HEALTHY MOTHERS, HEALTHY BABIES
Coalition of Georgia

October 26-28, 2020

Maternal & Infant Health in the Digital World:

Patient-Centered Care During COVID and Beyond

VIRTUAL CONFERENCE

hmhbga.org/event/beyondcovid2020

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Beyond the Bundles: Advocacy Initiatives to Improve Maternal Health

Ginger Breedlove, PhD, CNM, FACNM, FAAN
President, MarchforMoms
October 27, 2020

Learning Objectives

Explore	…consequences of maternal events from patient, family and institutional lens.
Reflect	…on personal role, implicit bias, and institutional health of workplace.
Discuss	…initiatives to champion change at every opportunity and every level.

My 4 Decade Lens on Maternal Health

Maternal Mortality – KS, 1978

9.8/100,000 (KDH)

- Few shortage areas
- Wide coverage of maternity care & state-funded M&I clinics
- Comprehensive services e.g. Family planning, WIC, Social Workers
- High engagement in Childbirth Education & Preparation

Maternal Mortality – Ks, 2019

26.6/100,000 (KDH)

- Increased medicalization – "Too much too soon, or, too little too late"
- Loss of funding for community programs and services
- Less consumer interest and/or access to education
- Fragmented and rising inequities of MCH services

And GA? (2016 last available data)

- Number of births in 2016: 130,042
- Predicted Mortality Rate: 37.2 per 100,000 births
  - Ranked worst in U.S.
- Efforts now in place with mandatory reporting measures and MMRC

http://www.georgiahealthnews.com/2019/01/maternal-death-rate-is-problem-factual-approach/

Reasons for Maternal Morbidity and Mortality

- Absence of universal health coverage
- Worsening overall health of population
- System and Provider errors
- Maternal Health Deserts in Rural areas
- Generational poverty and health inequities
- Affordability and coverage of all contraceptives
- Rise of C-section and subsequent complications

Additional Factors:

- Rise in co-morbid chronic conditions e.g. Hypertension, Diabetes, Obesity, Smoking, Substances, Mental Health
- Decades of society ignoring implicit bias, racism, classicism and other ‘ism’s
- Workforce Shortage, Burnout, Provider Fatigue
- Lack of seamless and effective Team-based care
- Inadequate integration of care for choice in place of birth
- Lack of uniform definitions and mandatory reporting

Lens of Others?

- MCH Professional Societies
- The Public
- Institutional Setting
- Payers
- Policy Makers
- Today's audience

https://www.theguardian.com/global-development/2018/sep/24/why-do-women-still-die-giving-birth

PROVIDERS: The ‘Bundles’ AIM Initiatives

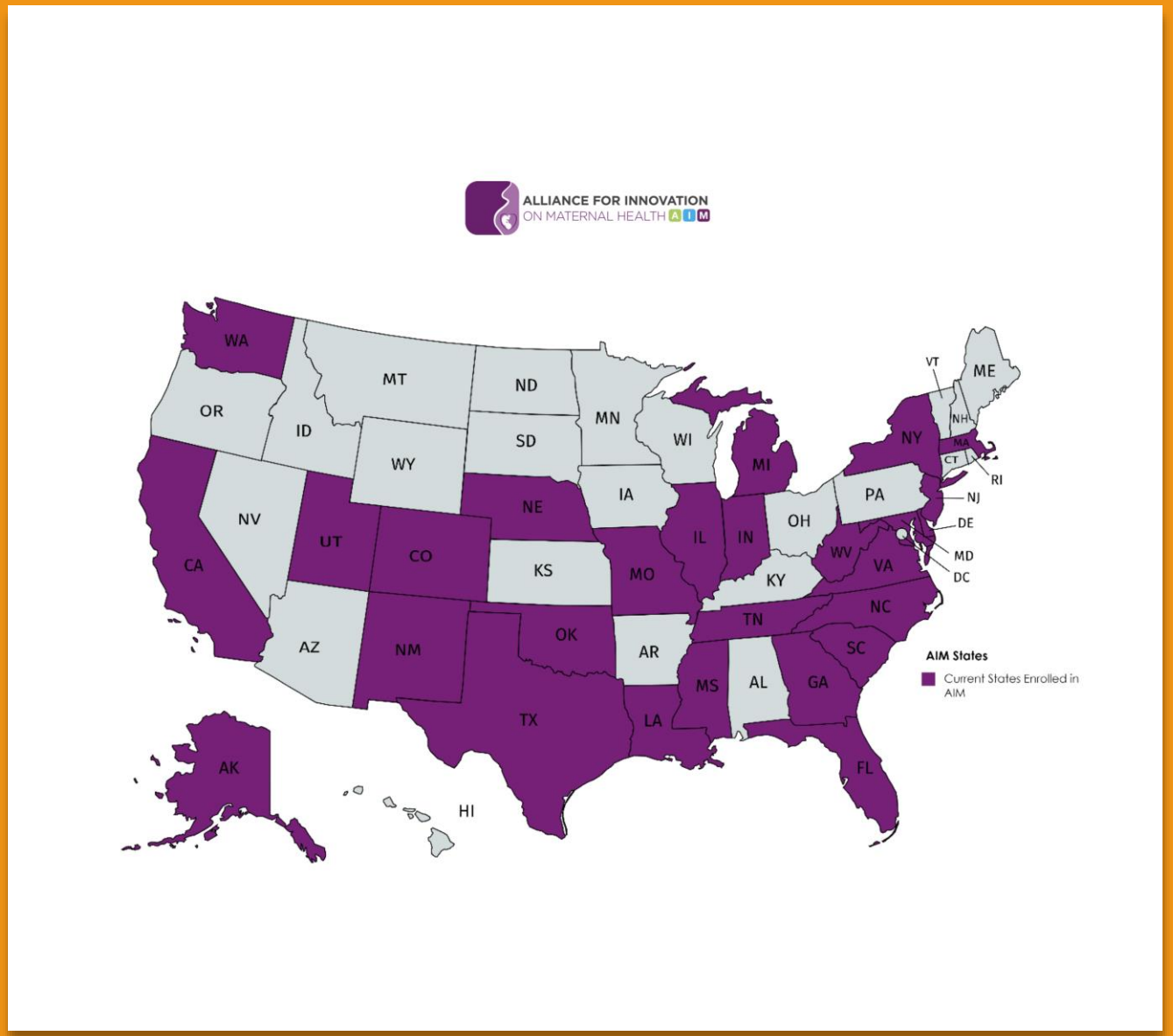
National program to equip every state, perinatal quality collaborative, hospital network/system, birth facility and maternity care provider to significantly reduce severe maternal morbidity and maternal mortality through proven implementation of consistent maternity care practices

https://safehealthcareforeverywoman.org/patient-safety-bundles/

AIM States

GA partnered as an AIM state in 2018

https://georgiapqc.org/obstetric-hemorrhage



9 AIM BUNDLES

GA implemented two:

Obstetric Hemorrhage

Severe Hypertension

- 30 of 62 GPQC member hospitals implemented both
- 6/62 only implemented NAS training

https://georgiapqc.org/member-hospitals

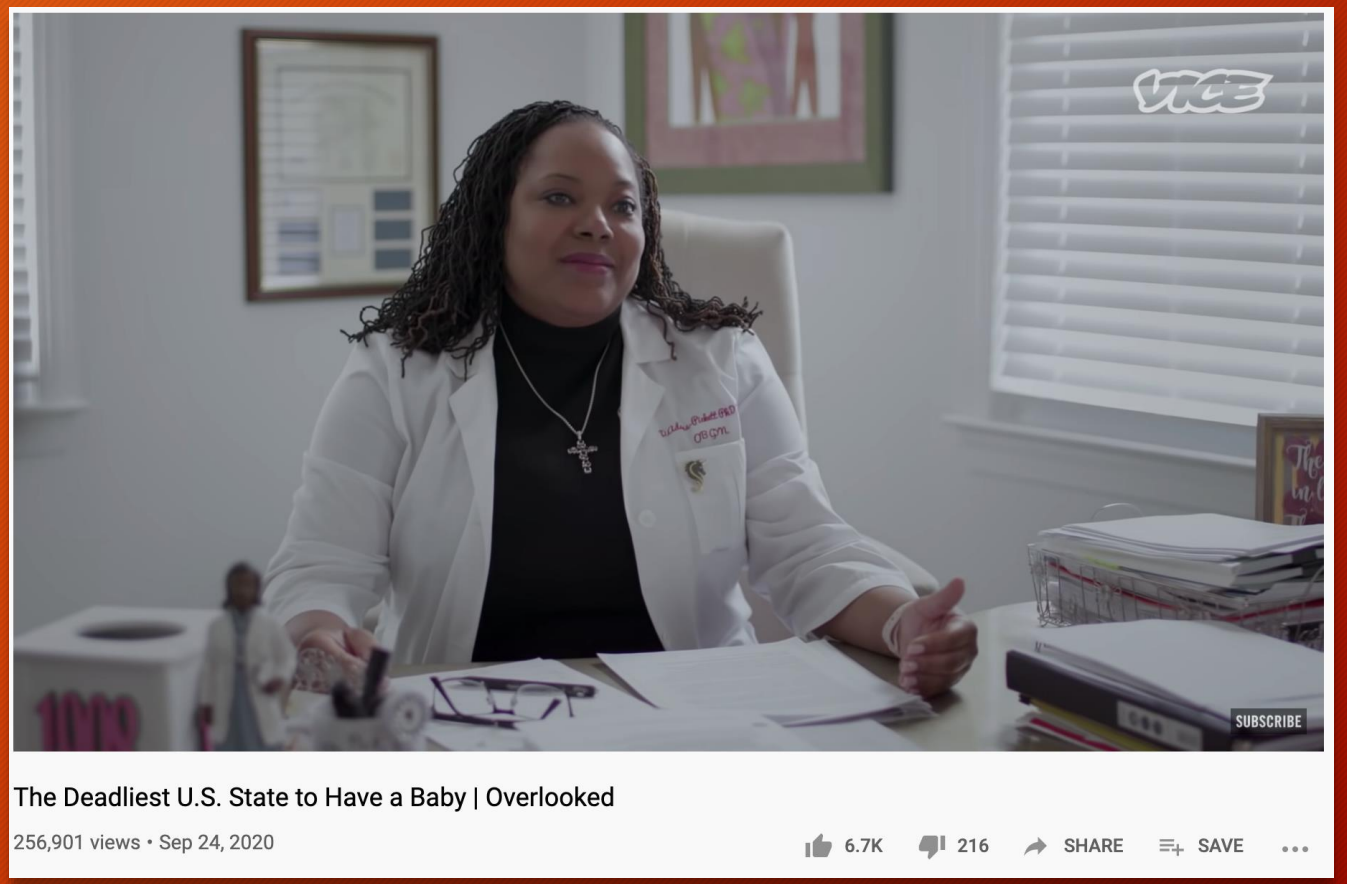
- Maternal Mental Health: Depression and Anxiety
- Maternal Venous Thromboembolism (+AIM)
- Obstetric Care for Women with Opioid Use Disorder (+AIM)
- Obstetric Hemorrhage (+AIM)
- Postpartum Care Basics for Maternal Safety
  - From Birth to the Comprehensive Postpartum Visit (+AIM)
  - Transition from Maternity to Well-Woman Care (+AIM)
- Prevention of Retained Vaginal Sponges After Birth
- Reduction of Peripartum Racial/Ethnic Disparities (+AIM)
- Safe Reduction of Primary Cesarean Birth (+AIM)
- Severe Hypertension in Pregnancy (+AIM)

Beyond AIM: Professional Society Initiatives

- Fetal Infant Mortality Review Boards (FIMR)
- Perinatal Quality Collaboratives (PQCs)
- Maternal Mortality Review Committee's (MMRC)
- California Maternal Quality Care Collaborative (CMQCC)
- Patient Safety Network (PSNET) for Maternal Safety
- And many more…

PUBLIC
VICE Video: Raises awareness about GA

- https://www.youtube.com/watch?v=dT0rL4TvX-I
- **Released September 24,2020**
- Features Dr. Donna Adams-Pickett from Augusta, GA
- Describes alarming maternal mortality rate in State of Georgia



PATIENT & FAMILY

(With permission/March for Moms)

NearMiss

DenyandDelay Stroke
MaternalDeath
MentalHealth
Suicide Homicide HealthInequity
RuralAmerica Hemorrhage
AmnioticFluidEmbolism
Eclampsia Accreta Deaths
Racism PulmonaryEmbolism
GeographicLocation
Infection Cardiomyopathy
BlackWomen Preventable
SubstanceAbuse
LostMothers
Hypertension

NJ Near Miss Survivor (Bio-tech Scientist)

STOP If a patient does not feel well, or believes something is wrong, the provider should stop and not assume that they are typical complaints that all new mothers experience.

LOOK Conduct an examination to be sure there are no evolving problems such as high blood pressure, internal bleeding or infection.

LISTEN Hear the patient's complaints in their own words and never consider them a usual part of having a baby.

Dad left behind

- Posted on Face Book on **July 13th** after surviving a near-miss postpartum event (With Permission/March for Moms)

- On her passing **September 24th**, 2018 she was 6 months postpartum and Mom to her first children, twin boys

Lian Shalala Gravelle shared a post.
July 13 ·

OK friends... the committee members include reps from OH, IN, TX, FL, NJ, IL and NY. NY-- Chris Collins is on this list that is the Buffalo area! Please please please help get this passed. March for Moms makes it so easy to express your support for this bill. If you care about the women in your lives, do it. Don't let your loved ones experience what I did - or actually die - from giving birth!

March for Moms
July 13 ·

The members of the house energy and commerce committee are responsible for the hearing of, mark up and passage of #HR1318 #MaternalMortality bill In the house o...

See More

ENERGYCOMMERCE.HOUSE.GOV
About - Energy and Commerce Committee
The Committee on Energy and Commerce is the oldest standing...

March for Moms

Dr. Shalon Irving, CDC Epidemiologist


Shalon Irving

- Lieutenant Commander in the U.S. Public Health Service and a CDC epidemiologist, she earned a dual doctorate in sociology and gerontology; was an accomplished author and talented chef; skilled photographer, world traveler; and an ecstatic mother-to-be.
- **Just three weeks after giving birth** to her daughter she suffered complications from high blood pressure and died in February 2017. She was just 36.

https://www.hrsa.gov/enews/past-issues/2018/july-5/shalons-story.html

INSITUTIONAL SETTINGS

- **ASK:** Can **more be done** to implement changes to reduce preventable events?
  - Lack of trained and appropriate personnel when needed
  - Missed or delayed diagnosis
  - Lack of guiding protocols
  - Emergency Dept limited experiences with perinatal health issues

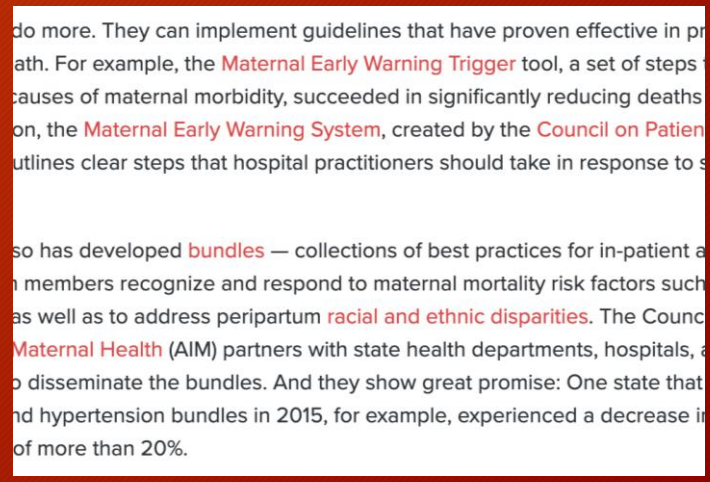
https://news.aamc.org/patient-care/article/painful-truth-about-maternal-deaths/

PATIENT CARE

Tuesday, March 19, 2019 | by Lisa M. Hollier, MD

The painful truth about maternal deaths

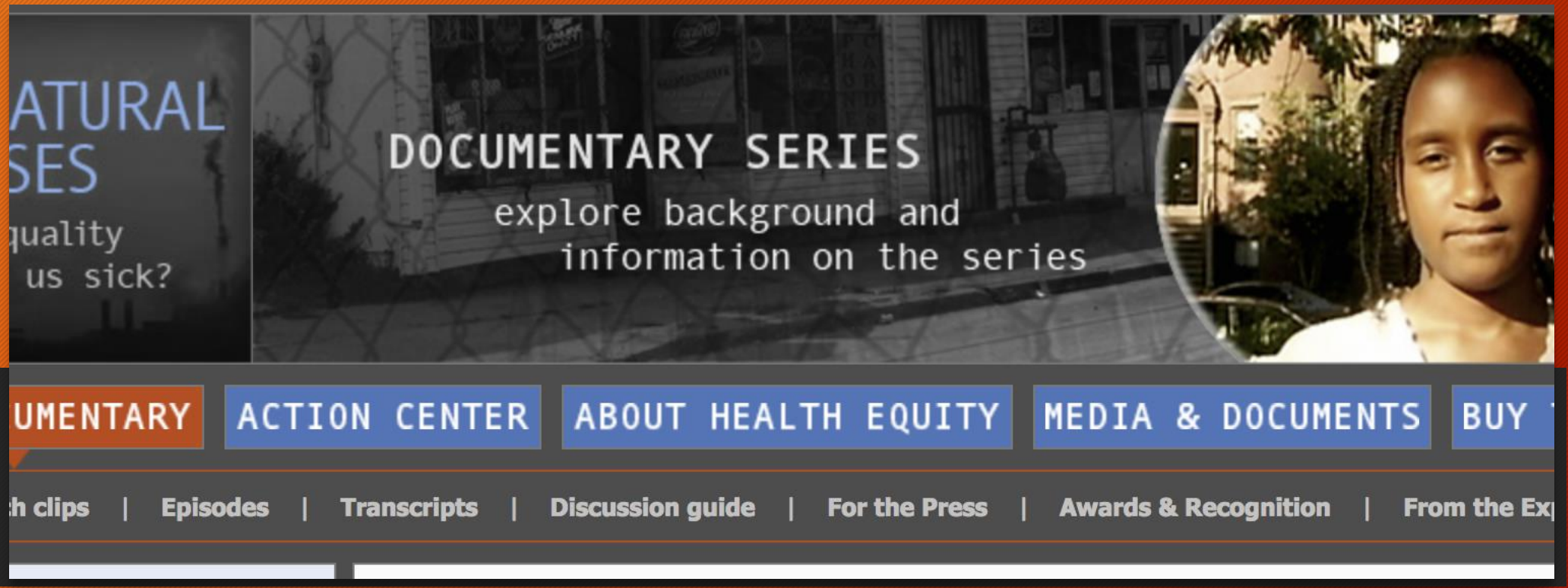
The United States has the worst maternal mortality rate in the developed world. If we're going to save women's lives, all providers have to step up. Here's what you can do.



do more. They can implement guidelines that have proven effective in pr
ath. For example, the Maternal Early Warning Trigger tool, a set of steps
causes of maternal morbidity, succeeded in significantly reducing deaths
on, the Maternal Early Warning System, created by the Council on Patien
utlines clear steps that hospital practitioners should take in response to s

so has developed bundles — collections of best practices for in-patient a
members recognize and respond to maternal mortality risk factors such
as well as to address peripartum racial and ethnic disparities. The Counc
Maternal Health (AIM) partners with state health departments, hospitals,
o disseminate the bundles. And they show great promise: One state that
nd hypertension bundles in 2015, for example, experienced a decrease i
of more than 20%.

Do we acknowledge INEQUITIES in maternity care? "How Racism Impacts Pregnancy Outcomes" (2008)



https://www.unnaturalcauses.org/video_clips_detail.php?res_id=70

What can Institutional Settings DO?

Require Implicit Bias/Unconscious Bias training beyond the IBT. Include:

1. Unconscious Bias Test (IAT/Harvard most commonly used)
2. Debrief results within diverse groups
3. Receive education on anti-racism
4. Understand impact of unconscious bias on health delivery outcomes
5. Provide ongoing assessment to reduce racism

https://implicit.harvard.edu/implicit/takeatest.html

PAYER status influences outcomes!

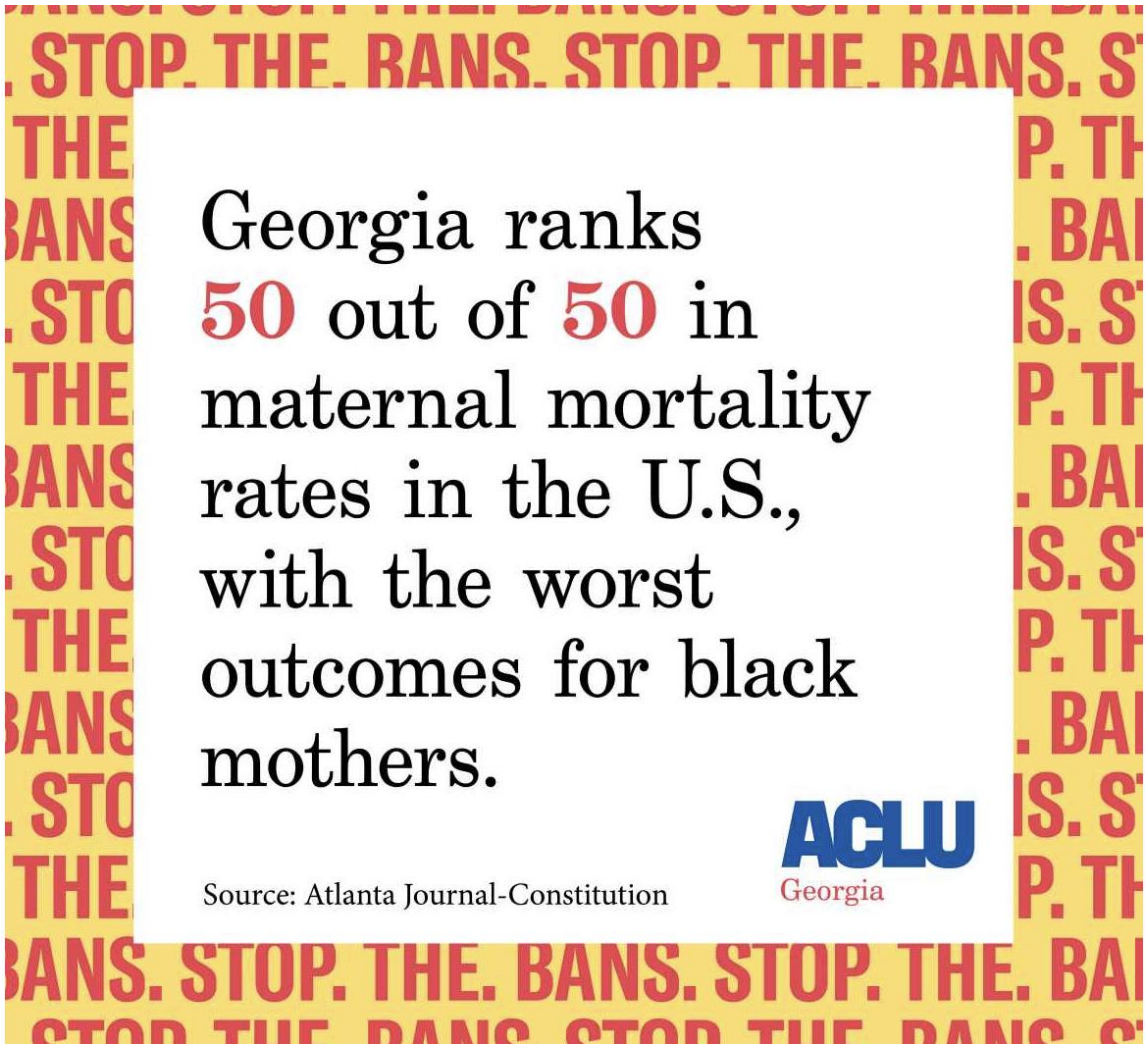
- As of May 2020, 23 percent of Georgia residents were uninsured
  - GA has the fourth highest uninsured rate in the U.S.
- Kaiser Foundation - 51% of all GA births are to moms with Medicaid
  - GA is one of 12 States that ends Medicaid 60 days after delivery
- *60% of maternal deaths are preventable occurring up to 1 year postpartum*

POLICY: Change in Complex Landscape

https://www.acluga.org/en/problem-georgia-has-maternal-mortality-crisis

Behavior that brings CHANGE

- Collaboration is the Cornerstone
- Embracing Change is Non-Negotiable
- Help Educate Others
- Take **Personal Steps** to work with:
  - Policy groups
  - Policy leaders and
  - Elected officials
  - ***Maintain vigilance in message and contact***



Combine Advocacy With Facts

Embrace WHO Steps to Eliminate Disrespect & Abuse

UNDERSTAND MEANING OF RESPECTFUL CHILDBIRTH

(Global Movement in 2015)

https://www.mhtf.org/topics/respectful-maternity-care/

World Health Organization

hrp

The prevention and elimination of disrespect and abuse during facility-based childbirth

WHO statement

Every woman has the right to the highest attainable standard of health, which includes the right to dignified, respectful health care.

photo: UNICEF

Many women experience disrespectful and abusive treatment during childbirth in facilities worldwide. Such treatment not only violates the rights of women to respectful care, but can also threaten their rights to life, health, bodily integrity, and freedom from discrimination. This statement calls for greater action, dialogue, research and advocacy on this important public health and human rights issue.

Background

Ensuring universal access to safe, acceptable, good quality sexual and reproductive health care, particularly contraceptive access and maternal health care, can dramatically reduce global rates of maternal morbidity and mortality. Over recent decades, facility delivery rates have improved as women are increasingly incentivized to utilize facilities for childbirth, through demand generation, community mobilization, education, financial incentives or policy measures.

However, a growing body of research on women's experiences during pregnancy, and particularly childbirth, paints a disturbing picture. Many women across the globe experience disrespectful, abusive or neglectful treatment during childbirth in facilities. (*1-3*) This constitutes a violation of trust between women and their health-care providers and can also be a powerful disincentive for women to seek and use maternal health care services. (*4*) While disrespectful and abusive treatment of women may occur throughout pregnancy, childbirth and the postpartum period, women are particularly vulnerable during childbirth. Such practices may have direct adverse consequences for both the mother and infant.

Reports of disrespectful and abusive treatment during childbirth in facilities have included outright physical abuse, profound humiliation and verbal abuse, coercive or unconsented medical procedures (including sterilization), lack of confidentiality, failure to get fully informed consent, refusal to give pain medication, gross violations of privacy, refusal of admission to health facilities, neglecting women during childbirth to suffer life-threatening, avoidable complications, and detention of women and their newborns in facilities after childbirth due to an inability to pay.(*5*) Among others, adolescents, unmarried women, women of low socio-economic status, women from ethnic minorities, migrant women and women living with HIV are particularly likely to experience disrespectful and abusive treatment.(*5*)

Every woman has the right to the highest attainable standard of health, which includes the right to dignified, respectful health care throughout pregnancy and childbirth, as well as the right to be free from violence and discrimination. Abuse, neglect or disrespect during childbirth can amount to a violation of a woman's fundamental human rights, as described in internationally adopted human rights standards and principles.(*6-9*) In particular, pregnant women have a

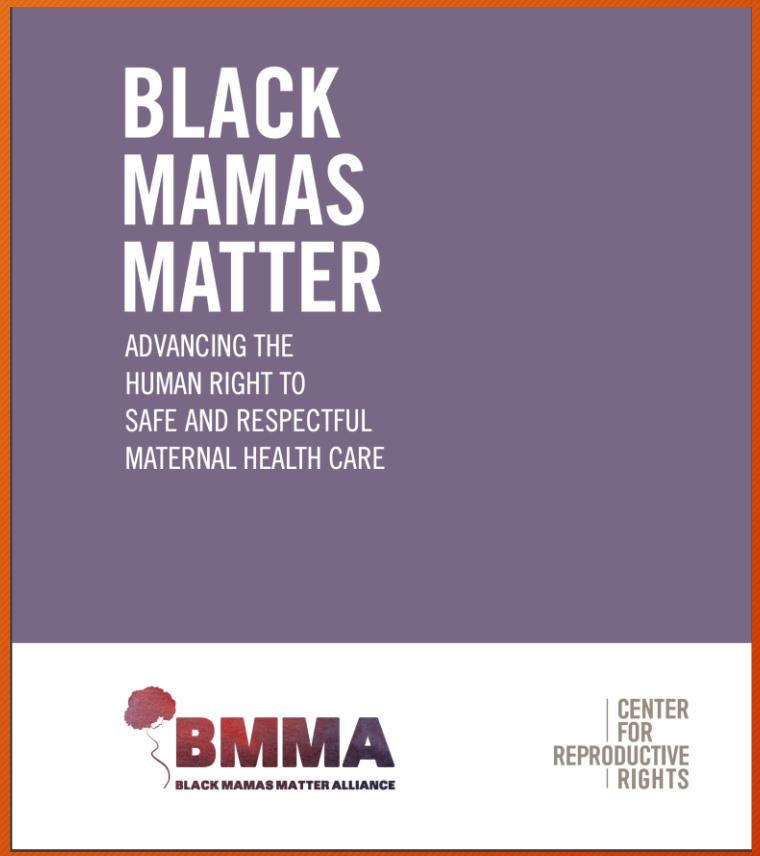
Implement ACOG Team-Based Care (2016)

What Collaboration Should Look Like

Break Down the Silos'

https://www.acog.org/Clinical-Guidance-and-Publications/Task-Force-and-Work-Group-Reports/Collaboration-in-Practice-Implementing-Team-Based-Care

Read and Use: Black Mommas Matter Toolkit



https://blackmamasmatter.org/

Essential Elements of the Right to Health

Availability: Health care facilities, goods, services, and programs must be available in sufficient quantity in all areas, urban and rural. This includes, for example, a sufficient number of health clinics, trained medical personnel receiving domestically competitive salaries, and adequate stocking of medicines in health facilities.

Accessibility: Health facilities, goods, and services have to be accessible to everyone without discrimination. Accessibility has four overlapping dimensions:

1. **Non-discrimination** – health facilities, goods, and services must be accessible—both in law and in fact—to everyone regardless of race, sex, gender, sexual orientation, nationality, disability or other status.

2. **Physical accessibility** – health facilities, goods, and services must be within safe physical reach for all sections of the population, and especially for vulnerable or marginalized groups such as women and ethnic minorities, residents of rural areas, and people with disabilities.

3. **Economic accessibility** – whether publicly or privately provided, health facilities, goods, and services must be affordable for all, and payment for health care services should be based on the principle of equity.

4. **Information accessibility** – information and ideas concerning health issues should be made accessible to everyone, without discrimination, and provided in an accessible format.

Acceptability: Health facilities, goods, and services must respect medical ethics, respect the culture of individuals and their communities, and be sensitive to gender and life-cycle requirements.

Quality: Health facilities, goods, and services must be scientifically and medically appropriate and of good quality.[22]

Read & Implement Black Birthing Bill of Rights

- https://thenaabb.org/black-birthing-bill-of-rights/

hospitals, health providers, government health agencies and others to change/improve their ethic, policies, and delivery approach to serving Black women and persons throughout the birthing process.

I have the right to be listened to and heard.

I have the right to have my humanity recognized and acknowledged.

I have the right to be respected and to receive respectful care.

I have the right to be believed and acknowledged that my experiences are valid.

I have the right to be informed of all available options for pain relief.

I have the right to choose how I want to nourish my child and to have my choice be supported.

I have the right to early postpartum visits and individualized postpartum care.

I have the right to restorative justice and mediation to address obstetric violence, neglect, or other injustices.

I have the right to choose the family and friends that are present during my pregnancy, birth and postpartum care.

I have the right to receive accurate information that will allow me to give informed consent or refusal.

Integrate Role of Midwives and Doulas

Role Confusion

Misunderstood

Disrespected

Fragmented Care

https://www.wnpr.org/post/women-america-are-dying-childbirth-are-midwives-and-doulas-answer

Women In America Are Dying From Childbirth. Are Midwives And Doulas The Answer?

By BETSY KAPLAN • JUL 31, 2019

PROGRAM
The Colin McEnroe Show

Share Tweet Email

GOAL: EVERY health care interaction is "Person-Centered"

"Tell me everything important to know about you in order to facilitate the best possible care while you are here."

"What has changed in how you feel or want to share since we last talked?"

"How can I help make this experience as positive as possible while you are with our health care team?"

Partner with Consumers (RWJ/Cleveland Clinics Project)

Engaging with Maternal Near Miss Advocates

https://www.facebook.com/POP.PowerofPartnership/videos/324358014960730/

Evaluate Facility Design

DOI: 10.1097/JPN.0000000000000376

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Facility Design

Reimagining Approaches to Childbirth in Hospital and Birth Center Settings

Ginger Breedlove, PhD, CNM, FACNM, FAAN; Lesley Rathbun, MSN, FNP, CNM, FACNM

ABSTRACT

Few maternity care clinicians are aware of the current regulations that guide design standards for childbirth facilities in the United States or the regulatory history. There is considerable variance among state regulations as well as oversight of facility standards for healthcare settings. Understanding evidence-based recommendations on how facility design affects health outcomes is critical to reversing the rise in maternal mortality and morbidity. A variety of measures can be implemented that promise to improve user satisfaction, quality of care, and efficiency for all who engage in the childbirth environment. Recommendations for change include broader assessment to better understand how clinicians and consumers simultaneously maneuver within a complex system. Key metrics include evaluation of workflow within available space, patient acuity and census patterns, integration of evidence-based recommendations, and options that promote physiologic birth. For the changes to succeed, human centered design must be implemented and diverse clinicians and consumers engaged in all phases of planning and implementation. Exploring characteristics and outcomes of low-risk women who receive care in a freestanding birth center or the European alongside maternity unit provides opportunity to reimagine and address improvements for inpatient, hospital birth.

Author Affiliation: Grow Midwives, LLC, Shawnee, Kansas.

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Each author has indicated that he or she has met the journal's requirements for Authorship.

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Submitted for publication: July 28, 2018; accepted for publication: September 30, 2018.

Key Words: alongside birth unit, birth center, childbirth setting, design influence on childbirth, evidence-based design of childbirth setting, facility design

In the United States (US), the healthcare setting (HCS) is constructed by balancing architectural recommendations with federal standards, state regulations, city codes, and operating budget. Design considerations include structural and environmental safety, infection control, staff function and efficiency, organizational philosophy, operational workflow of the unit, and federal requirements for individuals with physical accessibility needs.[1–3] Equally important is an environment that provides spiritual comfort, hospitality-based service, and homelike privacy for patients. For childbirth settings, physical surroundings can affect the performance of staff as well as the mother's perception of how easy or difficult it is to give birth.[4–6]

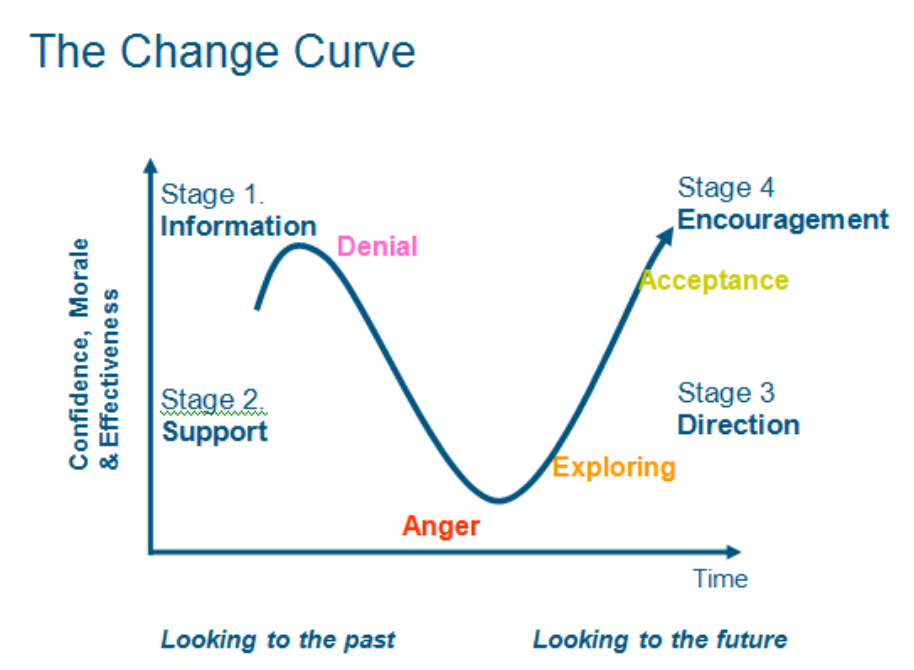
The Centers for Disease Control and Prevention final data for 2016 indicate that 98% of all births occurred in-hospital with a physician in attendance.[7] Safe care requires that trained staff are ready to manage inductions, spontaneous labor admissions, peak admission times, variance in patient acuity level, emergency cases, and obstetric triage. Safe and satisfying care includes staff who promote physiologic birth for women who desire low intervention offering an array of options, care not universally provided in all obstetric units. To reimagine childbirth settings for the majority, those who are at low risk, clinicians must increase knowledge about how facility design influences maternity outcomes and embrace approaches that promote a human-centered experience. For this to happen, clinicians and consumers must be engaged in all phases of design planning and implementation. The primary aim of this review is to increase awareness of US guidelines and standards that

Does Your Setting PROMOTE or IMPEDE Optimal Outcomes?

Selected as best manuscript of the year for 2018/19

(Journal of Perinatal and Neonatal Nursing, Vol 33, Number 1, 26-34)

Beyond AIM: Navigating the "Change Curve"



- Institute for Health Improvement tools
- Partnership with Patients model
- Black Mammas Matter Toolkit
- Consumers Serving on Committee's
- Implement Anti-Racism Training alongside structural changes
- Make CHANGE a Quality Initiative

Practice Collaboration, *It's a Skill not a Value*

1. Teach people to listen- not talk
2. Train people to practice empathy
3. Learn to be comfortable with Feedback
4. Model how to Lead AND Follow
5. Speak with Clarity and Avoid Abstractions
6. Seek 'Win-Win' Interactions

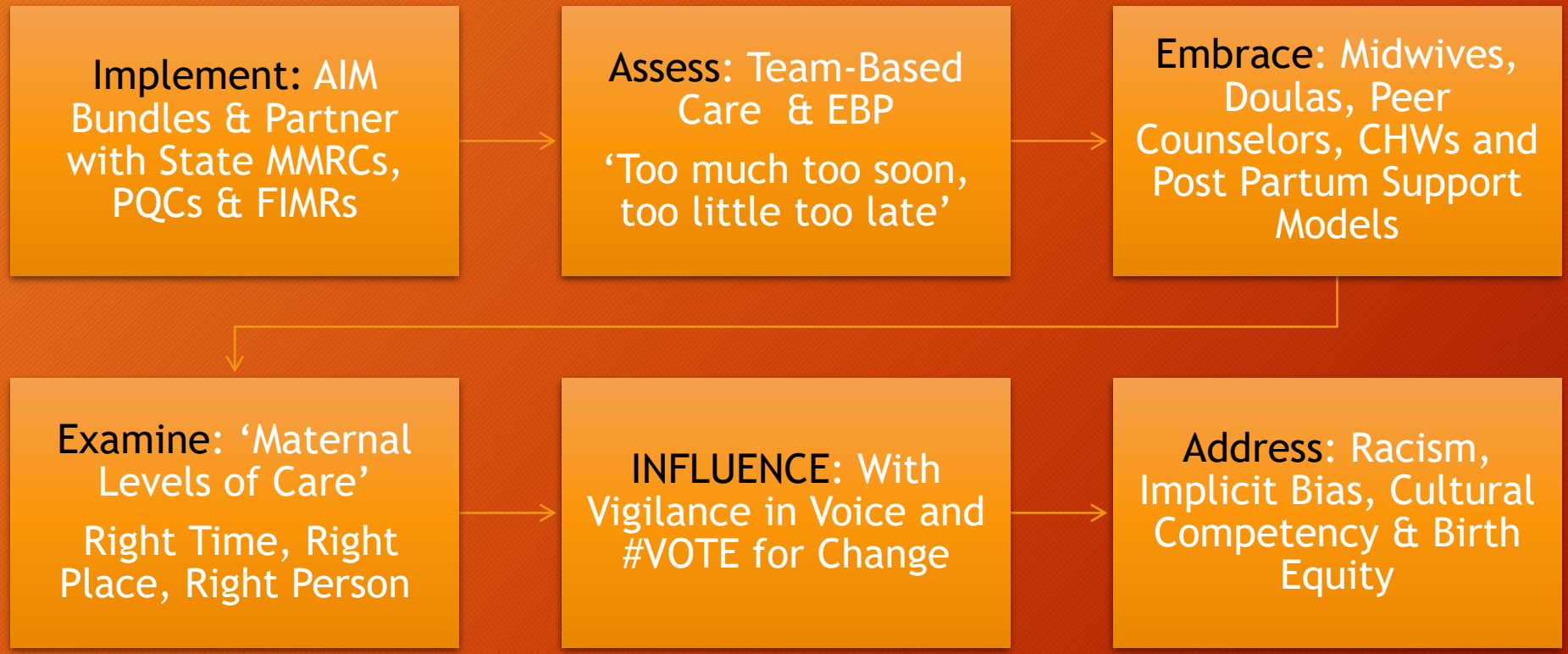
https://hbr.org/2019/11/cracking-the-code-of-sustained-collaboration

March for Moms Advocating TWO FEDERAL BILLS

H.R. 5977 – MOMMAs ACT

H.R. 6142 Black Maternal Health Momnibus ACT

- **Community-based funding for organizations** to improve outcomes for Black women.
- Investment in social determinants of health programs.
- Understanding maternal health risks facing **women veterans.**
- Grow and diversify **perinatal workforce.**
- Improve **data collection processes and quality measures.**
- Invest in **maternal mental health care** and substance use disorder treatments.
- Improve maternal health care and support for **incarcerated women**.
- Invest in telehealth in underserved areas.
- Promote **innovative payment models** and **continuity of health insurance coverage** up to 1 year postpartum.



ACTIONS LEADING TO CHANGE

What will YOU do?

Beyond the AIM Bundles to bring CHANGE

- Advocacy is more than discussing policy - It includes **action** on who you are advocating for.
- Collaborative care reflects evidence-based policies that must **be patient-centric**.
- **Acknowledge role of racism** and implicit bias and implement steps to eliminate.
- **DEMAND policy changes** at local, state, and national levels.

MARCH *for* MOMS

Follow Us

www.marchformoms.org

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Questions

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