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AAMC Center for Health Justice
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It Takes a Village

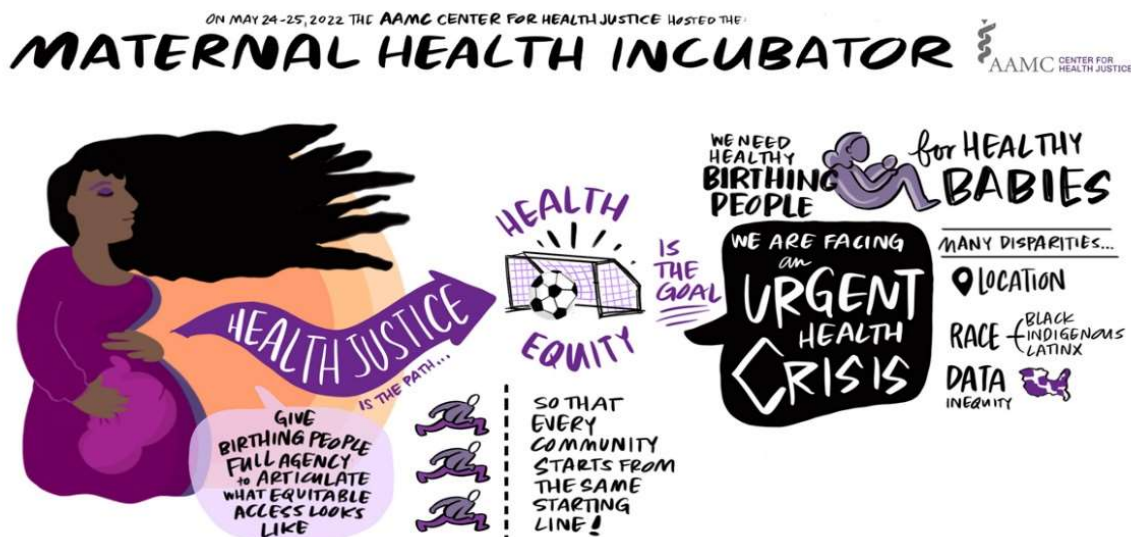
A Multisector Approach to Health Equity for
Women and Birthing People

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Executive Summary

The United States has one of the highest rates of maternal mortality among developed countries. Birthing people who identify as Black or American Indian/Alaska Native are 2-3 times more likely than their White counterparts to die from pregnancy-related complications. The markedly higher rates of maternal morbidity and mortality are driven largely by longstanding inequities in maternal health that date back as far as slavery. These inequities are not limited to people with low incomes or low educational attainment — they are observed among diverse groups across all levels of socioeconomic status.

The root causes of health inequities for pregnant and birthing people are multifactorial and complex. They include the impact of unfavorable social determinants of health such as financial and food insecurity, lack of access to care, substandard housing, and lack of transportation. These health inequities are also driven by structural and interpersonal racism, implicit bias, and discrimination in health care systems, in medical education, and among practicing clinicians. They also result from other factors including inadequate postpartum care; lack of data describing the qualitative aspects of pregnancy, birth, and postpartum care; insufficient coverage for paid parental leave; limited access to midwives, doulas, and other non-physician maternal health care professionals, including mental health professionals; and insufficient numbers of culturally responsive maternal health care professionals.

Although there is a growing number of local, state, and federal efforts to address gaps in maternal health equity, much work remains. In response to these persistent challenges, the AAMC Center for Health Justice (the center) hosted the two-day Maternal Health Incubator (MHI) in May 2022 to begin crafting a thoughtful, forward-looking, and collaborative plan to address them. The meeting had several goals:

- Improve understanding of how better data can help close gaps in maternal health outcomes
- Explore how multisector and policy efforts can facilitate perinatal health equity.
- Develop a collaborative multisector Action Plan to inform the creation of policies to eliminate maternal health inequities

The MHI included presentations, panel discussions, and patient stories that highlighted the pressing need to improve birthing peoples' experiences, data collection and reporting, and strategies to accelerate development of evidence-based, culturally aware, and innovative approaches to decrease longstanding maternal health inequities. Several themes emerged from the two-day meeting:

- Birthing people must be heard
- Improved maternal health data collection and sharing are needed
- The condition or quality of social determinants of health influence care access, delivery, and outcomes
- Government is a critical partner in promoting perinatal health equity for pregnant and birthing people
- Do not separate the health of parents and babies
- Innovative, community-based strategies improve outcomes
- Training and deployment of the health care workforce must be improved

The impact of mental health on birthing people was also discussed throughout the conference, and this topic was embedded in each of the above themes. Drawing on these themes, MHI participants were asked to articulate ideas that could serve as a springboard for a future, action-oriented plan to address inequities. They offered the following suggestions for forward movement on these challenging issues:

- Identify and incorporate novel partners into maternal health equity efforts
- Build a larger tent that includes nonphysician health professionals
- Shift the power in decision-making to the local level
- Assess and act on the distinction between high- and low-risk pregnancies
- Overhaul the concept and delivery of postpartum care
- Promote paid family leave
- Improve maternal health and mental health data collection to inform policy change

Incubator participants agreed that no single approach or strategy will fully address the complex and longstanding constellation of factors that has driven these health inequities for generations. Yet, they were optimistic that these problems can be solved, and that communities are invested in working with other interested parties to identify and implement solutions. However, they emphasized that public and private insurers, policymakers, health systems, and entities that train all segments of the health care workforce need to prioritize improving maternal health and take active steps to coordinate a thoughtful and evidence-based strategy that supports parents and their children.

A note on language: This report uses *both* women-specific terms *and* gender-inclusive terms. *Maternal health* is an important term in the work already taking place around pregnancy and childbirth-related inequities, so the AAMC Center for Health Justice has continued to use it in tandem with inclusive terms. Using *only* gendered terms such as “women” and “mothers” to describe all people who become pregnant and/or give birth renders invisible those who become pregnant and/or give birth who are not women (including but not limited to transgender men, nonbinary and gender diverse people, and intersex people). With this invisibility, health inequities are also invisible and cannot be addressed. Using gender-inclusive language allows for a more complete understanding of who gives birth and who experiences health inequities, and it acknowledges the identities of all. Exclusionary language perpetuates health inequities.

The opinions expressed in this report do not necessarily reflect the opinions of the AAMC or its members.

Introduction

Among high-income, developed countries, the United States ranks near the highest in maternal mortality, and this trend is worsening.¹ Behind these statistics lie inequities in maternal health care and outcomes that date as far back as slavery.² According to the Centers for Disease Control and Prevention (CDC), women who identify as Black or American Indian/Alaska Native are 2-3 times more likely to die from pregnancy-related complications than their White counterparts.³ These differences are observed across all age groups and education levels, and they are present in a wide array of maternal morbidity outcomes.

To address the barriers and root causes of maternal health inequities, it is critical to understand factors that impact the maternal health experience. These include the social determinants of health (SDoH) — social conditions in which people live, work, and play that either promote or hinder health — along with the clinical manifestations of chronic health conditions that drive birthing complications. SDoH-related pathways are particularly important among racial/ethnic minority groups who are disproportionately placed at risk by chronic health conditions that impact pregnancy and birth outcomes.

Racism, not race, drives maternal health inequities and there are many examples of how structural and interpersonal racism, implicit bias, and discrimination contribute to the country's maternal health crisis. For example, conditions such as hypertension, which have been linked to the stress of living in a racist society, contribute to inequities in pregnancy-related complications such as preeclampsia.⁴ Other factors include access to care (including culturally sensitive care), rurality, language, and immigration status. The COVID-19 pandemic is another critical issue that introduced new challenges for birthing people of color.⁵ Communities that are disproportionately impacted by maternal health inequities — those identifying as Hispanic and/or Latino, Black, and/or Indigenous, those living in rural areas, for example — are often the same groups that experienced the worst morbidity and mortality of the COVID-19 pandemic.

Health care is a foundational element of maternal health equity, and this broad, complex landscape involves important policy drivers linked to hospitals and insurers. It is partly for these reasons that although most pregnancies are considered low risk, most births take place in hospitals.⁶ An additional consideration is that 42% of all births are financed by Medicaid, but this program offers postpartum coverage for only 60 days after the end of pregnancy.⁷ Yet, research shows that approximately one-third of pregnancy-related deaths occur between one week and up to one year after childbirth, well after many people no longer have postpartum insurance benefits.⁸ Not surprisingly, the current structure of insurance coverage and reimbursement policies can pose significant threats to health during and after pregnancy. Although states now have the option to extend postpartum coverage for Medicaid beneficiaries, fewer than half have done so. Limited postpartum coverage can impede integration of health care for birthing people and infants, a critical step in transitioning from obstetric to primary and pediatric care.

The United States is the only OECD (Organization for Economic Cooperation and Development) country without a national-level guarantee of paid leave, another important element impacting the health during and after pregnancy.⁹ For those people who have access to paid leave, differing lengths and conditions of leave can still exacerbate maternal health inequities.

In the United States, the shortage of obstetric care providers relative to the number of births is another driver of maternal health inequities.¹⁰ Although they are underutilized, doulas, midwives, community health workers, and other providers on maternal health outcomes provide benefits

that are documented by a growing body of research.¹¹ One reason for underutilization of these health professionals is that some are not reimbursed by Medicaid.

Federal- and state-level data that are currently being collected — through maternal mortality review committees (MMRCs), health surveillance systems, and other means — include clinical, death certificate, race/ethnicity, and other demographic information. But these measures can be both inconsistent and insufficient, particularly regarding collection of individual-level social need data and community-level SDoH-related data that impact maternal health outcomes.¹²

A growing number of state and federal efforts exist to address these issues. The Black Maternal Health Omnibus Act of 2021, which includes multiple provisions to improve maternal health data collection and related issues, is one such initiative, but there is still much work to be done.¹³ A persistent challenge is how to achieve sustained, bidirectional, patient and community engagement directed at improving maternal health outcomes.¹⁴ Partnering with communities most impacted by these issues is one way to drive lasting change, but many of these collaborations have not fully engaged community partners and have had limited success, in part due to lack of trust.¹⁵

The AAMC recognizes the complexity and challenges of the maternal health crisis in the United States and is committed to advancing a multipronged approach to avoid preventable deaths, decrease morbidity, and promote health equity. Maternal health equity is a key focus area of the AAMC Center for Health Justice, which builds on the expertise and efforts of communities, health care practitioners, and other interested parties across sectors to address longstanding gaps in maternal health. In addition to supporting members' efforts, the center develops resources, convenes experts, and provides opportunities to strengthen maternal health work.¹⁶

Through equitable partnerships with communities, the center works to raise awareness of the severity and complexity of maternal health inequities, advocate for related policy solutions, and support innovative research to eliminate inequities that threaten the health and well-being of all birthing people. Integral to this work are efforts to build the evidence base for maternal health equity solutions through research, policy analysis, and national public opinion polling. Additionally, the center's MHI is a key component of a larger effort to codevelop a multisector agenda and facilitate implementation of multilevel interventions to address maternal health inequities.

Meeting Rationale, Description, and Goals

In response to longstanding maternal health inequities, the center convened the two-day MHI to discuss persistent issues in maternal health equity and begin crafting a thoughtful, forward-looking, and collaborative plan to address them. The MHI had several goals:

- Improve understanding of how better maternal health data collection and sharing can help close gaps in maternal health outcomes
- Explore how multisector and policy efforts can facilitate maternal health equity
- Develop a collaborative multisector Action Plan to inform the creation of policies to eliminate maternal health inequities

The MHI focused on action through listening and partnership, improving data collection and dissemination, and promoting novel strategies that address the complex, persistent challenges

that drive maternal health inequities. It explored gaps in current state- and federal-level maternal health data, data collection, and reporting systems and how these shortfalls exacerbate persistent inequities in health care delivery, particularly for Black and American Indian/Alaska Native people, those in rural areas, and communities whose social conditions compound the challenges of securing access to high quality pre- and postnatal care.

“Health equity is about communities, not individuals.”

The first day of the MHI included a welcome from center staff followed by a keynote address, remarks on the need for qualitative maternal health data, and an excerpt of the short film, *Black Birth*. The day also included panel discussions on peoples’ perspectives on their birthing experiences, and on how local organizations, birthing equity advocates, and researchers are developing and implementing innovative, patient- and community-centered strategies to tackle barriers that stand between birthing people and high-quality care for themselves and their babies. Speakers on the first day of the MHI were:

- Philip M. Alberti, PhD, Founding Director, AAMC Center for Health Justice
- Olufunmilayo Makinde, MPH, Health Equity Research Analyst, AAMC Center for Health Justice
- Zsakeba Henderson, MD, Senior Vice President of Maternal and Child Health Impact and Interim Chief Medical and Health Officer, March of Dimes
- Joia Crear-Perry, MD, founder and President, National Birth Equity Collaborative
- Mariam Aydoun, community activist, Washington, DC
- Alannah Hurley, Executive Director, United Tribes of Bristol Bay
- Tennille S. Leak-Johnson, PhD, MS, Assistant Professor of Physiology, Morehouse School of Medicine
- Veronica Gillispie-Bell, MD, Medical Director, Louisiana Perinatal Quality Collaborative and Pregnancy-Associated Mortality Review, Louisiana Department of Health
- Wanda Barfield, MD, MPH, Director of the Division of Reproductive Health, National Center for Chronic Disease Prevention and Health Promotion, CDC
- Eugene Declercq, PhD, Professor of Community Health Sciences, Boston University School of Public Health, and Professor of Obstetrics and Gynecology, Boston University School of Medicine
- Sarah Kennedy, MPH, Senior Manager of Epidemiology and Evaluation, Generate Health STL
- S. Roxana Richardson, JD, Medical-Legal Partnership Director, Georgetown University Health Justice Alliance Perinatal Legal Assistance and Wellbeing Project
- Kristen Zycherman, RN, BSN, Maternal and Infant Health Initiative Lead and Maternal and Infant Health Subject Matter Expert, Division of Quality and Health Outcomes, Centers for Medicare and Medicaid Services (CMS) and Children’s Health Insurance Program (CHIP)
- Logan Burdette, Health Policy Intern, AAMC Center for Health Justice
- Yolanda Liman, Graphic Recorder, Drawing Change

The second day of the MHI focused on policy-driven solutions to address persistent maternal health challenges and how a multisector agenda can be established to drive needed change. Speakers on the second day of the MHI were:

- Daria Grayer, MA, JD, AAMC Lead Specialist for Science Policy and Regulations
- Ally Perleoni, MA, AAMC Manager of Government Relations
- The Honorable Sharice Davids, JD, United States Representative
- Kanika Harris, PhD, MPH, Director of Maternal and Child Health, Black Women's Health Imperative
- Anushay Hossain, writer and feminist policy analyst
- Terri Wright, PhD, MPH, health and racial equity strategist and public health scientist
- Yolanda Liman
- Olufunmilayo Makinde, MPH

The following sections summarize themes and concepts that were highlighted during the center's May 2022 MHI. Although these topics do not reflect the full spectrum of ideas, impressions, and perspectives that were shared during the meeting, they offer a starting point to pursue one of the MHI's key objectives: Building a multisector agenda for maternal health equity.

Birthing People Must Be Heard

Multiple MHI speakers indicated that the current health care system does not adequately hear and act on the preferences and concerns of women and birthing people during their pregnancies, births, and postpartum journeys. They said that a lack of productive connections and effective communication between people and their health care teams are highly prevalent among birthing people of color and other populations made marginalized, and these shortfalls result in unfavorable outcomes for parents and infants. These experiences manifest in different ways, including lack of satisfaction with birthing experiences and perceptions of discrimination and bias. They also reflect a concept that was voiced frequently during the MHI: that racism, not race, drives maternal health inequities in the United States.

Logan Burdette shared data that offered insights into the prevalence of some of these issues, and their differential impact on vulnerable populations. In partnership with Morning Consult, a national polling and research firm, the AAMC collected data from a nationally representative sample of 1,206 people who had given birth in the past five years. The survey showed that 20% reported their most recent experience as "less than good," but certain populations — those with incomes <\$50,000, people in rural areas, and LGBTQ+ people — reported unfavorable birthing experiences at higher rates ranging from 25% to 31%. Notably, 37% felt the quality of care they received was impacted by bias and discrimination, but these feelings were reported more often by non-Hispanic Black people (46%), those with incomes <\$50,000 (42%), and LGBTQ+ people (51%).

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MATERNAL HEALTH INCUBATOR




For research to inform policy, Declercq emphasized the importance of ensuring that maternal health data capture both objective and subjective outcomes from the birthing person’s perspective. He described the Listening to Mothers data sets, which include qualitative information that fills some of the gaps in existing maternal health data collection (discussed later in this report). Listening to Mothers data cover prenatal mental health, perceptions about treatment during labor and delivery, the transition to parenthood, and perceptions of disrespect and abuse during childbirth. Declercq explained that this information allows researchers to ask novel questions that have the potential to significantly impact maternal health outcomes. For example, the data showed that non-Hispanic Black and Hispanic mothers were more likely than non-Hispanic White mothers to be told that their babies might be “quite large” although Black and Hispanic mothers were less likely to give birth to very large babies. These findings are important because people who are told that they might have a very large baby are more likely to have medical induction of labor and other potentially unnecessary birth interventions. Declercq emphasized that listening carefully to patients’ experiences can shed light on persistent maternal health inequities, potentially offering insights that drive the design of interventions to close some of these gaps.

Henderson concurred with Declercq’s sentiments and stressed the importance of qualitative information that contextually and holistically considers factors beyond clinical elements. However, Rep. Davids, Anushay Hossain, and other MHI participants pointed out that in practice, women and other birthing people are often not heard, yet taking them seriously is a critical step in addressing their needs.

Several MHI participants shared that health care providers’ ability to listen and interact fully with birthing people is hindered by systemic factors such as financial pressures to see too many patients and lack of focus on developing diversity, equity, and inclusion-related competencies during medical training.¹⁷ The impact of these factors is exacerbated by the lack of birthing options — such as access to doulas, midwives, and birthing centers — that many people would prefer over hospitals. Together, these and other factors create an environment in which people

are often unable to express their concerns and preferences, or in which their care teams do not hear or honor them. The impact on Black mothers of health care encounters that are rushed, and in which providers do not fully engage with their patients, was echoed in *Black Birth*.

Although progress is being made on maternal health data collection, Barfield emphasized the need for more opportunities for people to share their stories, as well as ways to amplify those stories. She described the CDC's HEAR HER campaign, which aims to raise awareness of potentially life-threatening signs during and after pregnancy and improve communication between patients and their health care providers. The program offers digital and print material to help facilitate conversations and improve communication between patients and providers, as well as resources for health care professionals that emphasize the importance of listening to and asking targeted questions of patients who are pregnant or have been pregnant in the last year. Importantly, some HEAR HER campaign resources are tailored to the needs of American Indian and Alaska Native people and communities.

Personal perspectives on the importance of being heard were offered by several MHI panelists. During her pregnancy, birth, and postpartum journeys, Leak-Johnson not only felt that she did not receive the social or mental health support that she needed, but also said that her health care team pressured her to make decisions she did not want. In reflecting on these experiences, she emphasized the need for culturally aware and empathic care. Alannah Hurley stressed the unfavorable impact of being separated from her family and community for the last two months of her pregnancy because her rural community did not have a hospital or clinic that could manage her preeclampsia. She described the traumatic impact of this separation, and how it was exacerbated by COVID-19 isolation protocols.

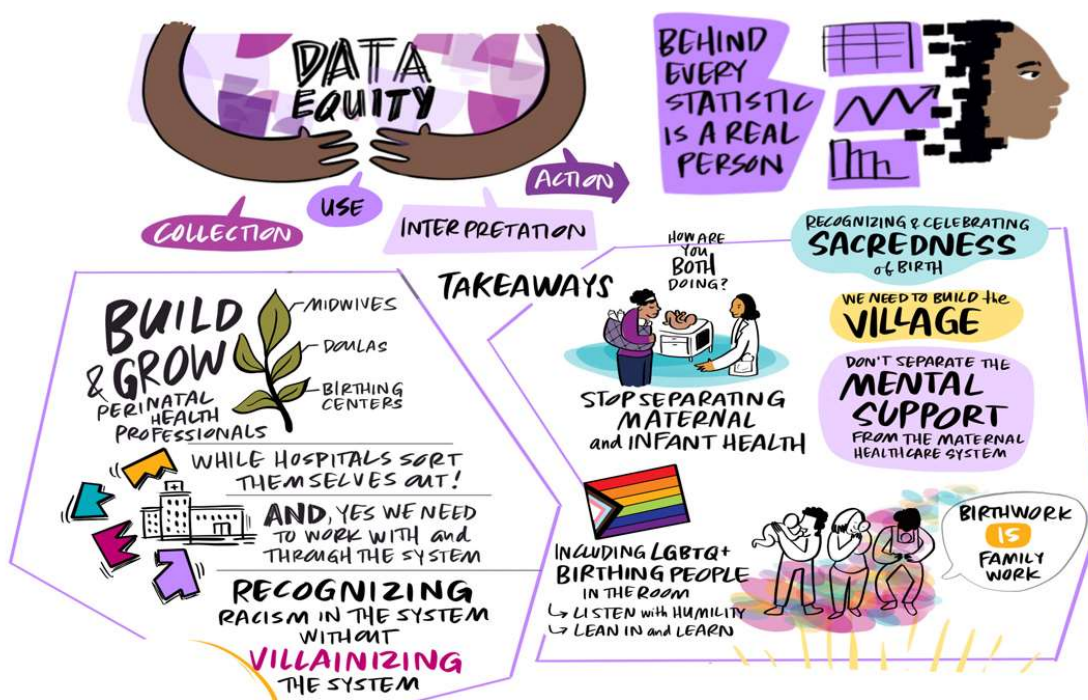
“These are still emotions that I deal with until this day.”

Mariam Aydoun shared her experience as an immigrant, single mother, and person who survived a domestic violence situation during her pregnancy. She pointed out that health systems do not recognize that many pregnant people need housing and food, and that they are financially insecure at the time of delivery. She said that providers need to hear and understand the implications of these nonclinical concerns and to act on them to ensure favorable outcomes for parents and babies.

Improved Maternal Health Data Collection and Sharing Are Needed

The availability of robust data that capture outcomes for birthing people and their babies allows interested parties to understand and track key indicators and helps to inform the development of new interventions and policies that can improve outcomes by addressing persistent inequities. The MHI included presentations from two federal officials — from the CMS, Kristen Zycherman, and from the CDC, Barfield. Both described the merits and limitations of existing maternal health data collection at their agencies, the improvements needed to address these shortfalls, and how their agencies are responding to gaps in maternal health data collection.

Currently, data are collected at the federal level for maternal mortality, including the race of birthing people, infant death, preterm birth, and geographic location, and these data points are combined to produce national mortality statistics. Additional data are collected at the state level among people who receive support under Medicaid and CHIP. Although informative, these data have significant limitations. For example, different entities collect data in different states, maternal mortality outcomes measures use a variety of timeframes and calculations, there is inconsistent reporting on some measures that stem from voluntary reporting, data are not always reported in a timely manner, and there is insufficient or non-existent SDoH and qualitative data collection.



A key issue that was widely discussed centered on the dearth of qualitative data describing maternal health. It was in this context that Barfield emphasized the importance to the MMRCs of improving qualitative maternal health data collection. MMRCs are multidisciplinary committees that review maternal deaths within a year of the end of a pregnancy. They often include representatives from public health, obstetrics-gynecology, maternal-fetal medicine, nursing, midwifery, forensic pathology, mental and behavioral health, and patient advocacy groups, as well as local community-based organizations. The CDC works with MMRCs to improve those review processes that inform recommendations for preventing future maternal deaths. However, because maternal mortality data focus on clinical features associated with mortality, to date limited attention has been directed toward the numerous nonclinical factors and SDoH that impact mortality risk. This precludes developing and implementing maternal health interventions targeting these factors.

“We need to change how we think about women’s health as only affecting women. It is something that impacts all of us.”

Recognizing these limitations, Barfield described how the CDC is working to improve data collection to better inform our understanding of the root causes of maternal mortality. She described the addition of data fields for discrimination, interpersonal racism, and structural racism in the Maternal Mortality Review Information Application (MMRIA), a data system that is designed to facilitate MMRC work through use of a common data language.

In Rep. Davids’ prerecorded remarks, she described the expressed need to direct resources into improving maternal health data collection. She described the Data to Save Moms Act of 2021, which extends MMRC infrastructure to include resources for a study to understand the scope of the Native American maternal health crisis and establishes the first tribal MMRC.

Adding to Barfield’s description of the CDC’s role in promoting maternal health equity through the MMRCs, Kristen Zycherman described how the CMS is driving maternal health equity through improved data collection and reporting. She framed her comments by explaining that because 42% of all births in the United States are financed by Medicaid, analyzing CMS data offers valuable opportunities to understand outcomes for both birthing people and their babies. She explained that CMS data help the agency and states understand the quality of health care received by Medicaid and CHIP beneficiaries through a core set of measures that is voluntarily reported by state Medicaid and CHIP agencies. Although state-level reporting of this information is currently voluntary, Zycherman said that reporting on some of the measures will become mandatory in 2024.

Zycherman also described the CMS’s efforts to improve maternal and infant health care quality, including decreasing cesarean sections among people with low-risk pregnancies, increasing use of postpartum care, and increasing well-child visits. She described the evolving concept of postpartum care and how postpartum visit data can be harnessed to inform interventions to improve care quality and outcomes. This expansion 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; and health maintenance. Zycherman said that because discrimination, systemic inequities, and SDoH contribute to poor postpartum outcomes for Black birthing people and other populations made marginalized, understanding these factors is a critical aspect of developing a full understanding of the birth and postpartum periods. She also explained that the American Rescue Plan Act of 2021 gave states a new option to provide 12 months of extended postpartum coverage to pregnant individuals enrolled in Medicaid and CHIP beginning April 1, 2022. This coverage, along with the new CMS maternal health reporting requirements that will take effect in 2024, will offer new data on the impact of postpartum coverage on key outcomes, potentially encouraging other states to adopt this coverage, with the goal of reducing longstanding inequities.

Henderson of the March of Dimes offered additional ideas about maternal health data needs from an advocacy perspective. She explained the organization’s work to promote better data collection on variables describing pregnancy and delivery, with a focus on improving information

about SDoH. She described four focus areas: pregnancy surveillance, delivery surveillance, postnatal surveillance, and mortality surveillance. To work toward these goals, a MITRE/March of Dimes data summit yielded 14 recommendations in several data-focused action areas, including improving data collection practices, enabling data sharing and remove barriers to care, and elevating and supporting state and locality-based data acquisition.

The Condition or Quality of Social Determinants of Health Influence Care Access, Delivery, and Outcomes

MHI participants agreed on the critical role that SDoH play in driving maternal health outcomes. Individually and together, these factors — economic stability, education access and quality, health care access and quality, the built environment, and social and community context — impact health throughout the lifespan. However, maternal health outcomes are a special subset of health episodes because those SDoH that impact birthing people also affect their babies. The unavoidable overlap between the well-being of parents and their infants was emphasized repeatedly throughout the MHI.

To close gaps in maternal health outcomes, the impact of SDoH must be recognized across the health care system, and steps must be taken to improve collection of data that accurately describe peoples' social circumstances before and during pregnancy and throughout the postpartum period. MHI participants felt that equity efforts that focus exclusively on the clinical aspects of maternal health without recognizing the intersections between these factors and SDoH will not be successful in closing persistent gaps that place people of color at higher risk of unfavorable outcomes. Presenters and panelists offered a wide array of examples of how SDoH and maternal health are linked, and how these links offer opportunities for novel interventions to address persistent challenges.

Henderson pointed out stark geographical differences in access to maternal health services, with vast areas of the South, Northern Plains, and Alaska classified as maternity care deserts. She explained that more than 50% of U.S. counties have limited or no access to maternal health care, and that seven million people with the capacity for pregnancy live in these counties. Henderson stressed the importance of collecting qualitative data that offer insights about pregnancy and delivery, pointing to the value of this information for the work of MMRCs.

“Birth work is family work, not just women’s work.”

During the MHI’s fireside chat, Alannah Hurley, Mariam Aydoun, and Tennille Leak-Johnson shared their firsthand experiences of the impact of factors outside health care on their birth experiences. Hurley described the impact of rurality, lack of social and community support, and her inability to access her community’s knowledge of traditional birth experiences. Aydoun shared the impact of being an immigrant, lacking social support, and being financially insecure, as well being a single parent and survivor of domestic abuse. Leak-Johnson emphasized

differences between her values and those of her health care team, and how these impacted decisions during her pregnancy.

Barfield's presentation included a detailed discussion of "circles of influence" that expand outward from infant to mother, then to family, and ultimately to systems and communities. She explained that economics, social policies, and politics impact each of these circles, and that SDoH are also in play in this complex landscape. For example, at the family level, factors such as social support, safety, violence, religion, income, and education impact maternal health outcomes. At the system and community levels, additional issues such as the built environment, policies, laws, water, sanitation, and transportation are also in play and can affect outcomes.

The role of transportation access was top of mind for other presenters. Sarah Kennedy described the importance of access to non-emergency transportation when she described how Generate Health STL is addressing this and other barriers between birthing people and healthy outcomes. As Roxana Richardson pointed out in her presentation on medical-legal partnerships, perinatal patients have a multitude of health-harming legal needs that stem from challenges they experience at home, at work, and in their family settings. These challenges are as varied as housing, employment, financial security, and exposure to domestic violence. None of these factors is typically assessed by health care teams during routine pregnancy care, yet they can all impact a patient's ability to access and optimize the health care that is needed for a healthy pregnancy and delivery. When considering the concept of "access" to resources that impact maternal health outcomes, Wright stressed the need to ensure we understand how communities define, perceive, and understand "access" because the availability of a service does not automatically make it accessible to all who need it.

Government is a Critical Partner in Promoting Maternal Health Equity for Pregnant and Birthing People

Much of the data describing maternal health inequities that were presented at the MHI were from data collection efforts administered by the federal government. Data from agencies like the CMS, the CDC, and the Health Resources and Services Administration contribute to our understanding of diverse aspects of maternal health. These data provide information about the age and race of birthing people, maternal and infant mortality and causes of death, birthweight, geographic availability of maternity care services, and utilization of various prenatal and postpartum health care services among people who are supported by Medicaid. Ongoing, federally sponsored maternal health data collection allows researchers and policymakers to quantify key maternal health outcomes and track them over time to understand trends and whether implementation of new policies or other interventions has a favorable impact on birthing people and their babies.

The CDC

In addition to its responsibility for collecting and disseminating vital statistics including maternal mortality, the CDC's important role in promoting maternal health through its work with MMRCs was detailed by Barfield. Under the Enhancing Reviews and Surveillance to Eliminate Maternal

Mortality Program, the CDC has awarded funds to 31 states to support agencies and organizations that coordinate and manage MMRCs. These groups identify, review, and characterize maternal deaths and identify prevention opportunities. The CDC also provides training for MMRC members and works with these groups to improve review processes that inform recommendations for reducing future maternal deaths. Barfield explained that this work helps determine what interventions at the patient, provider, facility, system, and community levels will have the most effect, and it informs the implementation of initiatives for families and communities who need them most. She emphasized that because MMRCs function at the local level, their members understand local circumstances, populations, and barriers to care that may impact maternal health outcomes in their areas. She also explained that MMRCs can identify missed opportunities for informing providers and systems about how to improve care delivery in the future.

As noted previously, Barfield said that efforts to support MMRCs are part of a larger drive to promote data equity and build equity into translation of these data into practice and quality improvement. Developed by the CDC in partnership with MMRCs and other subject matter experts, and supported by the CDC, MMRIA is a data system and strategy that facilitates MMRC functions through a common data language. Barfield explained that because MMRCs rely heavily on data to understand the causes of maternal mortality, it is critical for these data collection efforts to document SDoH-related information because of the known role of these factors in driving inequity in maternal health outcomes. She said that despite the inherent challenges of collecting SDoH data, some MMRCs have begun to document the impact of discrimination and racism in their review processes, and a group of MMRC members and subject matter experts convened to better understand and capture bias as a potential factor in maternal mortality. These efforts culminated in the addition of discrimination, interpersonal racism, and structural racism as data fields in the MMRIA system.

Barfield said that based on this work, the CDC is now working with the American College of Obstetricians and Gynecologists and the National Birth Equity Collaborative to extend work on discrimination and racism so this information can be incorporated into medical records and ultimately expanded in broadly in diverse care delivery settings. Expanding the availability of these data into medical records will greatly facilitate the ability of MMRCs to examine the role of SDoH in maternal mortality and allow for development of interventions to address these issues at the point of care, in a manner that is consistent with local circumstances.

Centers for Medicare and Medicaid Services

Kristen Zycherman explained that because 42% of U.S. births are financed by Medicaid, the CMS is uniquely positioned to improve perinatal outcomes and reduce inequities through quality measurement and quality improvement among people who receive benefits through Medicaid and CHIP. The CMS maintains a core set of measures that state Medicaid and CHIP agencies can voluntarily report to support maternal and perinatal health-focused efforts, and some of these measures will become mandatory in 2024.

The Maternal and Infant Health Initiative (MIHI) is another CMS effort that aims to improve access to and quality of care for pregnant and postpartum people and their infants. Initially, MIHI focused on improving the rate and quality of postpartum visits and increasing use of effective methods of contraception. But in 2019-2020, the CMS convened an expert workgroup to make

recommendations about where Medicaid and CHIP have opportunities to improve maternal and infant health. These efforts identified three focus areas: decreasing cesarean sections among people with low-risk pregnancies, increasing use and quality of postpartum care, and increasing use and quality of well-child visits.

Zyberman also discussed the evolving concept of postpartum care and how the CMS is helping to shape that discussion through policy. She explained that postpartum visits provide an opportunity to assess physical recovery from pregnancy and childbirth and to address chronic health conditions, mental health status, and family planning. She said that historically, people who were enrolled in Medicaid and CHIP were covered for six weeks of postpartum care. However, under the American Rescue Plan Act of 2021, states were given a new option to provide 12 months of extended postpartum coverage beginning April 1, 2022. As of June 2022, 25 states have taken steps to extend this coverage.

In addition to these efforts, Zyberman described other ways that the CMS supports maternal health. The agency provides targeted technical assistance to nine states in a postpartum care affinity group and hopes to use lessons learned from that group to develop materials to share publicly with all states. The CMS also provides technical assistance to states for smoking cessation, and it partnered with the Office of Women’s Health to establish the Health and Human Services Postpartum Equity in Care Challenge. The Challenge prize competition aims to identify innovative strategies to improve postpartum care for Black and American Indian/Alaska Native postpartum individuals with an 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 inequities and improve outcomes for postpartum Black and American Indian/Alaska Native people.



Do Not Separate the Health of Parents and Babies

Among the many challenges birthing people face are factors that uncouple their health from that of their babies. MHI participants explained that these separations stem from issues as varied as differences in which health care professionals treat birthing people and babies and where this care is delivered; lack of linkage between maternal and infant health records; reimbursement policies that result in approaching the postpartum period separately for birthing people and their infants; lack of recognition of, and response to, the impact of postpartum mental health on the well-being of infants, and failure to optimize existing pediatric care delivery streams for the benefit of parents. MHI panelists indicated that the same factors that contribute to poor maternal health outcomes also contribute to poor outcomes among infants and young children.

“Babies come from mamas and if we take care of the mamas then that’s going to take care of the babies.”

Crear-Perry described several scenarios in which birthing people are separated from their babies, including cases in which critically ill newborns are transferred to a children’s hospital while their parents remain at the hospital where the infant was born. These separations inhibit initiation of breastfeeding and bonding between the parent and the infant. Leak-Johnson agreed, saying that when she first met her son, he was 10 days old and in a different hospital. Although children’s hospitals are equipped to manage critically ill children, Crear-Perry emphasized the need to improve how new parents whose children have been separated from them can engage with their children in these situations.

When asked what the CMS can do to incentivize collaborative care, Kristen Zycherman said that pediatric well-child visits could be better utilized to touch base with new parents, particularly concerning mental health and other issues that potentially impact the ability of new parents to effectively care for their newborns. She explained that although many new parents do not attend recommended postpartum visits for themselves because they do not see the value, they are much more likely to attend recommended check-ups for their newborns, making those visits appealing targets for new ways of delivering postpartum care. Although more pediatricians are being trained to screen new parents for postpartum depression, mechanisms to ensure seamless referrals for people who screen positive still need to be optimized.

Zycherman said the CMS recognizes the interconnectedness between birthing parents and their babies as well as the need to identify novel ways to intervene. She pointed out that improved ability to identify postpartum depression is a potential benefit of Medicaid’s extension of postpartum care from six weeks to 12 months, adding that this makes the Medicaid population particularly vulnerable to gaps in care in the postpartum period when their needs remain high. In addition to using well-child visits to screen for parental depression, these visits could also be used to counsel parents on smoking cessation, screen for diabetes and hypertension, and offer lactation support. Despite the potential value of optimizing these visits, this approach to promoting postpartum care must consider practical issues linked to reimbursement: pediatricians need to be able to bill for services provided to their patients’ postpartum parents.

Optimizing novel strategies to address the lack of linkage between maternal and infant health records was a key message of Declercq’s presentation describing linked health records for birthing people and their babies. Declercq and his colleagues have collected Massachusetts data for 21 years from rich and varied data sources that describe prenatal experiences, including information about program participation and early intervention, maternal and infant mortality, geocoded birth data, payer claims, newborn hearing screening, and other topics. The novel aspect of this data system is its ability to connect information about mothers to health outcomes for their babies, a fundamental aspect of improving maternal health that remains absent in our current national data infrastructure. Improving these linkages more broadly offers considerable promise for understanding connections between the health of birthing people and that of their babies, and this understanding can be directed into meaningful policies and quality improvement efforts.

Innovative, Community-Based Strategies Improve Outcomes

MHI participants discussed how community-based programs and resources are important elements in the rich tapestry of services and supports that drive maternal health equity. Alannah Hurley touched on the importance of the Alaska Native Birthworkers Community, and Mariam Aydoun pointed to the impact of the District of Columbia Perinatal Quality Collaborative. In addition, the MHI included two presentations that demonstrated how highly localized, community-driven programs are positioned to tackle complex maternal health challenges.

“It takes a village to raise a child and sometimes I wish I had community support.”

Sarah Kennedy described Generate Health STL, an organization that mobilizes and inspires the St. Louis region to advance racial equity in pregnancy outcomes, family well-being, and community health. She described three of Generate Health’s programs, FLOURISH, the Bloom Network, and the Social Determinants of Health Tour. Together, these community-based and community-driven programs illuminate the root causes of racial inequities, advocate for the redirection of resources to eliminate these inequities, catalyze action within the ecosystem, and advance regional accountability for equitable systems. In FLOURISH, these goals are pursued by addressing challenges with transportation and housing — two key SDoH— with the guidance of a Community Leaders Cabinet. This program’s motto is “Nothing about us without us,” reflecting its community roots and community-driven leadership. Program leaders either live in zip codes with a high concentration of, or have experienced, adverse birth outcomes, and they are the people who make decisions about FLOURISH and where the program allocates its resources and efforts.

As part of those efforts, FLOURISH addressed the challenges of access to non-emergency medical transportation in the region, especially for pregnant and postpartum individuals. The program educated health system leaders about the difference between how non-emergency transportation is supposed to work on paper, and the reality of how it actually works in St. Louis.

This led to work with area health system leaders, transportation officials, local students, and managed care organizations, which has begun to address these challenges.

Another of Generate Health's programs is the Bloom Network. This network of providers is working to bring coordinated quality care to pregnant and postpartum people. It includes home visits, perinatal behavioral health providers, safe sleep educators, doulas, community health workers, and others who are focused on improving perinatal health care. A key program goal is to create a "one-stop shop" for pregnant and postpartum people that will allow families to choose their support team and get connected to whatever resources they need to have healthy pregnancies, births, and postpartum experiences. To educate the community, Generate Health has developed the Social Determinants of Health Tour, a physical and virtual tour that illuminates the historical policies and events that created the community conditions in which many birthing people in St. Louis live in today.

Kennedy stressed that Generate Health operates under the collective impact approach, which creates a common agenda, builds and manages shared measurement systems, participates in mutually reinforcing activities, and communicates openly and continually with all partners. Generate Health incorporates a racial equity lens into all its work, including program evaluation efforts, which recognizes that change involves multiple systems and is frequently nonlinear. A key feature of Generate Health's successes in the community is its choice to fully incorporate community-based leadership into program development and implementation, as well as strategic planning and information dissemination.

Harris advocated for these approaches. She emphasized the importance of placing communities at the forefront of meetings in terms of leadership, defining priorities, and determining what data should be collected and how to use this information. Wright agreed, saying that communities have the best solutions, and these should be sought and elevated into action.

A common theme throughout the MHI was that SDoH and other nonclinical problems are not assessed, recognized, or addressed during health care assessment and delivery. Some of these challenges involve complex issues that require considerable legal knowledge or access to an attorney, resources that many birthing people do not have. Responding to the disconnect at the intersection of the maternal health and legal systems, Roxana Richardson Esq., described a novel approach to addressing maternal health inequities that has received limited attention — medical-legal partnerships. These health care teams work with lawyers to address "health-harming legal needs," social problems that adversely affect a person's health or access to health care, and that are better remedied through joint legal and health care than through health care services alone.

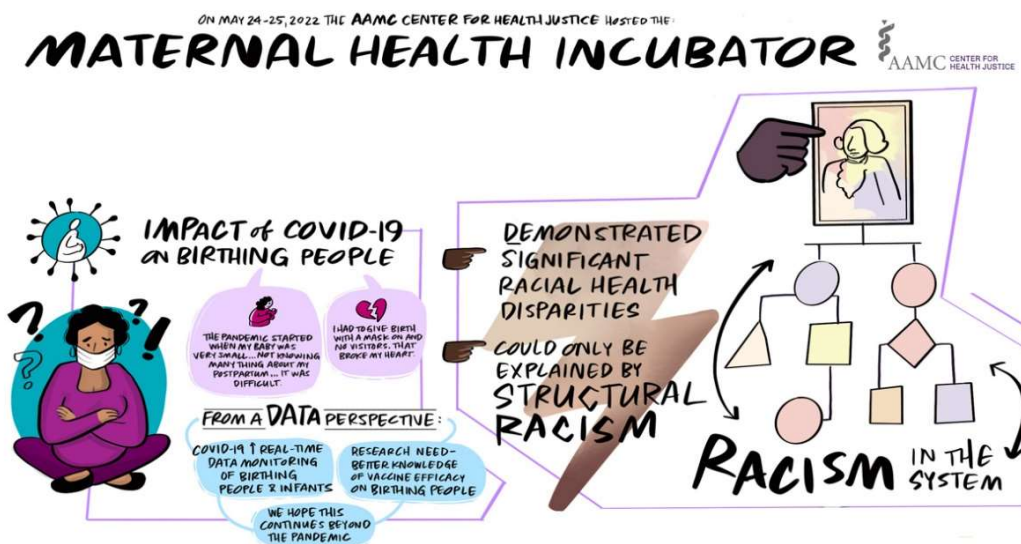
"I asked for help and...I'm ready to keep fighting."

Richardson explained that there is a wide array of health-harming legal needs. They fall under several categories, many of which are linked to SDoH: employment (e.g., job accommodations, parental leave, Family Medical Leave Act), home (e.g., housing conditions, housing accessibility, eviction), and family (e.g., custody, paternity, child support, domestic violence).

These problems are outside of what most people consider to be the health care system’s purview, yet they can all have a profound impact on maternal health outcomes through their impact on patients’ access to care, ability to maintain secure housing and safe living environments, and a host of other factors that create barriers between patients and the care they need. Richardson explained that housing insecurity during pregnancy is associated with increased risk of low birthweight and/or preterm birth and extended hospitalization, food insecurity and material hardship is associated with perinatal depression and anxiety, and that low birth weight and preterm births are increased among survivors of domestic violence. She also indicated that medical-legal partnerships have significant beneficial impacts for patients and providers, as well as health care systems, and she described the partnership that she leads in the Washington, D.C., area.

The Perinatal Legal Assistance and Well-Being Project is a maternal health medical-legal partnership between the Georgetown University Health Justice Alliance and MedStar Washington Hospital Center Women’s and Infants’ Services. It provides legal services to pregnant and postpartum patients to address barriers to health and well-being, trains health care teams to identify and refer patients with legal needs to the legal team, provides opportunities for Georgetown students to engage in the medical-legal partnership model, and evaluates its impact on patients, providers, and the health system to contribute to the evidence base for these models.

Richardson said that the Perinatal Legal Assistance and Well-Being Project works with a population that disproportionately experiences unfavorable perinatal health outcomes: 84% of patients are Black, 87% are unmarried, 95% are on public assistance, and more than 50% live in medically under-resourced parts of the city. Even though the Perinatal Legal Assistance and Well-Being Project is still quite new, Richardson described several successes. These included securing a paid extended leave of absence and short-term disability claim for a pregnant patient during a suicidal mental health crisis, reversing an administrative decision that denied a first-time mother facing food insecurity benefits, and securing an emergency housing voucher and transfer for a single mother of six who was being stalked and harassed at her current home by the family and friends of her abusive ex-partner.



Training and Deployment of the Health Care Workforce Must be Improved

Throughout the MHI, participants pointed out features of the health care workforce that contribute to ongoing maternal health inequities, and how these can be addressed in the future. However, there was also consensus that elimination of maternal health inequities will require actions and policies that touch on all levels of the health care ecosystem, not just the attitudes of providers. With this framework in mind, MHI participants voiced concerns about several issues related to the health care workforce.

Traditional knowledge has been replaced by a hypermedicalized approach to pregnancy and birth

Several MHI participants pointed out that most pregnancies and births are low risk, yet these journeys have been highly medicalized. They explained that people in other countries with lower maternal mortality rates have healthy babies with much less medical intervention. Alannah Hurley emphasized the consequences of the loss of traditional knowledge and the diminished role for community and social support in the birthing process. Citing high levels of cesarean sections, Crear-Perry and others argued that interventions should only occur when they are needed, not as a matter of routine. She also pointed out that one consequence of the loss of traditional knowledge about pregnancy and birth was a reduction in the numbers of people in communities that are prepared to assist people throughout their pregnancies and beyond. This contributes to a broader reduction in the availability of culturally aware pre- and postnatal care for women of color and other populations made marginalized, as well as health care delivery that has migrated from the home and community to health care facilities that are often cut off from family and community support.

There is a need for improved recognition and treatment of mental health issues and better access to mental health professionals

Inadequate recognition of mental health challenges and provision of needed mental health services was a common theme throughout the MHI. Alannah Hurley described how her high-risk pregnancy resulted in being cut off from her community, and how the resulting isolation added considerable stress to what was already a challenging pregnancy journey. Hurley said she was unprepared for the mental health aspects of her pregnancy, and that she would have benefitted considerably from more mental health support from her health care team. In addition to the need for access to better mental health services during pregnancy, MHI speakers also emphasized the need for added focus on and resources for postpartum depression.

Crear-Perry said that postpartum depression is linked to the separation of birthing people and their babies after delivery, lack of adequate screening for depression, and a persistent lack of investment on the part of health care professionals and the health care system on promoting mental health among birthing people. Mariam Aydoun described the consequences of these shortfalls by pointing out that trust is broken between patients and their doctors when needed mental health services are not provided. Leak-Johnson emphasized that in addition to inadequate screening for depression among people who have recently given birth, there is also

a profound shortage of health care professionals who are trained to deliver culturally aware mental health care to those who need it. She pointed out that although there are specialists for relatively uncommon maternal complications, there is inadequate access to mental health professionals despite the relatively high levels of anxiety and depression that many people experience during and after pregnancy. Barfield supported other panelists' concerns with data showing that mental health conditions lead to more pregnancy-related deaths than preeclampsia and eclampsia. These observations underscore the need for medical professionals to be adequately trained to assess patients' mental health status as well as the need to train enough of these professionals to meet birthing peoples' current and future mental health needs.

Leveraging the roles of midwives and doulas

There was a call for increased access to, and use of, midwives and doulas. Gillispie-Bell advocated for using a risk assessment at the beginning of pregnancy to identify patients at low risk for negative outcomes who could receive care from a midwife. This model would not only allow patients more choice, but would also allow physicians to have more time to allocate to patients at higher risk. Crear-Perry agreed that most women don't need a high degree of intervention and that midwives have a long track record of positive outcomes in many countries with less health care infrastructure than the United States. Wright pointed out that there are only 800 Black midwives in the United States, far fewer than the number needed to adequately support Black birthing people.

“The sacredness of bringing life into the world is life-changing.”

Kristen Zycherman said that if their potential is optimized, doulas can also make meaningful contributions to reducing maternal health inequities. These professionals could be called on to do more community-based education during pregnancy and the postpartum periods, services that Sarah Kennedy described the Bloom Network doing in St. Louis. However, many people do not have access to doulas, and some who can access these supports do so only through informal networks. Mariam Aydoun's pregnancy was characterized by financial, food, and other insecurities, but she was able to access a volunteer doula who had a positive impact on her experience. Other MHI participants said that expanded roles for nurses, lactation consultants, and community health workers would also help reduce maternal health inequities by facilitating access to these segments of the health care workforce. Ideally, these workers would be community-based and able to provide culturally aware, in-home care when and where it is needed.

Medical education needs to produce doctors who understand communities of color

Wright and others emphasized the shortcomings of current medical education, including, for example, falsely teaching medical students that Black patients' skin is thicker than that of White

people and for this reason Black people have a higher pain threshold. She stressed the need to dispel these and other myths in medical education to create a cadre of physicians that is culturally aware, exhibits cultural humility, understands the discriminatory complexities that people of color must navigate, and is prepared to deliver outstanding care to all birthing people.

Group Activity Synthesis

Day two of the MHI featured an opportunity for attendees to join smaller Zoom breakout rooms with moderators and participate in an activity that guided them through a series of questions to answer and discuss. The questions centered around strategies for improved community engagement and data collection to enhance maternal health equity. The moderators also asked participants for suggestions about nontraditional community partners and initiatives the AAMC Center for Health Justice could support in this space. The group exercise questions were:

1. Share your name, title, organization, and one word that comes to mind when you hear “maternal health.”
2. What strategies can we use to deepen patient and community engagement across all related data collection, use, sharing and coordination for maternal health equity? How do we engage these communities?
3. What additional data, data sources, or data collection methods can enhance maternal health equity interventions? What data are missing for maternal health equity work?
4. Can you think of other key nontraditional partners or sectors which should be engaged in these efforts?
5. What metrics should be used to evaluate maternal health interventions that leverage multisector data? How should we measure our impact?
6. What are some practical next steps that the AAMC can take to help facilitate this work and build upon the discussions today?
7. What types of maternal health equity research or policy initiatives would you like to see the AAMC Center for Health Justice support or implement moving forward?

After the MHI concluded, AAMC staff reviewed and synthesized the answers to distill salient themes. Four major themes emerged:

1. Improvement of data collection and sharing practices
2. The need for collaboration between community, providers, and other partners to improve patient care and outcomes
3. An increased focus on maternal mental health
4. A revised medical school curriculum

Improvement of Data Collection and Sharing Practices

The first theme that emerged was the need for improved data collection practices and data sharing. Participants shared that both qualitative and quantitative data should be collected about birthing people to obtain accurate background information, which they explained could improve the experience of birthing people at health care facilities. The collection of demographic data was highlighted as a need (e.g., race, ethnicity, gender identity, socioeconomic status), as were

SDoH-related data points (e.g., food security, housing security, education). Participants also felt health care providers should be collecting data about patients' experiences with racism and bias to build a better rapport with future patients, improving their trust in health care workers.

One suggestion for improved qualitative data collection was to create community forums and conduct unstructured patient interviews. These forums would create a storytelling space for birthing people and their families to share their maternal health experiences. In these forums, information would be collected about the people's concerns throughout the span of their perinatal period. This information could be made available to both clinicians and medical school students for training purposes. Participants expressed that access to qualitative information would paint a clearer picture of what patients need and allow providers to have a better understanding of who they are serving.

Equally as important as data collection itself, is transparency about the reason data are being collected. Participants explained that at times, birthing people are less likely to share their personal data because they are unsure of how the data will be used. To establish trust, health care providers must be clear about what information is being collected from patients, why the information is needed, how it will be used, and if and when, it will be disseminated. Participants noted the data collection process should have privacy measures built in that would ensure birthing people are protected, as "some data (drug use, immigration status, etc.) can lead to really negative consequences." Participants shared that data transparency would help build a sense of trust and strengthen the relationship between patients and health care providers. One participant suggested that health care providers "invite community members to the table and listen and incorporate their feedback, creating co-ownership of data."

Participants also discussed the need for standardization of the electronic health record (EHR) across the health system. This includes sharing the information captured by hospitals. One participant expressed that "there is a wealth of data that could be aggregated from EHRs, but we don't have access to those records." Interoperable EHR systems that can share patient information will allow a patient's medical history to seamlessly follow them if they require multiple health care providers or relocate. Several participants suggested that health care systems start to pull all EHR data into one central database. They also expressed the desire to add qualitative data to the EHR, including many of the points mentioned previously, to attempt to create a complete picture of the patients they treat.

The Need for Collaboration Between Community, Providers, and Other Partners to Improve Patient Care and Outcomes

The sentiment that patient care is done best when there is a partnership between community members and those who provide services to the community emerged as a prominent theme. These service providers and collaborators are not just limited to traditional health care workers and local governments. Participants indicated there should be active collaboration between members of the community and a broad spectrum of health care providers such as doulas, midwives, visiting nurses, and social workers. Participants communicated that community leaders such as religious and spiritual leaders and local business owners should provide their input through community forums, since they have already earned the trust of the people they serve every day. Examples of these organizations include non-profits, religious entities, and housing and employment agencies. This multisector approach to health care can create strong

and culturally appropriate public education campaigns. Other potential community partners mentioned by participants were:

- Educational systems, including childcare facilities, K-12, and higher education
- Judicial systems
- Historically Black fraternities and sororities
- Parks and recreation systems
- Grocery store chains
- Advocates for people with substance use disorder

An Increased Focus on Maternal Mental Health

Another prominent theme that stood out from the conversations was the desire for more action and attention to maternal mental health. Participants emphasized that better and more consistent screening methods are needed to identify and treat anxiety, depression, and other mental health issues throughout the perinatal period. This mental health information, in addition to the patient's clinical and demographic information, is part of how birthing people "define and experience health." The mental health of the birthing person is just as important as any other aspect of their health, so mental health information should be part of the data being collected. Additionally, participants asked that more resources be made available for patients after they experience a miscarriage or the loss of an infant, including both mental and emotional health interventions that would be free or covered by health care insurance. Participants discussed the idea of these mental health interventions being made available for as long as they are needed, as this support can help prevent any mental health deterioration. Participants expressed that there is not sufficient information currently available about how these losses affect future pregnancies. Any interventions to investigate this question must also exhibit cultural sensitivity, as most current patient satisfaction surveys and other materials fail to "touch on cultural differences in wellbeing." Participants expressed the need for communities to bring in mental health and mindfulness practitioners, as well as local mental health organizations that are currently servicing communities.

A Revised Medical School Curriculum

The last theme that emerged from the conversations was that MHI participants conveyed a desire for an updated medical school and residency curriculum. Participants shared that an updated curriculum would encourage medical schools and teaching hospitals to become anti-racist, and it would include implicit and explicit bias training, maternal health bias training, and instruction in how to deal with racist patients. Patients' experiences with racism and bias from both clinical and nonclinical health care staff were mentioned as issues that could be addressed with updated policies and procedures. Participants also discussed pushing for more minority medical school applicants, which would help birthing people have access to providers who share similar experiences and backgrounds. The desire to create a culturally aware health care workforce was discussed in many breakout rooms.

Proposed Next Steps for AAMC

The final two questions asked in the small group exercise focused on the next steps the AAMC can take to build on outcomes of the MHI and related future initiatives the AAMC Center for

Health Justice should support. Participants would like the AAMC to facilitate advocacy efforts centered around patient experiences and work with community partners to create updated data collection standards. It was also stated that the AAMC should be involved in efforts to convene multisector partners who may have been previously excluded from the maternal health equity table. Participants would like the center to share the insights from the MHI broadly, create similar programming in the immediate future, highlight community programs with a focus on maternal health, and collaborate with them while helping them find new opportunities for funding. Participants indicated that the center should help discover funding for nontraditional maternal health care models, identify long-term mental health services for birthing people, and promote policies in alignment with the Momnibus act.

These activities, along with the four themes that emerged from this breakout session, made for an informative discussion. Participants used this opportunity to discuss current practices and make recommendations that would positively impact equity in maternal health care. Once the small group exercise concluded, participants returned to the larger group to hear the closing remarks of the MHI.

Looking to the Future

MHI participants suggested numerous strategies to address the longstanding maternal health inequities that were highlighted during the meeting, and this section of the report highlights some of these ideas. Attribution of specific suggestions to individual speakers is not included because in many cases, multiple MHI participants either proposed or supported the same or similar recommendations.

Identify and incorporate novel partners into maternal health equity efforts

MHI participants stressed the need to acknowledge that to date, efforts to reduce maternal health inequities have not fully optimized the knowledge and skills of individuals and entities that can help address these complex issues. They urged the need to think outside the box to address this shortcoming by incorporating attorneys and legal support into patient assessments to address health-harming legal needs or by finding ways to partner with employers to leverage their influence as insurance purchasers. These are just two examples of nontraditional partnerships that could be pursued more actively in the future.

Build a larger tent that includes nonphysician health professionals

Several MHI participants voiced concerns that the knowledge and skills of a wide array of nonphysician health professionals were either undervalued or inaccessible to many birthing people. They urged systemic recognition of the value of these professionals to people of color and other populations made marginalized and advocated for active measures to facilitate access to nonclinical professionals. For example, historically Black colleges and universities can create doula programs to address the shortfall of culturally aware, community-based birthing professionals. Similarly, the role of community health workers and lactation consultants could be expanded, facilitating their ability to deliver targeted education to people at home in both the

prenatal and postpartum periods. There was broad agreement concerning the need for better diversification of the health care workforce, both culturally and in terms of credentials and training. However, MHI participants also acknowledged that incorporating these professionals more fully to improve quality and reduce inequities is tied to insurance coverage and other policies that facilitate or hinder access to these segments of the health care workforce.

Shift the power in decision-making to the local level

MHI participants stressed the need to shift decision-making power from hospitals and the medical establishment and share it with the communities that are best positioned to understand the needs of those served by these institutions. They urged that community-based organizations have a meaningful seat at the table when key decisions are made and when programs are designed and implemented. To be most effective in these roles, these organizations need to have better access to funding for maternal health research and evaluation. It is only under these circumstances that organizations can fully leverage the trust that underpins their longstanding relationships with the people they serve and encourage uptake and adherence to new maternal health programs and services.

Assess and act on the distinction between high- and low-risk pregnancies

Most pregnancies are low risk and do not require a high degree of medical intervention. Several MHI participants advocated for new approaches to assess pregnancy risk early so prenatal care and delivery can be tailored according to risk level. In this model, physician-driven prenatal care would be delivered primarily to people at higher risk for complications who need these services, while people at lower risk could choose to be cared for by a physician, or by a midwife. This approach to prenatal care and childbirth would allow more choice about who assists birthing people with their care and would facilitate care delivery in the community or at birthing centers when appropriate, rather than nearly always at hospitals.

Overhaul the concept and delivery of postpartum care

MHI participants discussed the need to reimagine the concept of postpartum care and update how this care is delivered, and one shared a series of related recommendations published by the American College of Obstetricians and Gynecologists.¹⁸ That report urged expansion of the postpartum care period beyond a single six-week postpartum check. It recommended contact with a health care provider within the first three weeks postpartum, and that the initial visit should be followed by individualized ongoing care including a comprehensive postpartum visit no later than 12 weeks after birth. The report also recommended expanding the scope of postpartum care to include recovery from childbirth and assessment of (1) physical, social, and psychological well-being; (2) infant care and feeding; (3) reproductive health; (4) sleep and fatigue; (5) chronic disease management; and (6) health maintenance. Consistent with the themes presented at the MHI, this report also stated that discrimination, systemic inequities, and SDoH contribute to poor postpartum outcomes for Black women and other people of color.

“Comprehensive postpartum care goes beyond just the physical recovery from childbirth and includes physical, social, and psychological well-being.”

Although state Medicaid agencies now have the option to extend postpartum care to 12 months, only 13 states have offered these additional benefits. In addition to more widespread enactment of these expanded Medicaid benefits, participants called for thinking more creatively about how to combine well-child check-ups with postpartum screening, an approach that recognizes the strong connection between the health of birthing people and their newborns. Participants urged that pediatric infant well visits should be used to touch base about the parent’s health as well, and some pointed out that these visits may be the only postpartum touchpoints for some people.

Promote paid family leave

The need to promote access to paid family leave was also emphasized by MHI participants. The AAMC’s polling data showed that 39% of people had no access to paid leave following their most recent birthing experience. However, because it is not clear if access to paid leave differs by race, income, or other factors, these issues need to be studied to understand their potential impact on maternal health outcomes. Although 11 states and the District of Columbia have enacted some form of paid family leave, there is currently no federal law requiring paid family leave; while Congress has been engaged on this issue and several bills have been introduced, participants agreed that much work remains to be done to improve paid family leave.

Improve maternal health and mental health data collection to inform policy change

Considerable MHI discussion focused on improving data collection so that federal, state, and local officials and other interested parties will be better able to design and implement interventions that drive maternal health equity. Some participants pointed to the importance of the Data to Save Moms Act, currently under consideration by the United States Congress. This bill would require that MMRCs use the most up-to-date indicators of severe maternal morbidity; review deaths caused by suicide, overdose, or other behavioral health conditions attributed to or aggravated by pregnancy or childbirth; and consult with representatives of communities about nonclinical factors that may contribute to adverse maternal outcomes. It would allow the CDC to award grants to MMRCs to increase their engagement with local communities, such as bringing on community representatives as committee members. It also calls for the Indian Health Service and the Department of Health and Human Services to arrange for studies on adverse maternal health outcomes among tribal populations and others made marginalized, and would require the CMS and other agencies to review maternal health data collection processes and quality measures and make recommendations to improve them. This more robust information, along with other data streams, provides the raw material that implementation scientists can leverage to improve maternal health care quality and delivery.

Other MHI participants suggested a continued focus on efforts to collect and incorporate qualitative SDoH data into medical records. This information could be leveraged by MMRCs and others who seek to better understand the roles that nonclinical factors play in maternal health inequities. Other participants recommended investment in expanded data collection to include pregnancy, delivery, postnatal, and mortality surveillance, with more granular data collection on the community and facility levels. Taken together, this information will help elucidate state-level variation in maternal health outcomes. Without it, the picture of how these complex issues differ across the country will be left incomplete.



Conclusion

The Association of American Medical Colleges Center for Health Justice’s inaugural Maternal Health Incubator covered a wide array of topics that impact maternal health outcomes, particularly among women and birthing people of color and other populations made marginalized. The MHI featured a diverse group of presenters and panelists. These interested parties offered expertise in community-based activism, obstetrics-gynecology, nursing, and physiology as well as first-hand experience as recipients of pregnancy, birth, and postpartum health care. Presentations and panel discussions were open and honest, touching on a multitude of subjects that are often set aside or avoided in care delivery and policy discussions because of the discomfort they cause to some. The MHI addressed these issues head on, and in doing so, achieved its objectives: improving understanding of how better data can help close gaps in maternal health outcomes, how multisector and policy efforts can facilitate maternal health equity, and how to begin developing a collaborative multisector Action Plan to inform the creation of policies to eliminate health inequities for birthing people.

The Maternal Health Incubator yielded priority tasks that include improving data infrastructure with a focus on social determinants of health, delivering care that recognizes the distinction between high- and low- risk pregnancies, changes to utilization and training of various segments of the maternal health care workforce, placing communities at the forefront of change, and overhauling the current approach to postpartum care and paid family leave.

Participants agreed that there is much work to be done, and that no single approach or strategy will fully address the complex and longstanding constellation of factors that has driven maternal health inequities for generations. Yet, panelists were optimistic that these problems have solutions, and that communities are deeply invested in working with others to identify and implement these solutions. However, public and private insurers, policymakers, health systems, and institutions that train all segments of the health care workforce need to prioritize improving maternal health and take active steps to coordinate a thoughtful and evidence-based strategy that fully supports birthing people and their children.

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Founder and President, National Birth Equity Collaborative

The Honorable Sharice Davids, JD

Congresswoman, U.S. House of Representatives, Kansas Third District

Eugene Declercq, PhD

Professor of Community Health Sciences, Boston University School of Public Health; Professor of Obstetrics and Gynecology, Boston University School of Medicine

Veronica Gillispie-Bell, MD, MAS, FACOG

OB-GYN, Oschner Health; Medical Director, Louisiana Perinatal Quality Collaborative and Pregnancy Associated Mortality Review, Louisiana Department of Health

Kanika Harris, PhD, MPH

Director of Maternal and Child Health, Black Women's Health Imperative

Zsakeba Henderson, MD, FACOG

Senior Vice President of Maternal and Child Health Impact; Interim Chief Medical and Health Officer, March of Dimes

Anushay Hossain

Writer and Feminist Policy Analyst

Alannah Hurley

Executive Director, United Tribes of Bristol Bay

Sarah Kennedy, MPH

Senior Manager of Epidemiology and Evaluation, Generate Health STL

Tennille S. Leak-Johnson, PhD, MS

Assistant Professor of Physiology, Morehouse School of Medicine

S. Roxana Richardson, JD

Medical-Legal Partnership Director, Georgetown University Health Justice Alliance's Perinatal Legal Assistance and Wellbeing Project at MedStar Washington

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Kristen Zycherman, RN, BSN

Maternal and Infant Health Initiative Lead and Maternal and Infant Health Subject Matter Expert, Division of Quality and Health Outcomes, Centers for Medicare and Medicaid Services and Children's Health Insurance Program

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Kendal Orgera, MPH, MPP

Senior Research Analyst

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Manager of Government Relations

Sarah Piepenbrink

Communications Specialist, Center for Health Justice

Pamela Sharif, MBA

Director of Marketing

Other Support for the Maternal Health Incubator

Yolanda Liman, MA

Creative Director, Drawing Change

Helaine Resnick, PhD, MPH

President, Resnick, Chodorow and Associates

Additional Information and Resources

Association of American Medical Colleges

Center for Health Justice: <https://www.aamchealthjustice.org/>

Maternal Health Equity: <https://www.aamchealthjustice.org/our-work/maternal-health-equity>

From Pregnancy to Policy: Experiences of Birthing People in the United States: <https://www.aamchealthjustice.org/our-work/maternal-health-equity/polling>

Birth by the Numbers: <https://www.birthbythenumbers.org/>

March of Dimes: <https://www.marchofdimes.org/>

Centers for Disease Control and Prevention, Division of Reproductive Health:
<https://www.cdc.gov/reproductivehealth/index.html>

Centers for Medicare and Medicaid and CHIP Services

2022 Maternity Core Set of Maternal and Perinatal Health Measures:

<https://www.medicaid.gov/medicaid/quality-of-care/downloads/2022-maternity-core-set.pdf>

Postpartum Care Webinars Series:

<https://www.medicaid.gov/medicaid/quality-of-care/improvement-initiatives/maternal-infant-health/quality-improvement/postpartum-care/index.html>

Maternal & Infant Health Care Quality:

<https://www.medicaid.gov/medicaid/quality-of-care/improvement-initiatives/maternal-infant-health-care-quality/index.html>

Maternal and Infant Health Expert Workgroup Report of Recommendations:

<https://www.medicaid.gov/medicaid/quality-of-care/downloads/mih-expert-workgroup-recommendations.pdf>

Flourish St. Louis: <https://www.flourishstlouis.org/>

Generate Health: <https://generatehealthstl.org/>

National Birth Equity Collaborative: <https://birthequity.org/>

Georgetown University Health Justice Alliance Perinatal LAW Project:
<https://www.law.georgetown.edu/health-justice-alliance/our-work/perinatal-law-project/>

American College of Obstetricians and Gynecologists Presidential Task Force on Redefining the Postpartum Visit:

<https://www.acog.org/-/media/project/acog/acogorg/clinical/files/committee-opinion/articles/2018/05/optimizing-postpartum-care.pdf>

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- ² Owens DC, Fett SM. Black Maternal and Infant Health: Historical Legacies of Slavery. *Am J Public Health*. 2019;109(10):1342-1345.
- ³ Centers for Disease Control and Prevention. Infographic: Racial/Ethnic Disparities in Pregnancy-Related Deaths — United States, 2007–2016. <https://www.cdc.gov/reproductivehealth/maternal-mortality/disparities-pregnancy-related-deaths/Infographic-disparities-pregnancy-related-deaths-h.pdf>. Accessed September 7, 2022.
- ⁴ Center for American Progress. Eliminating Racial Disparities in Maternal and Infant Mortality: A Comprehensive Policy Blueprint. <https://americanprogress.org/wp-content/uploads/2019/04/Maternal-Infant-Mortality-report.pdf>. Published May 2019. Accessed September 7, 2022.
- ⁵ Urban Institute. Maternal Health Inequities During the COVID-19 Pandemic: Challenges, Promising Advances, and Opportunities to Promote Equitable Care. <https://www.urban.org/sites/default/files/publication/104306/maternal-health-inequities-during-the-covid-19-pandemic.pdf>. Accessed September 7, 2022.
- ⁶ National Academies of Sciences, Engineering, and Medicine; Health and Medicine Division; Division of Behavioral and Social Sciences and Education; Board on Children, Youth, and Families; Committee on Assessing Health Outcomes by Birth Settings; Backes EP, Scrimshaw SC, editors. Birth Settings in America: Outcomes, Quality, Access, and Choice. Washington, D.C.: National Academies Press; 2020. <https://www.ncbi.nlm.nih.gov/books/NBK555484/>. Accessed September 7, 2022.
- ⁷ Medicaid.gov. Maternal & Infant Health Care Quality. <https://www.medicaid.gov/medicaid/quality-of-care/improvement-initiatives/maternal-infant-health-care-quality/index.html>. Accessed September 7, 2022.
- ⁸ Centers for Disease Control and Prevention. Vital Signs. Pregnancy-Related Deaths. <https://www.cdc.gov/vitalsigns/maternal-deaths/index.html#:~:text=About%20700%20women%20die%20from,to%201%20year%20after%20delivery>. Published May 2019. Accessed September 7, 2022.
- ⁹ Raub A, Nandi A, Earle A, et al. Paid Parental Leave: A Detailed Look at Approaches Across OECD Countries. WORLD Policy Analysis Center. https://www.worldpolicycenter.org/sites/default/files/WORLD%20Report%20-%20Parental%20Leave%20OECD%20Country%20Approaches_0.pdf. Published 2018. Accessed September 7, 2022.
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- ¹² Petersen EE, Davis NL, Goodman D, et al. Racial/ethnic disparities in pregnancy-related deaths — United States, 2007-2016. *MMWR Morb Mortal Wkly Rep*. 2019;68(35):762-765.
- ¹³ United States House of Representatives Black Maternal Health Caucus. Black Maternal Health Omnibus. <https://blackmaternalhealthcaucus-underwood.house.gov/Momnibus>. Accessed September 7, 2022.

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- ¹⁴ Organizing Committee for Assessing Meaningful Community Engagement in Health & Health Care Programs & Policies. Assessing Meaningful Community Engagement: A Conceptual Model to Advance Health Equity through Transformed Systems for Health. National Academy of Medicine. <https://doi.org/10.31478/202202c>. Published February 14, 2022. Accessed September 7, 2022.
- ¹⁵ Association of American Medical Colleges. Center for Health Justice. The Principles of Trustworthiness. <https://www.aamchealthjustice.org/resources/trustworthiness-toolkit>. Accessed September 7, 2022.
- ¹⁶ Association of American Medical Colleges. Medical Schools' and Teaching Hospitals' Efforts to Address the Maternal Health Crisis. <https://www.aamchealthjustice.org/media/1001/download?attachment>. Published June 2021. Accessed September 7, 2022.
- ¹⁷ Association of American Medical Colleges. Diversity, Equity, and Inclusion Competencies Across the Learning Continuum. <https://store.aamc.org/diversity-equity-and-inclusion-competencies-across-the-learning-continuum.html>. Accessed September 7, 2022.
- ¹⁸ American College of Obstetricians and Gynecologists. Presidential Task Force on Redefining the Postpartum Visit. Committee on Obstetric Practice. Optimizing Postpartum Care. <https://www.acog.org/-/media/project/acog/acogorg/clinical/files/committee-opinion/articles/2018/05/optimizing-postpartum-care.pdf>. Published May 2018. Accessed September 7, 2022.

ON MAY 24-25, 2022 THE AAMC CENTER FOR HEALTH JUSTICE HOSTED THE:

MATERNAL HEALTH INCUBATOR



HEALTH JUSTICE IS THE PATH...

GIVE BIRTHING PEOPLE FULL AGENCY TO ARTICULATE WHAT EQUITABLE ACCESS LOOKS LIKE

HEALTH EQUITY IS THE GOAL

WE NEED HEALTHY BIRTHING PEOPLE FOR HEALTHY BABIES

WE ARE FACING AN URGENT HEALTH CRISIS

MANY DISPARITIES...

- LOCATION
- RACE (BLACK INDIGENOUS LATINX)
- DATA INEQUITY

SO THAT EVERY COMMUNITY STARTS FROM THE SAME STARTING LINE!

DATA EQUITY

COLLECTION USE INTERPRETATION ACTION

BEHIND EVERY STATISTIC IS A REAL PERSON

RECOGNIZING & CELEBRATING SACREDNESS of BIRTH

WE NEED TO BUILD THE VILLAGE

DON'T SEPARATE THE MENTAL SUPPORT FROM THE MATERNAL HEALTHCARE SYSTEM

IMPACT of COVID-19 on BIRTHING PEOPLE

THE PANDEMIC STARTED WHEN MY BABY WAS VERY SMALL... NOT KNOWING MANY THINGS ABOUT MY POSTPARTUM... IT WAS DIFFICULT.

I HAD TO GIVE BIRTH WITH A MASK ON AND THE VICTIMS THAT BROKE MY HEART.

FROM A DATA PERSPECTIVE:

COVID-19 ↑ REAL-TIME DATA MONITORING OF BIRTHING PEOPLE & INFANTS

RESEARCH NEED- BETTER KNOWLEDGE OF VACCINE EFFICACY ON BIRTHING PEOPLE

WE HOPE THIS CONTINUES BEYOND THE PANDEMIC

DEMONSTRATED SIGNIFICANT RACIAL HEALTH DISPARITIES

COULD ONLY BE EXPLAINED BY STRUCTURAL RACISM

RACISM IN THE SYSTEM

RACE IS NOT BIOLOGICAL RISK FACTOR SOCIAL CONSTRUCT

BUILD & GROW PERINATAL HEALTH PROFESSIONALS

- MIDWIVES
- DOULAS
- BIRTHING CENTERS

WHILE HOSPITALS SORT THEMSELVES OUT!

AND, YES WE NEED TO WORK WITH and THROUGH THE SYSTEM

RECOGNIZING RACISM IN THE SYSTEM WITHOUT VILLAINIZING THE SYSTEM

TAKEAWAYS

HOW ARE YOU BOTH DOING?

STOP SEPARATING MATERNAL and INFANT HEALTH

INCLUDING LGBTQ+ BIRTHING PEOPLE IN THE ROOM

- ↳ LISTEN WITH HUMILITY
- ↳ LEAN IN and LEARN

BIRTHWORK IS FAMILY WORK

WHAT BIRTHING PEOPLE IN THE U.S. ARE SAYING

LOGAN BURDETTE, HEALTH POLICY INTERNSHIP, AAMC CENTER FOR HEALTH JUSTICE, MAY 24, 2022

80% POSITIVE BIRTHING EXPERIENCE

IN SPRING 2022, AAMC CENTER FOR HEALTH JUSTICE CONDUCTED A POLL OF 1226 BIRTHING PEOPLE

20% FAIR OR POOR EXPERIENCE

66% (OF ALL BIRTHING PEOPLE) EXPERIENCED POSTPARTUM COMPLICATIONS

30% WERE NEVER SCREENED for MENTAL HEALTH

37% EXPERIENCED BIAS AND DISCRIMINATION

MORE LIKELY TO REPORT IF:

- NON-HISPANIC BLACK
- GEN 2
- LOWER INCOME
- LGBTQ+

DEPRESSION

ANXIETY

ESTABLISHING A SUPPORT NETWORK

ALSO BORN FROM EPIDEMIAL FOR LONG TIME

GEN-Z

LOW INCOME

RURAL

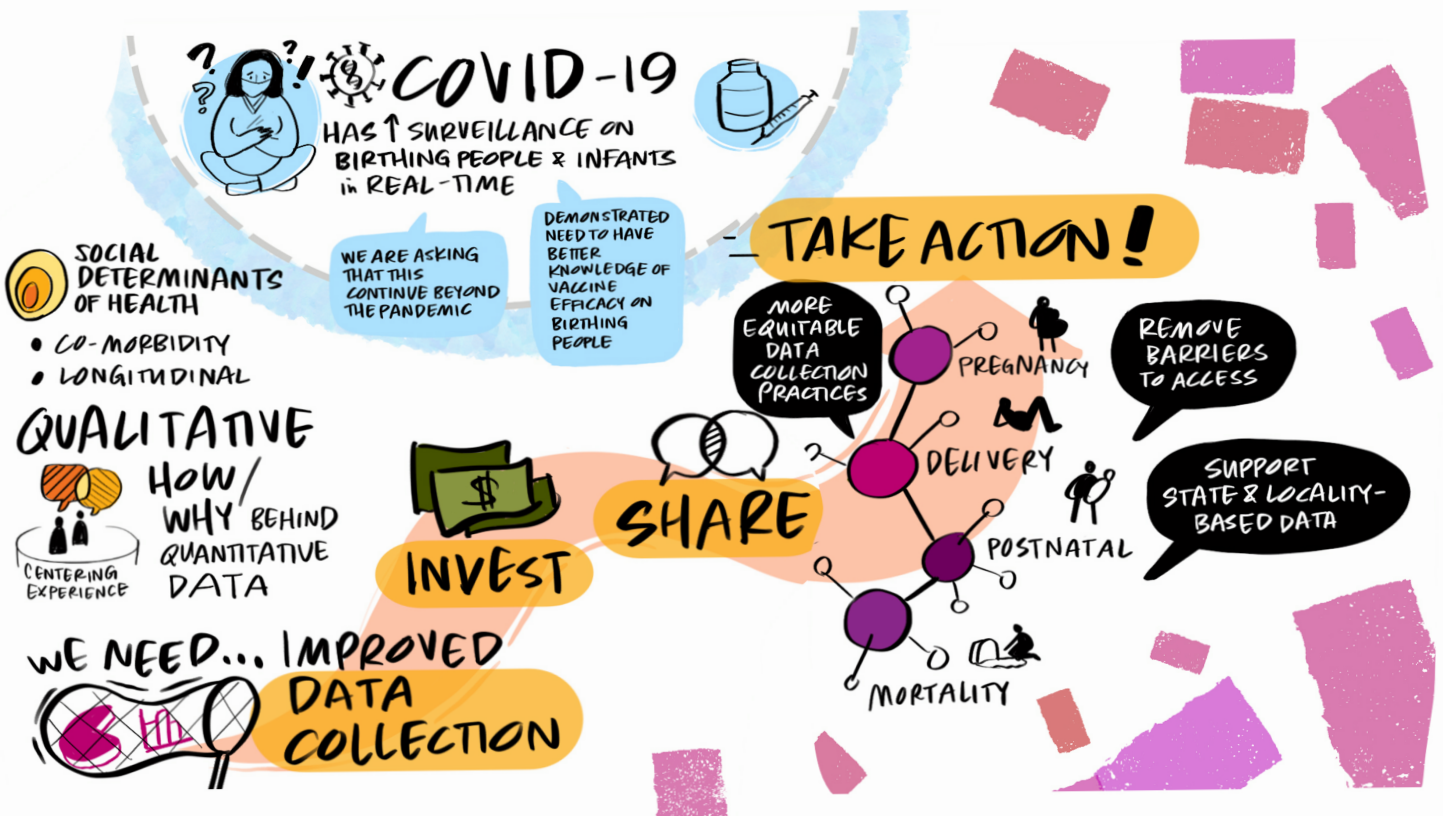
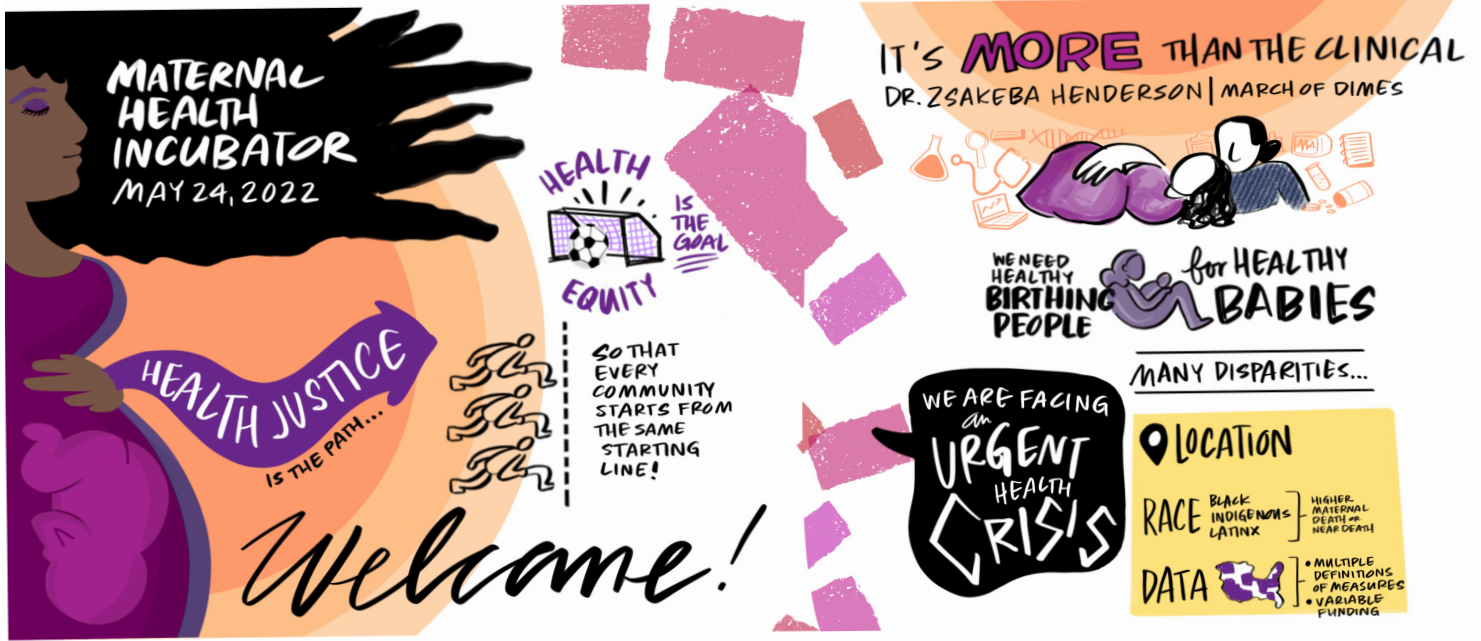
LGBTQ+

WE NEED TO GET TO ACTION

NEXT STEPS

ADVANCING MATERNAL HEALTH POLICY WHILE ADDRESSING RACIAL INEQUITY

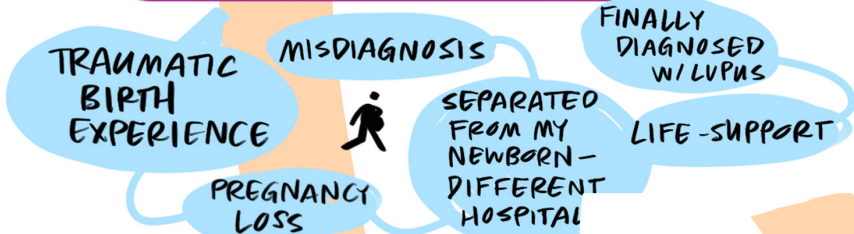
YOLANDA LIMAN | Drawing Change



Appendix A: Graphic Facilitation Images



TENILLE S. LEAK-JOHNSON
 ASST. PROFESSOR, PHYSIOLOGY,
 MOREHOUSE SCHOOL OF MEDICINE



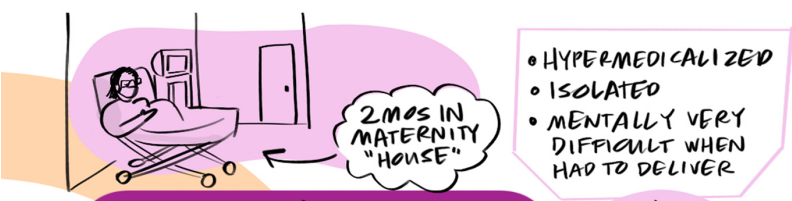
MODERATOR: DR. JOIA CREAR-PERRY

RECOGNIZING & CELEBRATING
SACREDNESS
 of BIRTH

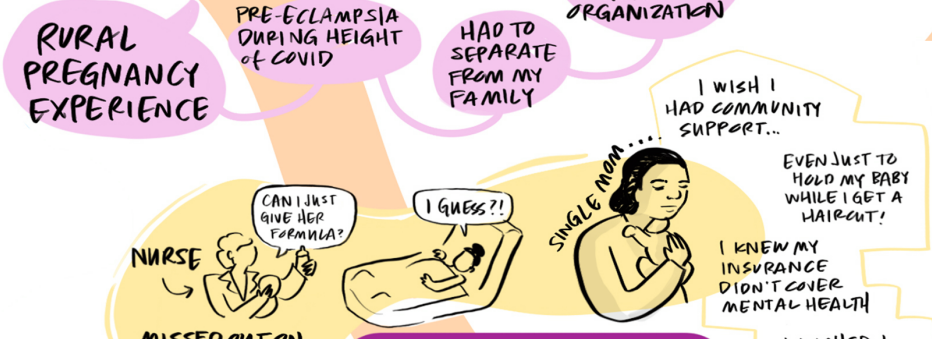
WE NEED TO BUILD the
VILLAGE

DON'T SEPARATE the
MENTAL SUPPORT
 FROM THE MATERNAL HEALTHCARE SYSTEM

YOLANDA LIMAN | Drawing Change | AAMC CENTER FOR HEALTH JUSTICE



UNITED TRIBES OF BRISTOL BAY



COMMUNITY ACTIVIST

IMMIGRANT- AND PROUD WASHINGTONIAN

JOB LOSS - PANDEMIC

HOMELESSNESS

SEXUAL VIOLENCE

RACISM

DOMESTIC VIOLENCE

Appendix A: Graphic Facilitation Images

WANDA BARFIELD

DIRECTOR, CDC DIVISION REPRODUCTIVE HEALTH



DISPARITIES in REPRODUCTIVE HEALTH across:

- GENERATIONS
- RACE
- EDUCATION
- NUTRITION
- ECONOMIC STATUS

NO ONE SHOULD DIE GIVING *Life*



NEED TO UNDERSTAND MEDICAL and NON-MEDICAL CONTRIBUTORS TO MATERNAL MORTALITY

EQUITY in DATA COLLECTION



FULL PICTURE THROUGH DIVERSITY - (WHICH WE ENSURE IN OUR COMMITTEES)

APPROACHES NEEDED:

- LONGITUDINAL
- MEASURING DISCRIMINATION
- TELLING THE STORIES BEHIND DATA POINTS and



DEMONSTRATES PATIENT VOICES

HEAR HER CAMPAIGN

RACE IS NOT BIOLOGICAL RISK FACTOR - SOCIAL CONSTRUCT

DEMONSTRATES BIAS:

- * DISCRIMINATION
- * INTERPERSONAL RACISM
- * STRUCTURAL RACISM

HOW TO

MEASURE?

PANEL DISCUSSION: LEADING BY EXAMPLE

MAY 24, 2022

EUGENE DECLERQ

BOSTON UNIVERSITY, SCHOOL OF PUBLIC HEALTH

HOW TO ASK BETTER QUESTIONS

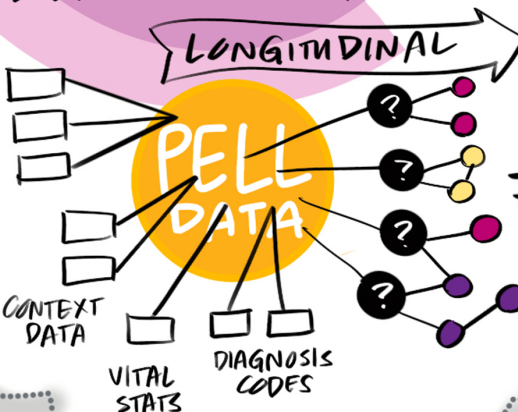


LISTENING TO BIRTHING PEOPLE

YOU'RE GOING TO HAVE A BIG BABY



ex. "BIG BABY" MYTH ACTUALLY BIRTH WEIGHT IS GOING DOWN!



BETTER QUESTIONS - (BASED ON MORE DATA/VARIETY, OVER TIME)

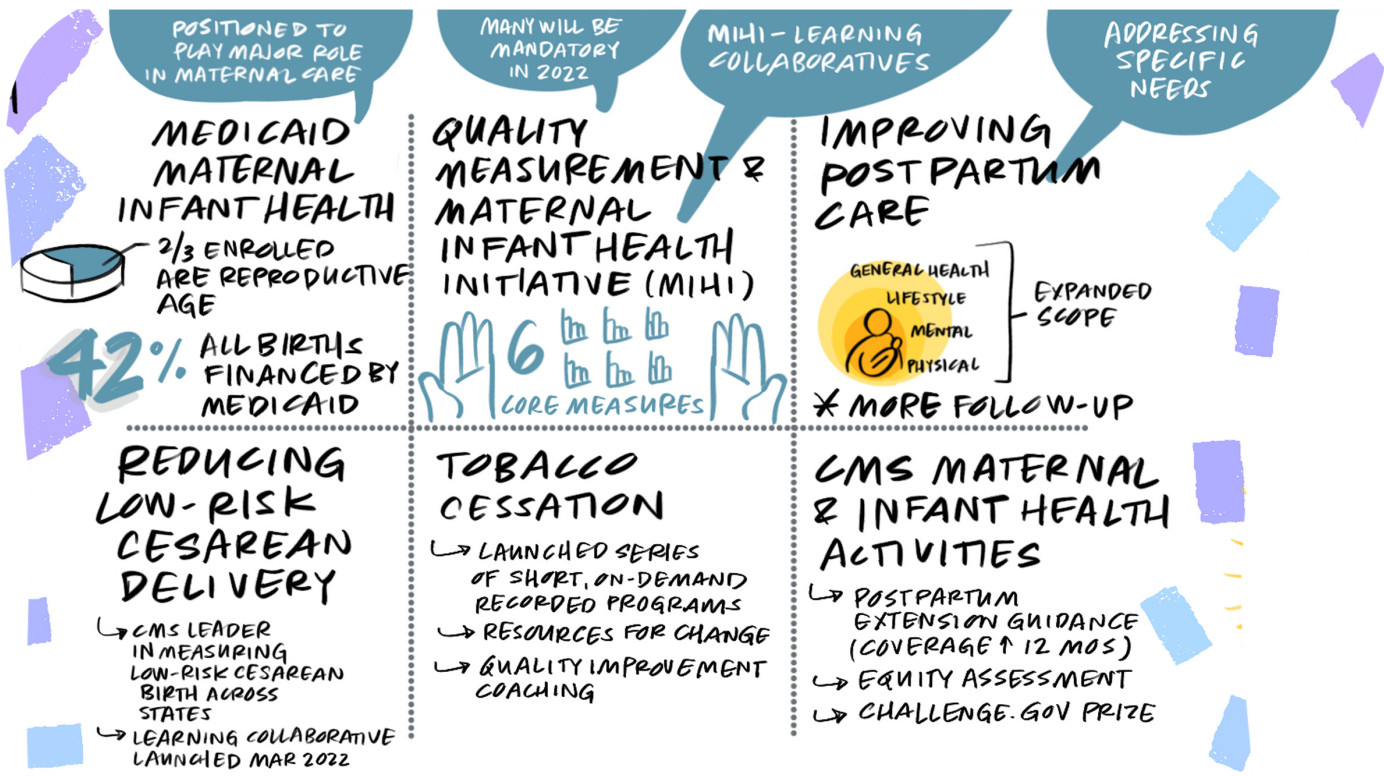
INFO HAS DOMINO EFFECT



- TENDED TO SELF INDUCE
- REQUEST EPIDURAL
- ALL ACTIONS AFTER BEING TOLD "BIG BABY"

NEED TO LISTEN TO BIRTHING PEOPLE TO ASK RIGHT QUESTIONS!

Appendix A: Graphic Facilitation Images

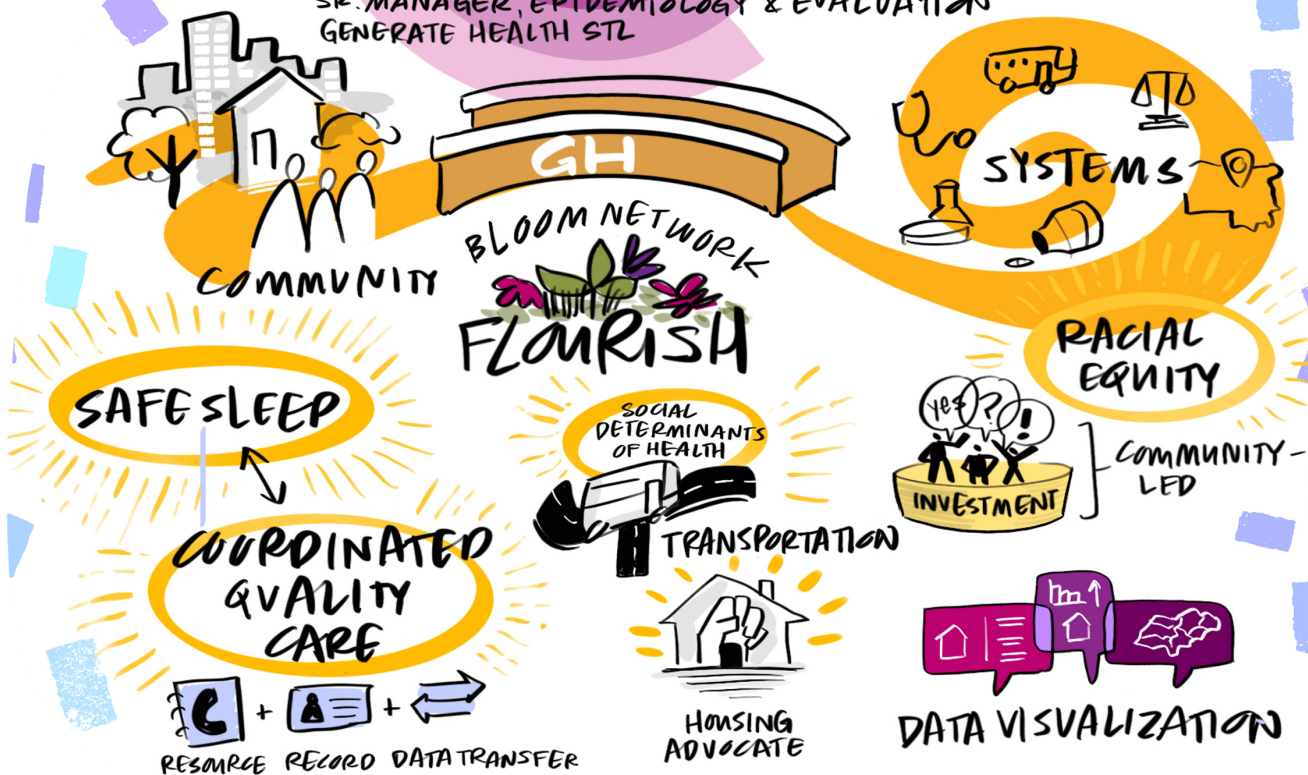


KRISTEN ZYCHERMAN

CENTERS FOR MEDICARE & MEDICAID SERVICES (CMS) and CHIP

SARAH KENNEDY

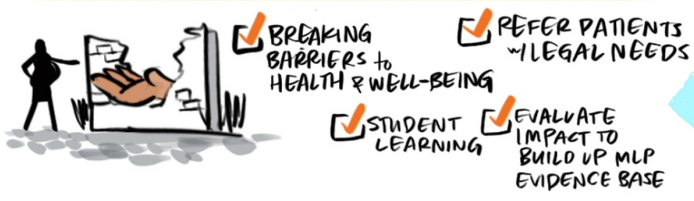
SR. MANAGER, EPIDEMIOLOGY & EVALUATION
GENERATE HEALTH STL



LEGAL SERVICES TO IMPROVE MATERNAL HEALTH OUTCOMES



P-LAW = PERINATAL LEGAL ASSISTANCE & WELL-BEING PROJECT



SYSTEMIC CHANGES

WE KNOW WHAT'S WRONG. BUT HOW TO MAKE THOSE STRUCTURAL CHANGES?

ROXANA RICHARDSON
 MEDICAL-LEGAL PARTNERSHIP DIRECTOR
 MANAGING ATTORNEY PERINATAL LEGAL ASSISTANCE AND WELLBEING PROJECT
 GEORGETOWN UNIVERSITY HEALTH JUSTICE ALLIANCE

Q & A

STOP SEPARATING MATERNAL AND INFANT HEALTH

BIAS IN DATA COLLECTION

↳ WHAT QUESTIONS ARE ASKED MAKES HUGE DIFFERENCE IN OUTCOMES

- LIKE REFERRING LOW-RISK PREGNANCIES TO MIDWIVES?
- LIKE GIVING HOPS MORE TIME w/ PATIENTS?

- ↳ MENTAL HEALTH SCREENING
- ↳ POSTPARTUM VISITS
- ↳ HEALTHY BIRTHING PEOPLE MAKE HEALTHY BABIES



HOW TO CONNECT DATA TO RESOURCES and ACTION?



YOLANDA LIMAN | Drawing Change



WHAT BIRTHING PEOPLE IN THE U.S. ARE SAYING

LOGAN BURDETTE, HEALTH POLICY INTERN, AAMC CENTER FOR HEALTH JUSTICE
MAY 24, 2022

80% POSITIVE BIRTHING EXPERIENCE

IN SPRING 2022, AAMC CENTER FOR HEALTH JUSTICE CONDUCTED A POLL OF 1206 BIRTHING PEOPLE

20% FAIR OR POOR EXPERIENCE

(OF ALL BIRTHING PEOPLE) 66% EXPERIENCED POSTPARTUM COMPLICATIONS

MENTAL HEALTH CONCERNS WERE THE MOST REPORTED COMPLICATIONS

30% WERE NEVER SCREENED FOR MENTAL HEALTH

37% EXPERIENCED BIAS AND DISCRIMINATION

MORE LIKELY TO REPORT IF:

- NON-HISPANIC BLACK
- GEN-Z
- LOWER INCOME
- LGBTQ+

TO REPORT LESS THAN "GOOD" BIRTHING EXPERIENCE

LOW INCOME

GEN-Z

RURAL

LGBTQ+

DEPRESSION

ANXIETY RETURNING TO WORK

ESTABLISHING MILK SUPPLY

BED-RIDDEN FROM EPIDURAL FOR LONG TIME



IMPACT of COVID-19 ON BIRTHING PEOPLE

62%.

INELEGIBLE FOR
VACCINE WHILE
PREGNANT



"THE PANDEMIC STARTED
WHEN MY BABY WAS
VERY SMALL... NOT
KNOWING MANY THINGS
ABOUT MY POSTPARTUM
...IT WAS DIFFICULT."



"I HAD TO GIVE BIRTH
WITH A MASK ON AND
NO VISITORS... THAT
BROKE MY HEART."



OF THOSE ELIGIBLE,
BIRTHING PEOPLE
MORE LIKELY TO BE
VACCINATED WERE

- HISPANIC
- COLLEGE EDUCATED
- HIGHER INCOME

COMMON THEMES:

- NO VISITORS ALLOWED
- FEAR FOR CHILD'S HEALTH
- LACK OF SOCIAL SUPPORT
- LIMITED ACCESS TO DOCTORS
- DIFFICULTIES w/ WORK and FINANCES

YOLANDA
LIMAN

Drawing
Change



AAMC CENTER FOR
HEALTH JUSTICE

PANEL DISCUSSION: IMPLICATIONS FOR POLICY
MAY 25, 2022

MODERATOR: ALY BERLIN, MANAGER, AAMC & GOVT RELATIONS

PANELISTS:
KANIKA HARRIS
ANUSHAY HOSSAIN
TERRI D. WRIGHT

HOW DO WE ENSURE THE RIGHT PEOPLE ARE AT THE TABLE?

PEOPLE CLOSEST TO PROBLEM HOLD THE SOLUTION

WORDS MATTER WHEN PARTNERING WITH COMMUNITIES

"ACCESS"

- YOU WILL ONLY KNOW WHAT THIS MEANS BY ASKING THE COMMUNITY
- NUMBERS → MAGNITUDE
- STORIES → WHY AND HOW

"CULTURALLY RELEVANT"

- ESPECIALLY WHEN ADDRESSING MENTAL HEALTH

WHICH IS WHY WE NEED TO TALK TO COMMUNITIES AND BRING THEM INTO LEGISLATION WORK!

BEHIND EVERY STATISTIC IS A REAL PERSON

LEADING BY EXAMPLE

EVEN THE WAY WE RUN MEETINGS

COVID

DEMONSTRATED RACIAL HEALTH DISPARITIES COULD ONLY BE EXPLAINED BY STRUCTURAL RACISM

DATA EQUITY

INTERPRETATION

COLLECTION

USE

BUILD & GROW PERINATAL HEALTH PROFESSIONALS

MIDWIVES
DALLAS
BIRTHING CENTERS

WHERE DO WE START?

STARTS IN MEDICAL SCHOOLS

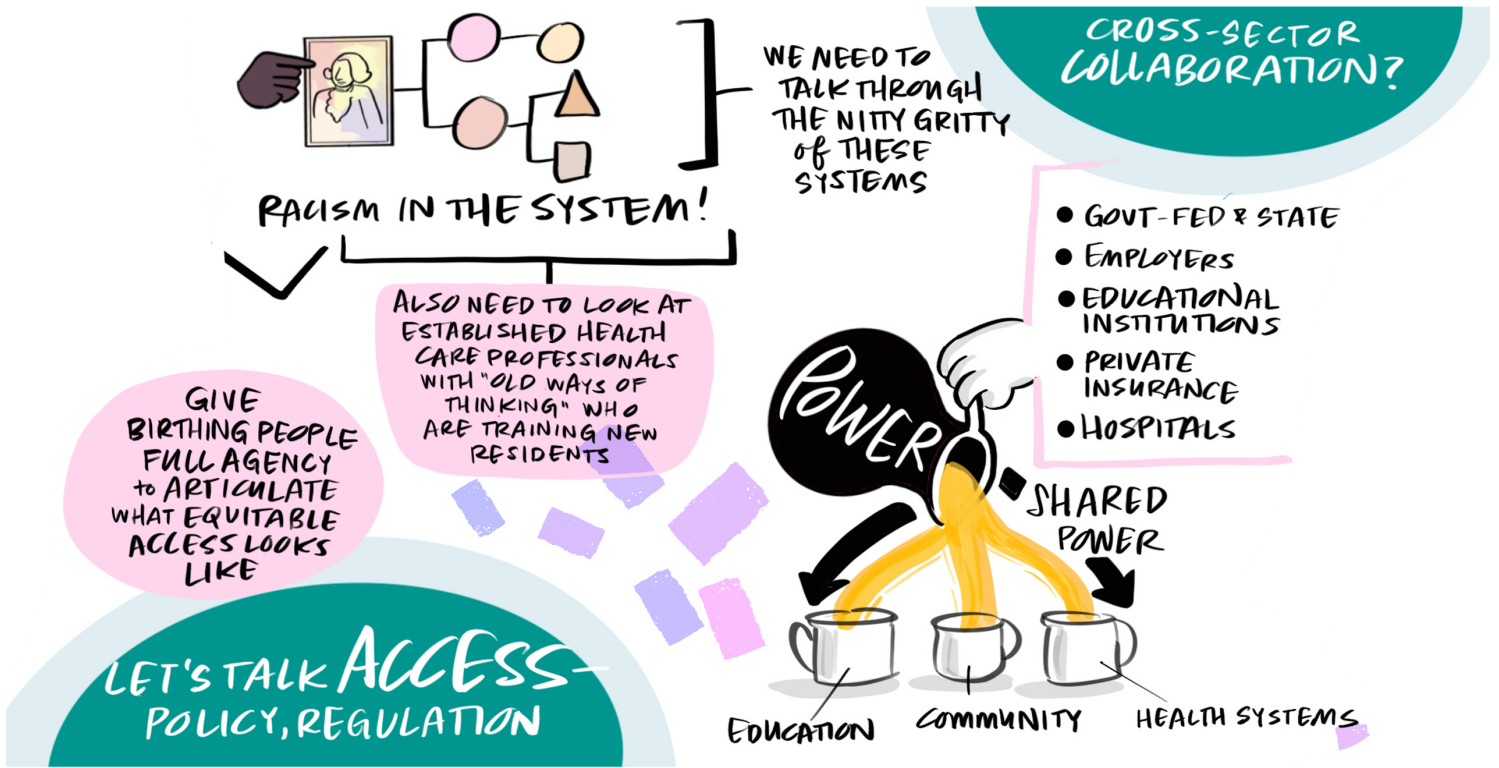
WE NEED TO BLOW THE CURRICULUM UP!

WHILE HOSPITALS SORT THEMSELVES OUT!

AND, YES WE NEED TO WORK WITH and THROUGH THE SYSTEM

RECOGNIZING RACISM IN THE SYSTEM WITHOUT VILLAINIZING THE SYSTEM

WHAT DO WE NEED TO CONSIDER IN LEGISLATION?



INCLUDING LGBTQ+ BIRTHING PEOPLE IN THE ROOM

- LISTEN w/ HUMILITY
- LEAN IN and LEARN

YOLANDA LIMAN | Drawing Change

AAMC CENTER FOR HEALTH JUSTICE





DARIA GRAYER

SENIOR LEAD SPECIALIST,
SCIENCE POLICY & REGULATIONS, SCIENTIFIC AFFAIRS
AAMC CENTER FOR HEALTH JUSTICE



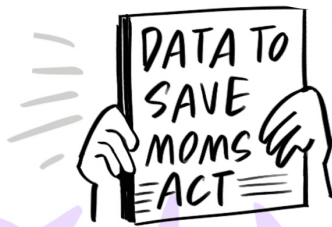
STATE AND FEDERAL POLICY

KEY ISSUES FRAMING TODAY

- HOW POLICY MAKERS & LEGISLATORS CAN USE EVIDENCE TO MOVE SWIFTLY TO ADDRESS MATERNAL HEALTH AND MORTALITY
- HOW COMMUNITIES CAN CO-DEVELOP POLICY AND LEGISLATION  CO-PRODUCTION OF KNOWLEDGE
- EXPANDING MATERNAL HEALTH RESEARCH FUNDING TO COMMUNITY ORGANIZATIONS
- ↑ COLLECTION AND EVALUATION OF DATA (INDIVIDUAL & LONGITUDINAL STUDIES)  CREATING ACCESS TO DIGITAL TECHNOLOGY
- ↑ ACCESS TO MATERNAL CARE
- ↑ DIVERSIFICATION OF HEALTHCARE WORKFORCE
- ↑ POSTPARTUM INSURANCE COVERAGE AND PAID LEAVE






Remarks: *LEAD SPONSOR*
SHARICE DAVIDS
U.S. REPRESENTATIVE, KS
ONE OF 1ST TWO NATIVE AMERICAN WOMEN IN CONGRESS!



WE ARE FACING A CRISIS OF MATERNAL HEALTH in the U.S.

ESPECIALLY BLACK AND INDIAN BIRTHING PEOPLE

  **DYING 3-4X HIGHER THAN WHITE COUNTERPARTS** 

↑ 
COMMUNITY ENGAGEMENT IN MATERNAL MORTALITY REVIEW COMMITTEES

IMPROVED DATA COLLECTION @ MINORITY SERVING INSTITUTIONS

1ST STUDY NATIVE AMERICAN MATERNAL HEALTH CRISIS

FRANKLY, IT'S SHAMEFUL.

YOLANDA LIMAN

Drawing Change

