Maternal Health Incubator: Data for Maternal Health Equity
The AAMC Center for Health Justice Welcomes You to the Inaugural Maternal Health Incubator

Philip M. Alberti, PhD
Senior Director, Health Equity Research & Policy
Founding Director, AAMC Center for Health Justice
Health equity is the goal.
Health justice is the path.
Every community begins at the same starting line for health.
HEALTH JUSTICE

Anti-Racist, Anti-Discriminatory

Community Wisdom & Multisector Partnerships

Research → Policy Action

AAMC Center for Health Justice

Model

Influence

Ease the Path
AAMC Center for Health Justice Focus Areas

- **Trustworthiness**: Guiding health care and other organizations as they work to demonstrate they are worthy of their communities’ trust.

- **Data for Health Equity**: Developing tools and building connections to ensure communities thrive.

- **Maternal Health Equity**: Understanding health inequities for birthing people and advocating for evidence-based policy solutions.

- **All in for Health Equity**: A multisector, co-designed “experiment” to determine a new focus area for the center.
AAMC Maternal Health Equity Portfolio

Olufunmilayo Makinde, MPH
Health Equity Research Analyst,
AAMC Center for Health Justice
What Brings Us Together Today?

• Maternal health inequities are not new

• Black and AIAN birthing people are 2-3 times more like to die from pregnancy-related complications than their White counterparts

• Maternal mortality (and morbidity) disparities are present even when controlling for factors such as education and income

Source: https://www.cdc.gov/mmwr/volumes/68/wr/mm6835a3.htm
Real Lives, Real Stories

Kira Johnson

Beyoncé Knowles-Carter

Stephanie Snook

Serena Williams

Allyson Felix

Shalon Irving

DAY 1: MATERNAL HEALTH INCUBATOR • MAY 24, 2022
Maternal Health at AAMC

- **Raise** awareness of the severity and complexity of maternal health inequities
- **Advocate** for related policy solutions
- **Support** innovative research to eliminate inequities that threaten the health and wellbeing of all birthing people
- **Develop** resources, **convene** experts, and **provide** opportunities to strengthen efforts around maternal health

https://www.aamchealthjustice.org/our-work/maternal-health-equity
Current and Future Activity

- Health Impact Assessments
- Polling
- Multisector Action Plan
AAMC CHARGE

- 1,200+ participants and growing
- Multisector and open to all
- Action and policy-focused
- Conduit to local communities across the U.S.

www.aamc.org/charge
Maternal Health Incubator: Our Goals

• Develop a better understanding of how various data can help to close gaps in maternal health

• Explore how multisector and policy efforts can facilitate maternal health equity

• Learn from you and brainstorm together about interventions needed to improve maternal health data and outcomes
Day 1 Agenda: Current Landscape

11:10 AM  Opening Address: It’s More Than the Clinical
11:30 AM  Fireside Chat: Patient Perspectives
12:30 PM  Break
12:45 PM  Panel Discussions: Leading by Example
2:15 PM   Break
2:30 PM   What Birthing People in the U.S. Are Saying
2:50 PM   Closing Remarks

*All times are EST
Opening Address: It’s More Than the Clinical

Zsakeba Henderson, MD, FACOG
Senior Vice President of Maternal and Child Health Impact
and Interim Chief Medical and Health Officer
March of Dimes
MATERNAL AND INFANT HEALTH DATA: CHALLENGES AND OPPORTUNITIES

Zsakeba Henderson, MD, FACOG
SVP Maternal Child Health Impact
Interim Chief Medical and Health Officer
MARCH OF DIMES LEADS THE FIGHT FOR THE HEALTH OF ALL MOMS AND BABIES.
OUR VISION

WE IMAGINE A WORLD WHERE EVERY MOM AND BABY IS HEALTHY REGARDLESS OF WEALTH, RACE, GENDER OR GEOGRAPHY.
AN 80+ YEAR LEGACY

- Founded by Franklin D. Roosevelt as NFIP
- The Salk vaccine (solving 20th century problem with 20th century tools)
- First Volunteer Leadership Conference
- Shift to incorporate perinatal health
- Campaign for Healthy Babies
- Campaign Against Preterm Birth

- 1938
- 1940
- 1955
- 1958-59
- 1964
- 1976
- 1970s
- 1970s
- 1990
- 1998
- 2005

- Crowdfunding for polio
- Announcement of new mission: birth defects prevention in 1958
- Publication of Toward Improving Outcome of Pregnancy
- Mobilizing communities through events and walks across the country
- Folic Acid Campaign

TODAY: Addressing health equity in the fight for healthy moms and strong babies
MOMS AND BABIES ARE FACING AN URGENT HEALTH CRISIS

The U.S. has one of the WORST RATES of maternal death in the developed world. African American women are significantly more likely to die.

1 IN 7 women are treated for depression some time between the year before or after pregnancy. Over half of the cases of postpartum depression go undiagnosed.

Women of color are up to 50% more likely to give birth prematurely. Their children can face a 130 percent higher infant death rate.

Premature birth and its complications are the largest contributors to INFANT DEATH in the U.S. and globally.
DISPARITIES IN PREGNANCY-RELATED DEATH

Black and American Indian mothers have death rates two to three times higher than White women.

<table>
<thead>
<tr>
<th>Race</th>
<th>Pregnancy-related mortality ratio</th>
</tr>
</thead>
<tbody>
<tr>
<td>Black</td>
<td>41.7</td>
</tr>
<tr>
<td>American Indian/Alaskan Native</td>
<td>28.3</td>
</tr>
<tr>
<td>Asian/Pacific Islander</td>
<td>13.8</td>
</tr>
<tr>
<td>Hispanic</td>
<td>11.6</td>
</tr>
</tbody>
</table>

Pregnancy-related mortality by race, U.S.

*Pregnancy-related mortality ratio is the number of pregnancy-related deaths per 100,000 live births. A pregnancy-related death is the death of a woman during pregnancy or within one year of the end of pregnancy from a pregnancy complication, a chain of events initiated by pregnancy, or the aggravation of an unrelated condition by the physiologic effects of pregnancy.


Prepared by March of Dimes Perinatal Data Center, December, 2020
DISPARITIES IN MATERNAL AND INFANT HEALTH OUTCOMES: LOCATION MATTERS

Source: U.S. Health Resources and Services Administration (HRSA), Area Health Resources Files, 2019

PRETERM BIRTH RATES AND GRADES BY STATE

Preterm birth rate is not included in the United States total. Preterm is less than 37 completed weeks of gestation, based on estimated gestational age. Source: National Center for Health Statistics, 2019 final pregnancy data.

Grades assigned by March of Dimes-Postratal Data Center.
CHALLENGES WITH MATERNAL AND INFANT HEALTH DATA

States Funded Through ERASE MM

[Map showing states funded through ERASE MM]
## MULTIPLE DEFINITIONS

### AN EXAMPLE: MATERNAL MORTALITY AND PREGNANCY RELATED MORTALITY

<table>
<thead>
<tr>
<th>Measure</th>
<th>Most Current Year</th>
<th>Timing of Review</th>
<th>Calculation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maternal Mortality Rate</td>
<td>2019</td>
<td>Up to 42 Days After Death</td>
<td>Recorded (or estimated) maternal deaths divided by total recorded (or estimated) live births in the same period and multiplying by 100,000 births.</td>
</tr>
<tr>
<td>Pregnancy-Related Mortality Ratio</td>
<td>2017</td>
<td>Up to 1 Year After Death</td>
<td>Total pregnancy-related mortality rate divided by total maternal mortality rate by the general fertility rate for the same period and are expressed per 100,000 births.</td>
</tr>
</tbody>
</table>
BETTER DATA COLLECTION ON VARIABLES SURROUNDING PREGNANCY AND DELIVERY

Figure 1
Social Determinants of Health

<table>
<thead>
<tr>
<th>Economic Stability</th>
<th>Neighborhood and Physical Environment</th>
<th>Education</th>
<th>Food</th>
<th>Community and Social Context</th>
<th>Health Care System</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employment</td>
<td>Housing</td>
<td>Literacy</td>
<td>Hunger</td>
<td>Social integration</td>
<td>Health coverage</td>
</tr>
<tr>
<td>Income</td>
<td>Transportation</td>
<td>Language</td>
<td>Access to healthy options</td>
<td>Support systems</td>
<td></td>
</tr>
<tr>
<td>Expenses</td>
<td>Safety</td>
<td>Early childhood education</td>
<td>Hunger</td>
<td>Community engagement</td>
<td>Provider availability</td>
</tr>
<tr>
<td>Debt</td>
<td>Parks</td>
<td>Vocational training</td>
<td>Access to healthy options</td>
<td>Discrimination</td>
<td></td>
</tr>
<tr>
<td>Medical bills</td>
<td>Playgrounds</td>
<td>Higher education</td>
<td>Hunger</td>
<td>Stress</td>
<td>Provider linguistic and cultural competency</td>
</tr>
<tr>
<td>Support</td>
<td>Walkability</td>
<td></td>
<td></td>
<td></td>
<td>Quality of care</td>
</tr>
<tr>
<td></td>
<td>Zip code / geography</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Health Outcomes
Mortality, Morbidity, Life Expectancy, Health Care Expenditures, Health Status, Functional Limitations
IMPORTANCE OF QUALITATIVE DATA SURROUNDING PREGNANCY AND DELIVERY
MOVING FORWARD IN MATERNAL AND INFANT HEALTH: INVEST IN DATA AND ACTION

1. Pregnancy Surveillance
   - CHW or ANC clinic health worker collects information using ANC checklist, Danger sign checklist & Pregnancy Wheel and enrolls woman into pregnancy surveillance cohort for monitoring.
   - Further information is collected during ANC visits by health workers.
   - Women at COVID-19 treatment center are enrolled in ISARIC-WHO Supplemental Pregnancy Surveillance Module and information is collected on pregnancy and COVID-19 status, with contact tracing follow-up if COVID-19 positive.
   - If maternal death occurs during pregnancy, community or facility-based mortality surveillance is conducted (see 4a and 4b).

2. Delivery Surveillance
   - During delivery, BEiMoN and ClenMRC facilities are trained in COVID-19 case management and reporting and record pregnancy outcomes including:
     - Mother Outcomes: Live, death, complications
     - Mother's age
     - Place of delivery
     - Birth Weight
     - Gestational Age
     - Birth Outcomes: Live, death, twins
   - COVID-19 status after birth for mothers and newborns are monitored and added to pregnancy surveillance platform if COVID-19 negative, and ISARIC-WHO Supplemental Pregnancy Module platform if COVID-19 positive with contact tracing follow-up.
   - If maternal or perinatal death occurs during delivery, facility-based mortality surveillance is conducted (see 4b).

3. Postnatal Surveillance
   - If woman is COVID-19 positive, stays if symptoms clear & information is entered into ISARIC-WHO Supplemental Pregnancy Module with contact tracing follow-up.
   - Health outcomes are tracked during postpartum follow-up visits using a PNC checklist at home within one week of delivery (postpartum surveillance).
   - Note: If woman does not visit ANC care and gives birth at home instead of health facility, CHW monitors health outcomes through postpartum surveillance.

4. Mortality Surveillance
   - A. Community-based
     - Maternal and perinatal deaths occur during pregnancy or postpartum and are discovered by CHW.
     - Deaths are entered into the death notification system, followed up with a Verbal Autopsy, death review, and Social Autopsy; data is sent to the district, and response is developed for the community as part of the larger Maternal and Perinatal Death Surveillance and Response system.
   - B. Facility-based
     - Maternal and perinatal deaths occur during facility-delivered birth.
     - Deaths are entered into the death notification system, undergo a death review, and a death certification response is developed as part of the larger Maternal and Perinatal Death Surveillance and Response system.
### Improve Data Collection Practices

1. **Balance Consistency and Flexibility**: Define a minimum required core set of measures for state collection with standard guidelines for collection and analysis to help eliminate confusion and inconsistencies.

2. **Include Race and Ethnicity Data**: Incentivize collecting and segmenting race and ethnicity data consistently using a national standardized set of measures to minimize reporting burden and facilitate system-wide collaboration through payment requirements.

3. **Look Beyond Clinical Data**: Create a multifaceted approach that contextually and holistically considers factors beyond clinical elements.

4. **Include Pregnant People in Research Trials**: Follow Recommendations for Common Data Elements for COVID-19 Studies Including Pregnant Participants when developing data elements and measures for future infectious disease studies.
<table>
<thead>
<tr>
<th><strong>Enable Data Sharing and Remove Barriers to Access</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>5. <strong>Prioritize Interoperability:</strong> Standardize data and data exchange to improve the ability to abstract data and follow a pregnant person’s care journey and empower the individual to take charge of their own health care choices with access to their data.</td>
</tr>
<tr>
<td>6. <strong>Connect VA and Community Veteran Data:</strong> Improve training and communication on the Veterans Health Information Exchange (VHIE) to promote sharing of pregnant and postpartum Veterans’ electronic health information between VA and non-VA providers.</td>
</tr>
<tr>
<td>7. <strong>Expand Medicaid Coverage:</strong> Expand Medicaid postpartum coverage in each state to one year to eliminate the data collection disruption currently experienced when coverage ends at 60 days.</td>
</tr>
<tr>
<td>8. <strong>Improve Comprehension of Maternal Event Timelines:</strong> Link birth certificates to hospital discharge data to calculate the timing of maternal events and help improve investigations of poor outcomes.</td>
</tr>
<tr>
<td>9. <strong>Create Rapid Cycle Review for Quality Improvement Efforts:</strong> Ensure states and localities have the tools, training, and support needed to effectively conduct process evaluation on federal maternal health quality improvement efforts and adjust maternal health programs in progress.</td>
</tr>
<tr>
<td>10. <strong>Flag Data to Prevent Morbidity from Turning into Mortality:</strong> Add a pregnancy flag in the electronic health record (EHR) and train on how to use it to improve the ability to identify emergency conditions related to pregnancy and help prevent or treat severe maternal morbidity while also improving EHR coding.</td>
</tr>
<tr>
<td>11. <strong>Share Data Between Agencies and Across Jurisdictions:</strong> Identify additional data needed in each state to evaluate maternal mortality and severe maternal morbidity and work to advance legislative changes or develop advance data use agreements (DUAs) to provide access to data.</td>
</tr>
</tbody>
</table>
### Elevate and Support State and Locality-Based Data

| 12 | **Include Diverse Perspectives and Provide Clear Guidance for MMRCs:** Create interdisciplinary state MMRC teams to expand beyond clinical expertise to ensure well-rounded data analysis and interpretation. |
| 13 | **Expand MMRC Support to Effectively Use MMRIA:** Expand support for states’ use of Maternal Mortality Review Information Application (MMRIA), create opportunities for collaboration among states to share best practices, and enhance opportunities to assign a CDC epidemiologist to each MMRC. |
| 14 | **Improve Collaboration Between PQC and MMRCs:** Ensure Perinatal Quality Collaboratives (PQC) have access to MMRC data to prioritize intervention efforts; create MMRC and PQC liaisons to share updates between the two teams. |
Black Birth Film

Initial release: 2021
Director: Haimy Assefa
https://www.youtube.com/watch?v=_OlO3NGJooA
Virtual Fireside Chat: Patient Perspectives

Alannah Hurley, Mariam Aydoun, and Tennille S. Leak-Johnson, PhD, MS

Moderated by Joia A. Crear-Perry, MD, FACOG
Founder and President
National Birth Equity Collaborative (NBEC)
Meet the Panelists

Alannah Hurley
Executive Director, United Tribes of Bristol Bay

Mariam Aydoun
Community Activist, Washington, D.C.

Tennille S. Leak-Johnson, PhD, MS
Assistant Professor of Physiology, Morehouse School of Medicine
Q&A and Moderated Discussion
Panel Discussions: Leading by Example

Wanda Barfield, MD, MPH, Eugene Declercq, PhD, Kristen Zycherman, RN, Sarah Kennedy, MPH, and Roxana Richardson, Esq

Moderated by Veronica Gillispie-Bell, MD, MAS, FACOG
OB-GYN, Oschner Health & Medical Director, Louisiana Perinatal Quality Collaborative and Pregnancy Associated Mortality Review for the Louisiana Dept. of Health
Meet the Panelists

Wanda Barfield, MD, MPH, FAAP, RADM USPHS (ret.)
Director of the Division of Reproductive Health (DRH), National Center for Chronic Disease Prevention and Health Promotion, CDC

Eugene Declercq, PhD
Professor of Community Health Sciences, Boston University School of Public Health & Professor of Obstetrics and Gynecology, Boston University School of Medicine

Kristen Zycherman, RN, BSN
Maternal and Infant Health Initiative Lead and Maternal and Infant Health Subject Matter Expert, Division of Quality and Health Outcomes, CMS & CHIP

Sarah Kennedy, MPH
Senior Manager of Epidemiology and Evaluation, Generate Health STL

S. Roxana Richardson, Esq.
Medical-Legal Partnership Director, Georgetown University Health Justice Alliance’s Perinatal Legal Assistance and Wellbeing Project at MedStar Washington
WORKING TOWARDS EQUITY IN DATA AND PRACTICE

AAMC MATERNAL HEALTH INCUBATOR

WANDA D. BARFIELD
MD, MPH, FAAP, RADM USPHS (RET.)
DIRECTOR, CDC DIVISION OF REPRODUCTIVE HEALTH

Centers for Disease Control and Prevention

National Center for Chronic Disease Prevention and Health Promotion

Division of Reproductive Health
DISPARITIES IN REPRODUCTIVE HEALTH

Teen birth rates for Hispanic, Black, Hawaiian or other Pacific Islander teens were more than two times higher than the rate for white teens.

American Indian, Alaska Native, and Black women are two to three times more likely to die of pregnancy-related causes than white women.

Inequities increase by age and are present at all education levels.

In 2018, the rate of preterm birth among Black women was about 50 percent higher than among white women.
EQUITY IN DATA COLLECTION
Understand medical and non-medical contributors to deaths, prioritize interventions that effectively reduce pregnancy-related deaths.
LEADING CAUSES OF PREGNANCY-RELATED DEATH

Cardiovascular & Coronary Conditions
Hemorrhage
Infections
Embolism
Cardiomyopathy
Mental Health Conditions
Preeclampsia & Eclampsia

Percent of pregnancy-related deaths

LEADING CAUSES VARY BY RACE/ETHNICITY

Non-Hispanic Black

- Cardiomyopathy
- Cardiovascular and coronary conditions
- Hypertensive disorders of pregnancy
- Hemorrhage
- Embolism*
- Infection or sepsis

Percent of Non-Hispanic Black Deaths

Non-Hispanic White

- Mental health conditions
- Hemorrhage
- Cardiovascular and coronary conditions
- Infection or sepsis
- Cardiomyopathy
- Embolism*

Percent of Non-Hispanic White Deaths

## IDENTIFYING, DOCUMENTING AND ADDRESSING BIAS

### Discrimination

- Treating someone **more or less favorably** based on the group, class or category they belong to resulting from **biases, prejudices, and stereotyping**. It can manifest as **differences in care, clinical communication and shared decision making**.

### Interpersonal Racism

- **Discriminatory interactions** between individuals resulting in differential assumptions about the abilities, motives and intentions of others and differential actions toward others based on their race. It can be **conscious** as well as **unconscious**, and it includes acts of **commission** and acts of **omission**. It manifests as **lack of respect, suspicion, devaluation, scapegoating and dehumanization**.

### Structural Racism

- The systems of power based on **historical injustices and contemporary social factors** that **systematically disadvantage people of color** and **advantage white people** through **inequities** in housing, education, employment, earnings, benefits, credit, media, healthcare, criminal justice, etc.
Help prevent pregnancy-related deaths.
Mom's health matters too.

Listen to her concerns. It could help save her life.

www.cdc.gov/HearHer

Learn More

Listening can be your most important tool.

Over 700 women in the U.S. die every year of pregnancy-related complications. Deaths can occur up to a year after pregnancy. Most of these deaths are preventable. Many women feel that their concerns are not heard. Be the one to listen. It could help save a life.

Hear Her Campaign

BE THE SUPPORT SHE NEEDS.

** Draft Material

**
MOVING FORWARD
There is more work ahead for optimal and equitable health

- More Robust Data
- Better Awareness
- More Equitable Practices
- Better Outcomes
Thank you!

Wanda D. Barfield, MD, MPH, FAAP, RADM USPHS (ret.)

wbarfield@cdc.gov
770-488-5200

For more information, contact CDC
1-800-CDC-INFO (232-4636)

The findings and conclusions in this report are those of the authors and do not necessarily represent the official position of the Centers for Disease Control and Prevention.
Using Innovative Datasets to Ask Different Questions

Eugene Declercq, PhD
Boston University, School of Public Health
The need to ask different, more challenging questions is closely tied to exploring new datasets with new methods.

“One searches where there is light”

- Johann Wolfgang von Goethe

## The Importance of Asking Different Questions

### Practice Categories

- **FOR ALL CHILDBEARING WOMEN AND INFANTS**
  - Education, Information, Health promotion
  - Assessment, Screening, Care planning
  - Promoting normal processes, Preventing complications

- **FOR ALL CHILDBEARING WOMEN AND INFANTS WITH COMPLICATIONS**
  - First line management of complications
  - Medical obstetric neonatal services

### Organization of Care

- Available, accessible, acceptable, good quality services – adequate resources, competent workforce.
- Continuity, services integrated across community and facilities

### Values

- Respect, communication, community knowledge
- Care tailored to women’s circumstances and needs

### Philosophy

- Optimizing biological, psychological, social, and cultural processes, expectant management, using interventions only when indicated, strengthening woman’s capabilities

### Care Providers

- Practitioners who combine clinical knowledge and skills with interpersonal and cultural competence – division of roles and responsibilities based on need, competencies, resources

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**DAY 1: MATERNAL HEALTH INCUBATOR • MAY 24, 2022**

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### PELL Core Data: 1998 - 2018

<table>
<thead>
<tr>
<th>Linked (21 years)</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Live Births</td>
<td>1,633,370</td>
</tr>
<tr>
<td>Total Fetal Deaths</td>
<td>8,130</td>
</tr>
<tr>
<td>Total Mass. Res. Deliv. in Mass. Hospitals</td>
<td>1,553,646</td>
</tr>
<tr>
<td>Total Mass. Residents</td>
<td>948,643</td>
</tr>
<tr>
<td>Repeat Mothers</td>
<td>457,631</td>
</tr>
<tr>
<td>Repeat Mothers 1st birth in PELL</td>
<td>387,307</td>
</tr>
</tbody>
</table>

**NOTE:** Includes all births to MA residents (in and out of state) and in state births to non-MA residents.
Advantages of PELL as Linked Data

• Population-based with 21 years of data
• Individual-level data previously available only on an encounter basis (hospital discharge)
• Longitudinal linkage allows a life course analysis of children’s health up to 20 years old
• Measurement refinement – diversity of datasets allows for the refinements of measures of maternal, infant & child health (e.g. BC on race; HD better for L&D procedures & severe morbidity)
Working with PELL Data
Identified 21.9% more cases of SMM in prenatal and ppm periods, led by cases of sepsis.
Listening to Mothers (III & CA)
Listening to Mothers

• 30-minute postpartum surveys at national or state (CA) level of a representative sample (~1,500-2,500) of birthing people

• Developed to fill in an existing gap in PRAMS survey by looking in-depth at birthing experience from the birthing person perspective

• Explores prenatal mental health; experience and perceptions of treatments in L&D; postpartum transition to parenthood and return to work; social supports; attitudes toward birth

• Data is made available to researchers
The Rise of the Big Baby

19 pounds
## Reasons Why Mothers Experienced Medical Induction

<table>
<thead>
<tr>
<th>Reason</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Base: care provider tried to induce labor n=991</td>
<td></td>
</tr>
<tr>
<td>Baby was full term/close to due date</td>
<td>44%</td>
</tr>
<tr>
<td>Mother wanted to get pregnancy over with</td>
<td>19%</td>
</tr>
<tr>
<td>Care provider was concerned that mother was “overdue”</td>
<td>18%</td>
</tr>
<tr>
<td>Maternal health problem that required quick delivery</td>
<td>18%</td>
</tr>
<tr>
<td>MATERINITY CARE PROVIDER WORRIED THE BABY WAS TOO BIG</td>
<td>16%</td>
</tr>
<tr>
<td>Water had broken and there was a concern about infection</td>
<td>12%</td>
</tr>
<tr>
<td>Mother wanted to control timing of birth for work or other personal reasons</td>
<td>11%</td>
</tr>
<tr>
<td>Care provider was concerned that amniotic fluid around the baby was low</td>
<td>11%</td>
</tr>
<tr>
<td>Care provider was concerned that baby was not doing well</td>
<td>10%</td>
</tr>
<tr>
<td>Mother wanted to give birth with a specific provider</td>
<td>10%</td>
</tr>
<tr>
<td>Some other reason</td>
<td>10%</td>
</tr>
</tbody>
</table>

Source: Listening to Mothers 3
Are U.S. Babies Getting Bigger?...NO!

% Singleton, Full Term Babies by Birthweight, U.S., 1990-2020

What’s with these Big Babies?

Near the end of your pregnancy, did your maternity care provider tell you that your baby might be getting quite large?

<table>
<thead>
<tr>
<th>31.2% YES</th>
<th>ALL</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Actual Weight</strong></td>
<td>7 lbs 5 ounces</td>
<td>7 lbs 14 ounces</td>
<td>7 lbs 1 ounce</td>
</tr>
<tr>
<td><strong>Baby Actually Macrosomic (8lb 13ounces)</strong></td>
<td>9.9%</td>
<td>19.7%</td>
<td>5.5%</td>
</tr>
</tbody>
</table>

Disparities in Who Gets Told their Baby Might be “Quite Large”

- % Told Baby Might be Quite Large
- % Infants 4000+Gms

Non-Hispanic White: 26.9% (10.7%)
Non-Hispanic Black: 34.7% (7.8%)
Hispanic: 38.1% (9.4%)

Source: Listening to Mothers 3
What’s the Impact of Being Told You Might Have a Big Baby? Labor and Delivery Outcomes

<table>
<thead>
<tr>
<th>Suspected Large Baby</th>
<th>Yes</th>
<th>No</th>
<th>Significance (*** p &lt; 0.001)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tried Self Induction of Labor</td>
<td>43.0%</td>
<td>24.7%</td>
<td>***</td>
</tr>
<tr>
<td>Medical Induction of Labor</td>
<td>70.1%</td>
<td>51.1%</td>
<td>***</td>
</tr>
<tr>
<td>Cesarean Delivery</td>
<td>21.1%</td>
<td>18.1%</td>
<td></td>
</tr>
<tr>
<td>Epidural Analgesia</td>
<td>72.7%</td>
<td>61.7%</td>
<td>***</td>
</tr>
<tr>
<td>Requested Cesarean Section</td>
<td>32.5%</td>
<td>6.8%</td>
<td>***</td>
</tr>
</tbody>
</table>

Source: Cheng et al. MCH Journal. 2015. 19:2578–2586

*BirthByTheNumbers.org*
PARENTING

When a Big Baby Isn’t So Big

By Roni Caryn Rabin    January 11, 2016 3:36 pm

Were You Told You Were Having a Big Baby? Tell Us About It.

Required fields are marked with an asterisk.
Let Me Tell You About My Big Baby

By Roni Caryn Rabin  January 21, 2016 7:00 am

What happens when a doctor predicts the wrong birth weight?

My article last week about birth weight predictions and the impact they have on childbirth generated a lively online discussion, drawing responses from over 1,100 mothers with a wide variety of birth experiences.
www.birthbythenumbers.org

Email: birthbynumbers@gmail.com
Twitter: @BirthNumbers
FACEBOOK: www.facebook.com/BirthByTheNumbers

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Maternal and Infant Health Quality Improvement Initiative

Kristen Zycherman, RN, BSN
Centers for Medicare and Medicaid and CHIP Services
Overview

• Medicaid and Maternal and Infant Health
• Background on Quality Measurement and the Maternal and Infant Health Initiative
• Improving Postpartum Care
• Improving Maternal Health through Reducing Low-Risk Cesarean Sections
• Tobacco Cessation for Pregnant and Postpartum Women Technical Assistance
• Other Maternal and Infant Health Activities
Medicaid and Maternal Infant Health

- Nearly 2 out of every 3 adult women enrolled in Medicaid are in their reproductive years (ages 19-44)
- Medicaid currently finances about 42% of all births in the United States
- The Centers for Medicare & Medicaid Services (CMS) can play a major role in improving the quality of maternity care, birth outcomes and in measuring how care is delivered to pregnant and postpartum people
- CMS is in a unique position to improve perinatal outcomes and reduce disparities through quality measurement and quality improvement
Quality Measurement

• The data and measurement efforts of the Centers for Medicare & Medicaid Services (CMS) help CMS and states to better understand the quality of health care received by Medicaid and CHIP beneficiaries

• CMS identified Core Set measures for voluntary reporting by state Medicaid and CHIP agencies to support maternal and perinatal health-focused efforts

• The 2022 Maternity Core Set, which consists of six measures from the Child Core Set and three measures from the Adult Core Set, is a resource for CMS and states to measure progress toward improving maternal and perinatal health in Medicaid and CHIP

• More information about state reporting of these maternal and perinatal measures and the 2022 Maternity Core Set is available at https://www.medicaid.gov/medicaid/quality-of-care/improvement-initiatives/maternal-infant-health/data-and-measurement/index.html

• Reporting on the Child Core Set measures and Behavioral Health measures in the Adult Core Set will become mandatory in 2024
The Centers for Medicare & Medicaid Services (CMS) launched the Maternal and Infant Health Initiative (MIHI) in July 2014 to improve access to and quality of care for pregnant and postpartum persons and their infants.

Initially, the MIHI focused on improving the rate and quality of postpartum visits and increasing the use of effective methods of contraception based on recommendations from a CMS Expert Panel on Improving Maternal and Infant Health Outcomes in Medicaid and Children's Health Insurance Program (CHIP).

In 2019-2020, CMS convened an MIH expert workgroup to provide updated recommendations about where Medicaid and CHIP have a significant opportunity to influence change in maternal and infant health.

In December 2020, CMS launched the next phase of the MIHI to support state Medicaid and CHIP agencies in their efforts to improve maternal and infant health through a series of learning collaboratives.
Focus Areas to Improve Maternal and Infant Health Quality

Focus Areas

Maternal Outcomes

- Primary aims: Eliminate preventable maternal mortality, SMM, and inequities
  - Increased depression screening and increased breastfeeding competence
  - Decreased severe maternal morbidity
  - Decreased postpartum complications
  - Increased access to contraceptive care, better management of chronic diseases and behavioral health issues, increased connection to ongoing care

- Improved birth spacing, early initiation of prenatal care, healthy women at start of possible subsequent pregnancy
- Lower risk for C-section delivery on possible subsequent pregnancy

Infant Outcomes

- Primary aims: Reduce infant mortality and eliminate inequities in infant mortality rates
  - Fewer NICU admissions
  - Increased immunizations, increased breastfeeding, fewer injury related ED visits, safer sleep practices, and increased parent knowledge on injury prevention

- Healthier women at start of possible subsequent pregnancy, early initiation of prenatal care
- Healthy possible subsequent birth

Strategies to decrease cesarean births for women with low-risk pregnancies

Strategies to increase use and quality of postpartum care

Strategies to increase use and quality of well-child visits

DAYS 1: MATERNAL HEALTH INCUBATOR • MAY 24, 2022

DAY 1: MATERNAL HEALTH INCUBATOR • MAY 24, 2022

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During pregnancy: 31.3%
On day of delivery: 16.9%
1–6 days postpartum: 18.6%
7–42 days postpartum: 21.4%
43–365 days postpartum: 11.7%

Evolving Concept of Postpartum Care

Expansion of the postpartum care period beyond a single six-week postpartum check

All birthing people have contact with their health care providers within the first three weeks postpartum.

Initial visit followed by individualized ongoing care including a comprehensive postpartum visit no later than 12 weeks after birth.

Timely follow-up care with providers for women with pregnancy complications or chronic medical conditions.

Expansion of the scope of care includes recovery from childbirth and assessment of

- physical, social, and psychological well-being;
- infant care and feeding;
- reproductive health;
- sleep and fatigue;
- chronic disease management;
- health maintenance

Discrimination, systemic inequities, and social determinants of health contribute to poor postpartum outcomes for Black birthing persons and other people of color.

Sources:


A Median of 72 percent

The postpartum care measure assesses how often women delivering a live birth received timely postpartum care (between 7 and 84 days after delivery).

Postpartum visits provide an opportunity to assess women’s physical recovery from pregnancy and childbirth, and to address chronic health conditions (such as diabetes and hypertension), mental health status (including postpartum depression), and family planning (including contraception and interconception counseling).

Source: Mathematica analysis of MACPro reports for the FFY 2020 reporting cycle as of June 18, 2021.
Notes: This measure shows the percentage of deliveries of live births on or between October 8 of the year prior to the measurement year and October 7 of the measurement year that had a postpartum visit on or between 7 and 84 days after delivery. Specifications for this measure changed substantially for FFY 2020 and rates are not comparable with rates for previous years. This chart excludes Minnesota and Oregon, which reported the measure but did not use Core Set specifications.
Source: Mathematica analysis of MACPro reports for the FFY 2020 reporting cycle as of June 18, 2021.
Note: This chart excludes Minnesota and Oregon, which reported the measure but did not use Core Set specifications.
Addressing Specific Postpartum Needs

- Medicaid enrollees are more likely to smoke during pregnancy and have chronic diseases compared with uninsured and privately insured individuals.

- By ensuring individuals have access to the contraceptive method of their choice, and the support necessary to use their chosen method effectively, states can support not only the health of beneficiaries and their children, but also reduce the number of unintended pregnancies.

- People of color and low-income individuals have the highest rates of postpartum depression.

- Individuals with public insurance have lower breastfeeding rates than those with private insurance.

- Oral health during and after pregnancy affects the health of both the postpartum individual and the infant.
Postpartum Care Learning Collaborative

Webinar series

- Webinar 1: Maintaining Coverage and Access to Care During the Postpartum Period
- Webinar 2: Improving the Content of Care During the Postpartum Period
- Webinar 3: Models of Women-Centered Care


Postpartum Care Affinity Group

Action-oriented affinity group that is supporting nine state Medicaid and CHIP programs and their partners in the design and implementation of data-driven quality improvement (QI) projects to improve postpartum care.

Participating states (9): KS, TX, OK, WY, MO, KY, SC, MT, GA
Reducing Low-Risk Cesarean Delivery

One factor associated with rising maternal morbidity is the increased use of cesarean sections.

For births paid for by Medicaid in 2018, the overall cesarean rate was 31.7% and the cesarean rate among low-risk pregnancies was 24.9%.*

Low-risk pregnancies are defined as nulliparous (first-time pregnancies), term (37 or more weeks gestation), singleton (one fetus), vertex (head facing down in the birth canal) or “NTSV births.” Includes those that are first-time, term (ending in a birth at 37 weeks or greater gestation), a single baby, and with the baby in the vertex or head down position (NTSV).

Cesarean section for women with low-risk pregnancies is an overused procedure that has not led to better outcomes for infants or women. Maternal complications include infections, blood clots, and the need for an emergency hysterectomy.

Following the first cesarean, there is about a 10 percent likelihood of a subsequent vaginal delivery** and women with a history of previous cesarean births have a higher risk of maternal morbidity.***

Low-Risk (NTSV) Cesarean Delivery Data

- PC-02: Cesarean Birth measure has never been publicly reported by CMS due to the low number of states reporting the measure.

- The Low-Risk Cesarean Delivery (LRCD-CH) measure replaced the PC-02: Cesarean Birth measure in the 2021 Child Core Set.

- To reduce state burden and report a cesarean birth measure consistently across all states, CMS will calculate the LRCD-CH measure on behalf of states using National Vital Statistics System Natality data that are submitted by states and obtained through CDC Wide-ranging Online Data for Epidemiologic Research (WONDER) starting in FFY 2021.
Low-Risk Cesarean Delivery Learning Collaborative

In March, CMCS launched a learning collaborative focused on reducing cesarean section births among low-risk pregnancies to ensure birthing people and their babies have healthy birth outcomes and avoid the increased risks postpartum and in subsequent pregnancies.

The first webinar took place March 31, 2022, and dates for the subsequent webinars will be announced soon. Expression of Interest forms for participation in the affinity group will be due June 31, 2022.

The Low-Risk Cesarean Delivery learning collaborative will include:

• A series of webinars on effective strategies to lower the rates of low-risk cesarean deliveries closer to the recommended rate in Healthy People 2030
• An action-oriented affinity group to support states in developing and implementing QI projects to reduce the rate of low-risk cesarean deliveries
Tobacco Cessation for Pregnant and Postpartum Women

Smoking during pregnancy can harm the health of both the mother and the infant. Women covered under Medicaid are three times more likely to smoke during the last trimester of pregnancy than privately-insured women.

CMCS has launched new tobacco cessation technical assistance resources on Medicaid.gov including:

- On-demand series of short, recorded programs featuring subject matter experts and descriptions of successful state strategies to help Medicaid and CHIP beneficiaries be smoke-free during pregnancy and after delivery: https://www.medicaid.gov/medicaid/quality-of-care/quality-improvement-initiatives/tobacco-cessation/technical-assistance/index.html
- Resources to support tobacco cessation, including driver diagrams, change activities and project management tools (coming soon!)
- Option for quality improvement coaching by request
CMS Maternal and Infant Health Activities

Postpartum coverage extension guidance

- Sections 9812 and 9822 of the American Rescue Plan Act of 2021 (ARP) (Pub. L. 117-2) give states a new option to provide 12 months of extended postpartum coverage to pregnant individuals enrolled in Medicaid and CHIP beginning April 1, 2022. The State Health Official (SHO) letter is to provide guidance to states on implementation of this new state option, including considerations for ensuring access to equitable, quality care. CMS has also approved demonstrations to extend postpartum coverage through 1115 waiver authority: https://www.medicaid.gov/federal-policy-guidance/downloads/sho21007.pdf

The Maternity Core Set

- CMS identified a core set measures for voluntary reporting by state Medicaid and CHIP agencies, to support our maternal and perinatal health-focused efforts.
- The 2022 Maternity Core Set, which consists of 6 measures from CMS’s Child Core Sets and 4 measures from the Adult Core Set, will be used by CMS to measure and evaluate progress toward improvement of maternal and perinatal health in Medicaid and CHIP, and is available on Medicaid.gov at: https://www.medicaid.gov/medicaid/quality-of-care/improvement-initiatives/maternal-infant-health/data-and-measurement/index.html
CMS Maternal and Infant Health Activities

Equity Assessment

- CMS conducted an assessment of the equity of the quality of care in the postpartum period among Medicaid and Children’s Health Insurance Program (CHIP) postpartum women and birthing persons.

Challenge.gov Prize Competition

- Based on the findings of the CMS Equity Assessment on Equity in Postpartum Care, CMS partnered with the Office of Women’s Health to produce the HHS Postpartum Equity in Care Challenge.
- This Challenge prize competition aims to identify innovative strategies to improve postpartum care for Black and American Indian/Alaska Native (AI/AN) postpartum individuals and it has a particular emphasis on follow-up care for conditions associated with maternal morbidity and mortality in the postpartum period. Challenge entries will serve as examples of effective programs and practices to reduce disparities and improve outcomes for postpartum Black or African American and AI/AN women.
- These examples will inform CMS technical assistance to state Medicaid and CHIP agencies as they work to improve equity in postpartum care and outcomes.
CMS Maternal and Infant Health Activities

Maternal Health Agency Priority Goal

• Improve maternal health and reduce disparities nationwide and globally by assuring the equitable provision of evidence-based high-quality care and addressing social determinants of health, including racism, discrimination, and other biases, across the life course

Maternal Health Action Plan

• https://aspe.hhs.gov/topics/public-health/hhs-initiative-improve-maternal-health#maternal-health

• Targets:
  ▪ Reduce the maternal mortality rate by 50 percent in 5 years
  ▪ Reduce the low-risk cesarean delivery rate by 25 percent in 5 years
  ▪ Achieve blood pressure control in 80 percent of women of reproductive age with hypertension in 5 years
CMS Maternal and Infant Health Activities

Maternal Health Agency Priority Goal

• Improve maternal health and reduce disparities nationwide and globally by assuring the equitable provision of evidence-based high-quality care and addressing social determinants of health, including racism, discrimination, and other biases, across the life course

Maternal Health Action Plan


• Targets:
  ▪ Reduce the maternal mortality rate by 50 percent in 5 years
  ▪ Reduce the low-risk cesarean delivery rate by 25 percent in 5 years
  ▪ Achieve blood pressure control in 80 percent of women of reproductive age with hypertension in 5 years
Resources


Generate Health St. Louis

Sarah Kennedy, MPH
Senior Manager of Epidemiology & Evaluation, Generate Health STL
Generate Health St. Louis

OUR MISSION
Generate Health mobilizes and inspires the St. Louis region to advance racial equity in pregnancy outcomes, family well-being, and community health.

INTERMEDIARY ORGANIZATION
- Illuminate the root causes of racial disparities
- Advocate for the redirection of resources to eliminate racial disparities
- Catalyze action within the ecosystem
- Advance regional accountability for equitable systems

GENERATE HEALTH INITIATIVES

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Collective Impact Data & Evaluation

5 Conditions of Collective Impact

- 01 A Common Agenda
- 02 Shared Measurement System
- 03 Mutually Reinforcing Activities
- 04 Continuous Communication
- 05 Backbone Support Organization

Typical Focus of Program Evaluation

- Assessing the impact of a specific intervention
- Evaluating effects and impact according to a predetermined set of outcomes
- Using logic models that imply cause and effect, and linear relationships
- Providing findings at the end of the evaluation

Evaluating CI as a Complex Intervention

- Assessing multiple parts of the system, including its components and connections
- Evaluating intended and unintended outcomes as they emerge over time
- Evaluating non-linear and non-directional relationships between the intervention and its outcomes
- Embedding feedback and learning through the evaluation

Emphasis on Qualitative Data Collection

Equality

Equity

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FLOURISH
Infant Mortality Initiative

North Star: Eliminate racial disparities in infant mortality by 2033

FLOURISH Priorities

Safe Sleep
Coordinated Quality Care
Social Determinants of Health
Racial Equity Capacity Building
FLOURISH Priority- Social Determinants of Health

Transportation
• Community Leader Stories shaped an understanding about the reality of non-emergency medical transportation (NEMT)
• Engagement Sessions with systems leaders and community members helped reimagine a better system
• Data Work Group reviewed Managed Care data to understand how NEMT affects Health Outcomes of their consumers
• Complaint Survey collected information about times when the NEMT system failed a patient
• Maps and inventory of bus stop structures, bus routes, neighborhood walkability in FLOURISH’s high impact zip codes

Housing
• Story Elevation & Advocacy when community members brought attention to parents not practicing safe sleep because of mice infestation of a housing complex
• Photovoice Project for pregnant and parenting women to highlight their living conditions within a housing complex
FLOURISH Priority-Coordinated Quality Care & Safe Sleep

Community Information Exchange

- Safe Sleep
- Perinatal Behavioral Health
- Home Visitation

Resource Directory + Central Record + Data Transfer

Data Protection
### FLOURISH Priority-Racial Equity Capacity Building

#### Community Led Investments

<table>
<thead>
<tr>
<th>Category</th>
<th>Number</th>
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</thead>
<tbody>
<tr>
<td>Community Review Committee Members</td>
<td>14</td>
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<tr>
<td>Black Led Organizations</td>
<td>86%</td>
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<tr>
<td>Organizations Funded</td>
<td>93</td>
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<tr>
<td>Projects</td>
<td>119</td>
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<tr>
<td>COVID 19 Grants</td>
<td>58</td>
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<tr>
<td>Aligned Activities Grants</td>
<td>17</td>
</tr>
<tr>
<td>Community Mobilization &amp; Innovation Grants</td>
<td>44</td>
</tr>
<tr>
<td>Funding Distributed</td>
<td>$2.92 million</td>
</tr>
</tbody>
</table>

- Capacity building around various topics offered, including evaluation
- Project outcomes data collected & transformed into summary dashboard
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FLOURISH Data Visualization Project

Community Data Sessions

Infographic Series

Mini Dashboards

Story Map
Resources for Data Collaboration
Contact Information

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Using Legal Services to Address and Improve Maternal Health Outcomes

AN INTRODUCTION TO THE MEDICAL-LEGAL PARTNERSHIP APPROACH

S. Roxana Richardson, Esq.
Medical-Legal Partnership Director and Managing Attorney
Perinatal Legal Assistance and Well-being Project
Georgetown University Health Justice Alliance
# Table of Contents

I. The Medical-Legal Partnership (MLP) Model & Health-Harming Legal Needs

II. The Research Base—What We Know About the Impact of MLP

III. The Potential for MLP Intervention during the Perinatal Period

VI. The Perinatal Legal Assistance & Well-being Project: A Maternal Health MLP
The Medical-Legal Partnership Model

In a Medical-Legal Partnership (MLP), the health care team works with lawyers to address a subset of social determinants of health, called “health-harming legal needs,” that require legal advocacy to overcome.
Health-Harming Legal Needs

“A social problem that adversely affects a person's health or access to healthcare, and that is better remedied through joint legal care and healthcare than through healthcare services alone.” - National Center for Medical-Legal Partnership
Common Health-Harming Legal Needs of Perinatal Patients

**Work**
- Job Accommodations
- Discrimination
- Parental Leave
- Family Medical Leave Act
- Short-term/Long-term Disability Leave

**Home**
- Housing Conditions
- Housing Accessibility
- Eviction

**Family**
- Custody
- Paternity
- Child Support
- Domestic Violence
- Public Benefits/Income Supports

**DAY 1: MATERNAL HEALTH INCUBATOR • MAY 24, 2022**
### MLP Research Base – What We Know

<table>
<thead>
<tr>
<th>Patient Impact</th>
<th>Provider Impact</th>
<th>Health System Impact</th>
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<tbody>
<tr>
<td><strong>Healthcare:</strong></td>
<td><strong>Well-being:</strong></td>
<td><strong>Financial:</strong></td>
</tr>
<tr>
<td>• Decrease in missed appointments</td>
<td>• Increased provider satisfaction</td>
<td>• Financial return on investment (ROI)</td>
</tr>
<tr>
<td>2,3,18</td>
<td>16,17</td>
<td>14</td>
</tr>
<tr>
<td>• Decrease in treatment interruptions 2,3,18</td>
<td>• Mitigation of provider burnout</td>
<td>• Health care recovery dollars</td>
</tr>
<tr>
<td>• Decrease in ED visits 3,4,8,11</td>
<td>16,17</td>
<td>14,25</td>
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<tr>
<td>• Decrease in hospital visits 3,4,8,11,12</td>
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<td>• Increased reimbursement from</td>
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<tr>
<td>• Improved utilization of primary and preventive care 4</td>
<td></td>
<td>private and public insurers</td>
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<tr>
<td>• Improved treatment adherence 2,4</td>
<td></td>
<td>14,16,18,19</td>
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<tr>
<td><strong>Mental and physical health:</strong></td>
<td></td>
<td>• Reduced Charity Care payouts</td>
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<tr>
<td>• Alleviation of emotional distress 2</td>
<td></td>
<td>16</td>
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<tr>
<td>• Improved mental health 3,7</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Decreased stress 4,8,10,12</td>
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<td></td>
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<tr>
<td>• Improved physical health 3,8,11,12,13,14</td>
<td></td>
<td></td>
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<tr>
<td><strong>Overall well-being:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Improved quality of life 2,18</td>
<td></td>
<td></td>
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<tr>
<td>• Improved patient personal financial situation 5,6</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Improved well-being 4,9,12,13,15</td>
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</tbody>
</table>
MLP intervention during prenatal period has the potential to improve health outcomes.

HEALTH-HARMING LEGAL NEEDS LINKED TO NEGATIVE PERINATAL OUTCOMES

- Housing insecurity during pregnancy associated with increased risk of low birthweight and/or preterm birth and extended hospitalization.
- Food insecurity/material hardship is associated with perinatal depression and anxiety.
- Low birth weight and preterm births are increased among women exposed to domestic violence.
The Perinatal Legal Assistance & Well-being Project: A Maternal Health MLP

• A partnership between Georgetown University Health Justice Alliance and MedStar Washington Hospital Center’s (WHC) Women’s and Infants’ Services (WIS)

• Provides legal services to pregnant and postpartum WIS patients to address barriers to health and wellbeing

• Trains healthcare teams to identify and refer patients with legal needs to the legal team

• Provides opportunities for Georgetown students to engage in the MLP model

• Evaluates its impact on patients, providers, and the health system to contribute to the MLP evidence base
WIS Patient Population at High Risk for Negative Perinatal Health Outcomes

84% of WIS patients are Black

Majority of WIS patients (87%) are unmarried (single, divorced, or widowed)
  • In the U.S., 40% of births are to unmarried women

More than half of WIS patients live in neighborhoods that are underserved by health and social services (DC Wards 5, 7, and 8)

Teen pregnancy rate at WIS nearly double that of national rate (9% v. 4.8%)

95% of WIS patients are on public insurance
  • 51% of births in the U.S. are on public insurance
Perinatal LAW Project Successes

- Secured a paid extended leave of absence and short-term disability claim for a pregnant patient during a suicidal mental health crisis and connected her to behavioral health services
- By appealing and providing additional evidence that the patient was in fact eligible for Supplemental Nutrition Assistance Program (SNAP) benefits, we reversed an administrative decision that denied a first-time mother facing food insecurity SNAP benefits
- Secured an emergency housing voucher and transfer for a single mother of 6 who was being stalked and harassed at her current home by the family and friends of her ex-partner/abuser

“I had given up and was really thinking that this was it for me. But I put my pride to the side and asked for help and the [team at WIS] put me in contact with you and now I am ready to keep fighting!”
Evaluating the Impact of the Perinatal LAW Project

1. Evaluation Question: Was receiving legal services associated with improved patient outcomes?
   Metrics:
   - Patients perceive they were treated with compassion
   - Decrease in stress
   - Improved appointment attendance
   - Improved knowledge of legal rights
   - Improved ability to self-advocate
   - Improved personal financial situation

2. Evaluation Question: Was interaction with the P-LAW Project associated with improved provider outcomes?
   Metrics:
   - Increased confidence in legal issue spotting
   - Increased competence in legal issue spotting
1. The Hidden Cost of Cancer: Helping Clients Cope with Financial Toxicity; Chi, 2017
3. https://www.mlpcolorado.org/results
4. Medical-Legal Partnerships: A Scan of the Landscape and a Look Forward; Spangler, 2020
5. Doctors and Lawyers Collaborating to HeLP Children: Outcomes from a Successful Partnership between Professions; Klein et. al., 2013; via https://medical-legalpartnership.org/impact/
7. Medical-Legal Partnerships at Veterans Affairs Medical Centers Improved Housing and Psychosocial Outcomes for Vets; Tsai et. al., 2017; via https://medical-legalpartnership.org/impact/
8. Bridging Health Disparity Gaps through the Use of Medical Legal Partnerships in Patient Care; Martinez et. al., 2020
9. Pilot Study of Impact of Medical-Legal Partnership Services on Patients’ Perceived Stress and Wellbeing; Ryan et. al., 2012; via https://medical-legalpartnership.org/impact/
11. Environmental Improvements Brought by the Legal Interventions in the Homes of Poorly Controlled Inner-city Adult Asthmatic Patients: A Proof-of-Concept Study; O'Sullivan et.al., 2012; via https://medical-legalpartnership.org/impact/
12. Pilot Study of Medical-Legal Partnership to Address Social and Legal Needs of Patients; Weintraub et. al., 2010; via https://medical-legalpartnership.org/impact/
15. Medical-Legal Strategies to Improve Infant Health Care: A Randomized Trial; Sege et. al., 2015; via https://www.countyhealthrankings.org/take-action-to-improve-health/what-works-for-health/strategies/medical-legal-partnerships
16. The Health Law Partnership: Adding a Lawyer to the Health Care Team Reduces System Costs and Improves Provider Satisfaction; Pettignano et. al., 2012
17. Higher Perceived Clinic Capacity to Address Patients’ Social Needs Associated with Lower Burnout in Primary Care Providers; Olayiwola et. al., 2018
18. The Attorney as the Newest Member of the Cancer Treatment Team; Fleishman et. al., 2006
19. A Medical-Legal Partnership as a Component of a Palliative Care Model; Rodabaugh et. al., 2010
21. Severe housing insecurity during pregnancy: Associated with adverse birth and infant outcomes; Leifheit et. al.; 2020
22. Material hardship and mental health symptoms among a predominantly low income sample of pregnant women seeking prenatal care; Katz et. al.; 2018
23. Maternal exposure to domestic violence and pregnancy and birth outcomes: a systematic review and meta-analyses; Shah et. al.; 2010
24. Medical-legal partnership and Healthy Start: Integrating civil legal aid services into public health advocacy; Atkins et. al.; 2014
25. Health care recovery dollars: A sustainable strategy for medical-legal partnerships?; Knight; 2008
Questions?

Roxy Richardson, Esq.

https://www.law.georgetown.edu/health-justice-alliance/our-work/perinatal-law-project/

plaw@Georgetown.edu
What Are Birthing People in the U.S. Saying?

Highlights from AAMC Center for Health Justice's Polling of Birthing People

Logan Burdette
Health Policy Intern, AAMC Center for Health Justice
Polling

Sample: 1,206 birthing people
Conducted from March 29-April 3, 2022
Birthing people who reported their most recent birthing experience as ‘less than good’

- All Birthing People: 20%
- Gen Z: 18%
- Millennial: 28%
- Income <$50K: 11%
- Income $100K+: 25%
- Urban: 17%
- Rural: 25%
- Straight: 18%
- LGBTQ+: 30%

All demographic groups are significantly different from their comparison groups at the p<0.05 level.
Birthing people who reported postpartum complications

- Any Postpartum Complications: 66%
- Mental Health Complications: 38%
- Lactation/Breastfeeding Complications: 36%
- Physical Complications: 23%
Birthing people who did NOT receive mental health screenings

- All Birthing People: 30%
- Hispanic: 38%
- Non-Hispanic White: 25%
- Income: <$50K: 34%
- Income: $100K+: 21%
- Unemployed: 40%
- Working: 27%

All demographic groups are significantly different from their comparison groups at the p<0.05 level.
Birthing people who felt the quality of their care was impacted by experienced bias and discrimination

All birthing people: 37%
- Non-Hispanic White: 34%
- Millennials: 37%
- Income: <$50K: 42%
- Straight: 35%
- Gen Z: 47%
- Income: $100K+: 27%
- LGBTQ+: 51%
- Non-Hispanic Black: 46%

All demographic groups are significantly different from their comparison groups at the p<0.05 level.
Did you experience any challenges during pregnancy/labor, or after giving birth, that were caused or made difficult by the COVID-19 pandemic? If yes, please describe.

“The pandemic started when my baby was very small, and this made me feel frustrated because of the fear of the virus. Since I don't have help of any kind, not knowing many things about my postpartum and how to take care of my baby, it was difficult.”

“I had to give birth with a mask on and also no visitors - including my four-year-old who was dying to meet her baby sister - were allowed to visit. That broke my heart.”
What was the impact of COVID-19?

Common Themes:

- Not being able to have visitors
- Fear for child’s health
- Lack of social support
- Limited availability for doctor appointments
- Difficulties with work and finances
What was the impact of COVID-19?

COVID-19 Vaccine Uptake

• 62% ineligible while pregnant
• Of those eligible, 60% did not receive a vaccine
• Of those eligible, who received the vaccine while pregnant?
  ▪ Hispanic, college educated, and higher income birthing people were most likely to be vaccinated while pregnant
What specific complications did you face after most recently giving birth?

“Severe depression due to lack of emotional support.”

“Due to stress, I was not able to get a good milk supply to continue breastfeeding.”

“I had post-partum depression, a lot of anxiety, and I did not want to return to work and have to be away from my kids for 40 hours a week.”

“They hit my spinal fluid so I wasn't able to work. I was physically laying in the bed almost all the time.”

*Among those that report experiencing some type of complication following their most recent birth.
From Pregnancy to Policy: Experiences of Birthing People in the United States

https://www.aamchealthjustice.org/our-work/maternal-health-equity/polling
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DAY 2: MATERNAL HEALTH INCUBATOR • MAY 25, 2022

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Welcome to Day 2 of the Maternal Health Incubator!
The AAMC Center for Health Justice Welcomes You to Day 2 of the Maternal Health Incubator

Daria Grayer, MA, JD
Senior Lead Specialist, Science Policy and Regulations
Scientific Affairs, AAMC
Policy Team, Center for Health Justice
Day 2 Agenda: Action for Policy

11:15 AM  Roundtable Discussion: Implications for Policy
12:30 PM  Break
1:00 PM   Action Planning: Building a Multisector Agenda for Maternal Health Equity
1:45 PM   Break
2:00 PM   What's Next? Brainstorming Future Activities
2:50 PM   Closing Remarks

*All times are EST
State and Federal Policy: Key Issues to Note from Day 1

- Expansion of funding for maternal health research
- Need for increased collection and evaluation of data
- Increasing access to maternal health care (e.g., telehealth services)
- Increasing recruitment for a diverse health care workforce
- Expansion of postpartum insurance coverage (e.g., up to a year) and the enactment of federal paid family leave
Paid Leave

• Findings from the Center’s poll of birthing people:
  • 66% of birthing people worked for pay during their most recent pregnancy
  • 39% of working birthing people did NOT have access to paid leave
• Continued research and findings
  • 10 states + DC have enacted some form of paid family leave
Highlights from AAMC Center for Health Justice’s Health Impact Assessment (HIA) on Paid Leave

• Maternal HIA on paid family leave
  • Positive and negative impact on postpartum mental and physical health and associated inequities

• Findings from literature review

• Stay tuned for future updates

• Feel free to reach out with questions dgrayer@aamc.org

Special thanks to the HIA team: Philip Alberti, Diane Cassidy, Olufunmilayo Makinde, Kendal Orgera

& Policy team: Anurupa Dev, Heather Pierce, Phoebe Ramsey
Roundtable Discussion: Implications for Policy

Remarks from U.S Representative Sharice Davids, JD
Kanika Harris, PhD, MPH, Anushay Hossain, and Terri D. Wright, PhD, MPH

Moderated by Ally Perleoni, MA
Manager of Government Relations, AAMC
U.S. Representative, Sharice Davids, JD
Meet the Panelists

Kanika Harris, PhD, MPH
Director of Maternal and Child Health, Black Women’s Health Imperative

Anushay Hossain
Writer and Feminist Policy Analyst

Terri D. Wright, PhD, MPH
Health and Racial Equity Strategist, Public Health Scientist
Q&A and Moderated Discussion
Book Giveaway Winners

Rakiya Moore
Naomi Booker
Jasmine Bihm
Ruby Crawford-Hemphill
Rossana Roberts
Denise Willers
Michelle Debbink
Carnesha Keys
Karen Morris
Abigail Asare
Colleen Wilburn
Alison Williams
Moriah Bell

Tina Lopez
Samantha Benigni
Venus Uttchin
Kimberly Sherman
Monica Ray
Melody Bockenfeld
Anne McHugh
Penelope Karambinakis
Megan Horstman
Carleigh Frazier
Kim Drumgo
Deyanna Boston
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