-2020 NJ mandated bias training for maternity workers. We held a viewing of **Aftershock** .We also used a free HHS education tool with new hires. We facilitate a conversation and then do a viewing of Aftershock and then a debrief. We provide more resources for staff to do a deeper dive if they want to. The feedback we've received is that it's the first-time Black women have had a safe space to have these	• Attending weekly childbirth education can keep you connected to what people are experiencing. They want equitable, respectful high quality maternity care. But not don't know how to navigate that - questions of access, insurance, culturally congruent care. • Burke Foundation is doing work with ido.org, a research initiative. They are working with doulas, regionally based, to hear from them on how to

conversations. White women have recognized they possess implicit bias. And it's important to be aware of it and learn. Interrupt that narrative because if we don't then we are saying it's OK. We are going to mandate this education for all our staff.

- Others use a shorter version of Aftershock for shorter trainings and encourage people to go home and watch the full movie with their family and friends. Also, can use a trailer and series of reaction videos on the new Little Mermaid movie where Ariel is Black. People wonder why I use this in a health training. White people don't understand the harm in lack of representation. We have less implicit bias toward children. When people see the reactions of the children there is less room for deniability.
- A Foundation raised shifting power. Talking to the doula community about working with other clinicians in the hospital. They hired a human centered design firm to work with doulas to talk about barriers. Presented barriers and solutions last week.
- Dr. Mitchell-Williams shared that Cooper is a relatively new medical school. Early in the development process leadership recognized that diversity was a major aspect of our institution. Needed a full-time person to build diversity initiatives. That was Dr. Mitchell-Williams. And it was the springboard to a lot of what's happening at Cooper, our affiliated health system. There were not diversity initiatives in place until recently. Had to get out and talk to the community to find out what was lacking to best address them. Heard kids in their community were not going into the health care profession. Started a pipeline program in the elementary school with our medical students and faculty to introduce science and medicine. Now they have a pipeline of elementary, high school, college etc. The summer programs expose kids to becoming a physician or other health professional. We track that progress and use it to get state and federal funding. They got a $2 million grant to get kids from disadvantaged backgrounds to explore careers in health. They continue to listen to students to better understand how to retain them. That is a big part of DEI – how do you get to conversations about bias even though they are uncomfortable? As the Dean of Education, now including racism in our coursework each year. Students are even better at it than the faculty.

improve their experiences as a doula and sustainability of their work. A co-op approach was a named solution, two doulas per birth. More to come on the findings and next steps.

- GNHCC and Rutgers School of Public Health are working together through the Merck safer child initiative, 31 interviews with Black women who gave birth. They are disseminating themes that were learned and looking toward next steps. This work is meant to complement the richness of work and conversations happening.
- The work being done is piecemeal; this will not help move forward the quality and experience of Black birthing persons.
- We need to address the root cause of systemic racism to truly move things forward. And while we may have worked in a piecemeal way, everyone is here today because we are vested in this work to improve outcomes together.

Integrating that in everything you do is so important. • Summer long webinar series for students around the country interested in midwifery. Reached out to cities that may have students that are interested. For example, an afterschool program in Trenton. Faculty preparation – study found that faculty weren't prepared to be teaching about racism. That shows us the work that still needs to be done.	
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How would we collectively measure success for some of these ideas or projects? What are the near-term impacts? What does success look like a few years down the road?	
Did not discuss	• While cultural congruent care is pivotal, harm occurs across cultures. Accountability is key. How do we hold people accountable and talk about the bottom line because that is what others are interested in? Particularly focusing on the need to engage hospitals and others who can hold them accountable in these conversations. Those who work in safety and quality and insurance companies, and others in charge of ensuring patient safety, are often not at the table. How do we hear more about how they implement safety measures and use data to have a broader conversation with them about their practices? • Accountability and funding are important to focus on. She shared that Mississippi BCBS covers less if the hospital is not a baby friendly status – not that baby friendly status is the answer but shared more to point out how insurances should be in the conversation to add levels of accountability. • Within quality/patient safety in a hospital, many of the issues raised here are on the forefront of NJ hospital administrators mind, including board members. One area all hospitals participate in is trying to incorporate the AIM bundles, and they are members of NJ perinatal quality care collaborative. Outcomes drilled down to race/ethnicity. Each hospital required to develop action plan to address. • We must be cognizant of data we are looking at. The aspects of harm that are caused can be disrespectful treatment and micro aggressions – and how do you measure those? They have a huge impact on outcomes and wellness of the pregnant person. • Participant reported that a hospital in Essex County issued a new policy that severely restricts doulas.

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<tr><td></td><td>Many organizations are not talking to each other. We are trying to break down our own silos, but hospitals also have silos which further impedes the work.</td></tr>
<tr><td colspan="2">If you or your organization has held back or hesitated in engaging in new projects or pilots, what has held you back (resources, financial impact, connection and support from other organizations and partners, uncertainty about where to start, etc.)?</td></tr>
<tr><td>One challenge is in labor and delivery we see a dynamic between OBs, Nurses, Midwives, Doulas that may be tense. How do we build multi-disciplinary teams that include lactation consultants etc.? Equity among different team members.
Discussed whether anyone is thinking about training the care team?
Dr. Blumenfeld has been involved in efforts to speak to health system administration about this. Why we should champion doulas for patient support. Interprofessional dynamic – great program called educational redesign from ACOG and ACNM where 4 academic programs implemented an interprofessional curriculum that has been replicated. Great preliminary outcomes. When learners collaborate, it serves patients with better outcomes.
Dr. Mitchell-Williams has been trying to develop interprofessional education at Cooper and the women’s clinic. There is a power dynamic and we’re not doing enough to reduce disparities, so we need to work together better. Clinic can embed social workers for mental health services but only 2 days a week. Other places can’t afford to add social workers. Must be a leadership priority and funded.
She worked on labor and delivery yesterday while her daughter was giving birth. It was only the second time in her 25-year career that she worked with a black nurse. In a community with 90% black and Hispanic population, that’s crazy.</td><td>Did not discuss</td></tr>
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