2019 Annual Meeting & Conference

OCTOBER 28-29, 2019

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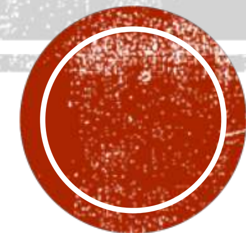
Healthy Mothers, Healthy Babies. In That Order.

Centering Mother's Voices in Maternal Care.

AMCHP
ASSOCIATION OF MATERNAL & CHILD HEALTH PROGRAMS

PUTTING MOM FIRST - *PRIORITIZING MATERNAL CARE IN MATERNAL & CHILD HEALTH*



Jonathan Webb, MPH, MBA

Chief Executive Officer

Association for Maternal and Child Health Programs (AMCHP)

October 29, 2019

AMCHP MISSION AND VISION

AMCHP leads and supports programs nationally to protect and promote the optimal health of women, children, youth families,
and communities.

AMCHP envisions a nation that values and invests in the health and wellbeing of all women, children, youth, families, and communities so that they may thrive.

OBJECTIVES FOR TODAY:

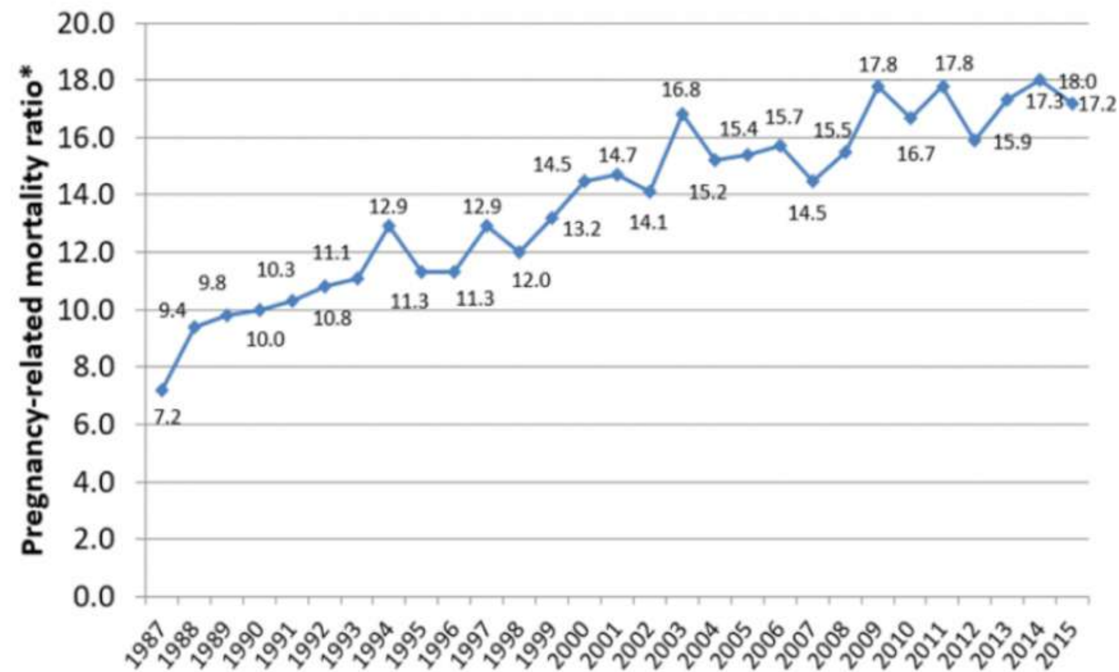
- PROVIDE INSIGHT ON HOW WE (AND OUR PARTNERS) ARE CENTERING WOMEN
  - BE URGENT, INTENTIONAL, AND PARTNER STRATEGICALLY
  - ACCELERATE. UPSTREAM. TOGETHER.
- TAKE A LOOK AT WHAT AMCHP IS DOING TO CENTER MOMS
  - POLICY
  - PLAN
  - PROGRAMS
- ENCOURAGE COLLABORATION WITH COMMUNITY – COMMUNITY VALUE AND THE CHANGING POWER DYNAMIC

“Casserian Engeri”

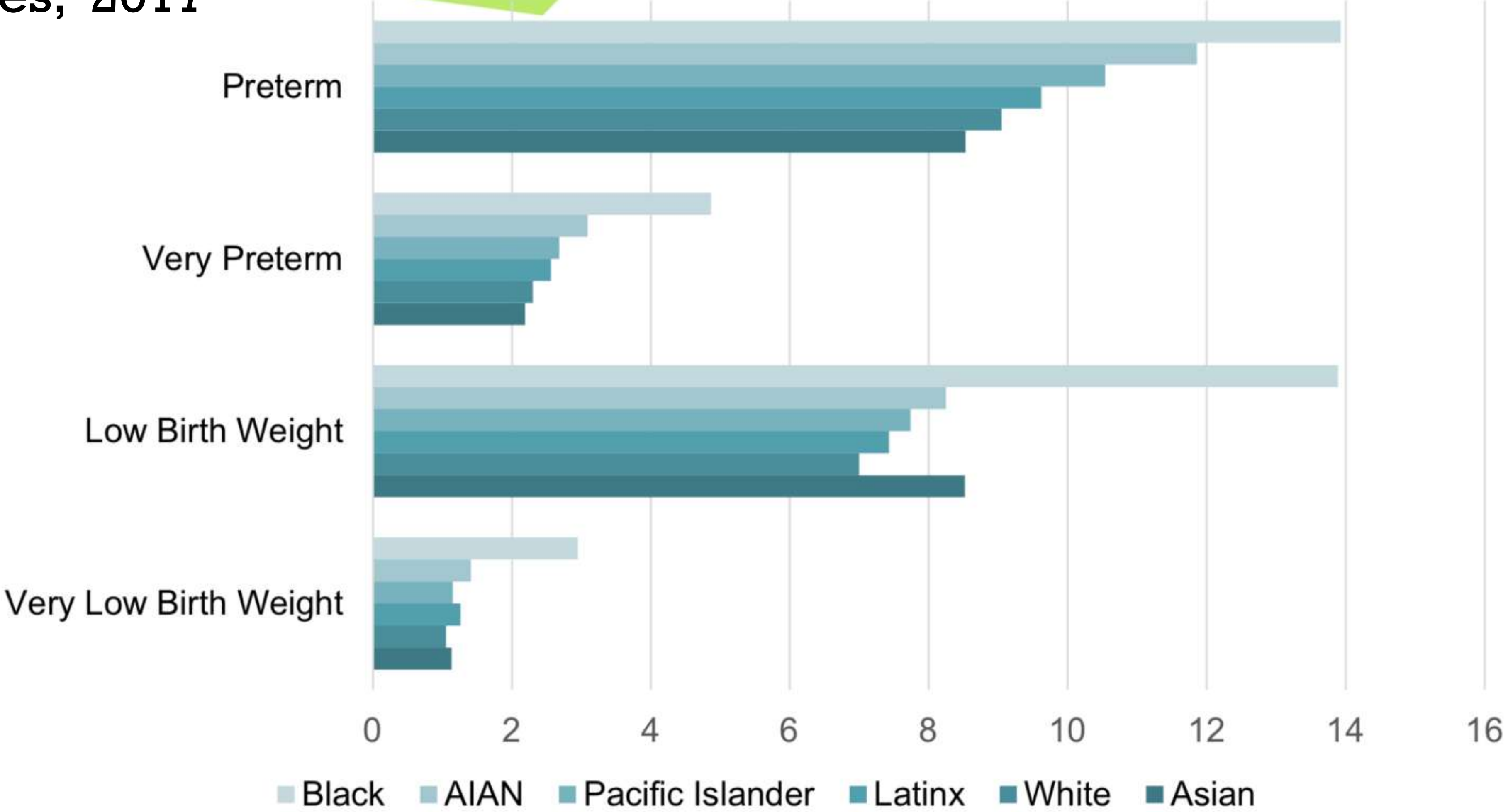
AND HOW ARE THE CHILDREN?

…ALL THE CHILDREN ARE WELL!

Trends in pregnancy-related mortality in the United States: 1987-2015

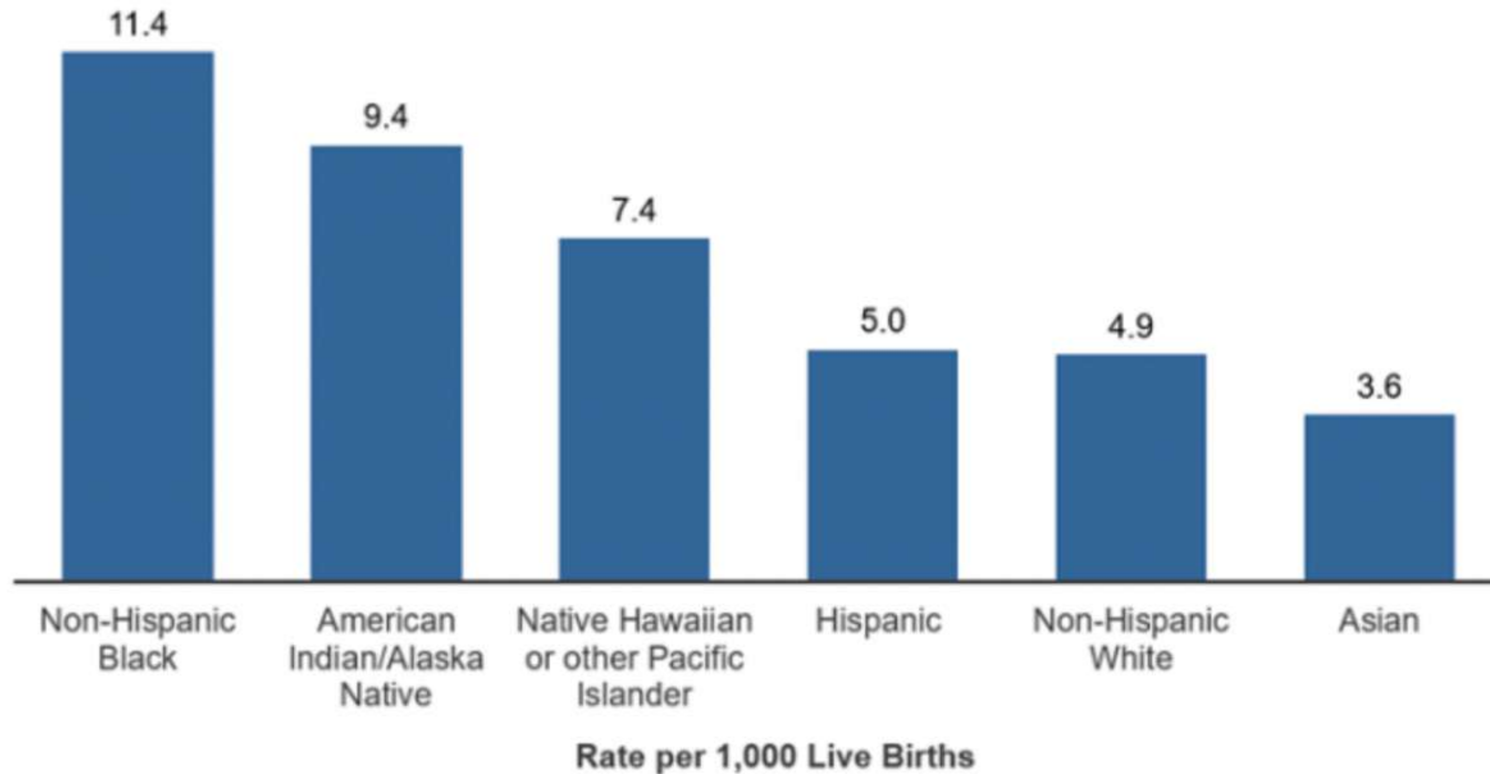


Birth Outcomes, By Race, United States, 2017



Source: NCHS, National Vital Statistics System, Natality. AIAN: American Indian/Alaskan Native, PTB: Born prior to 37 weeks completed gestation, VPTB: Born prior to 34 weeks completed gestation, LBW: < 2,500 grams or 5 lb 8oz, VLBW: < 1,500 grams or 3 lb 4 oz.

Infant Mortality Rates by Race and Ethnicity, 2016



Source: CDC, Reproductive Health

THE CALL TO ACTION…FOR STATES

AMCHP

- Urgent
- Intentional
- Partner Strategically

Maternal and Child Health Bureau

- Accelerate
- Upstream
- Together

URGENT

- Lost or damaged lives
- Broken families
- Impacted communities
- A cycle of pain
- Can't wait…

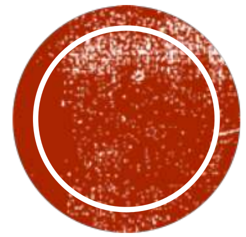
NOT JUST A STATISTIC

AMCHP

BE INTENTIONAL

PLACE MOMS AT THE CENTER

- Addressing this on 3 levels:
  - Policy
  - Plan
  - Program



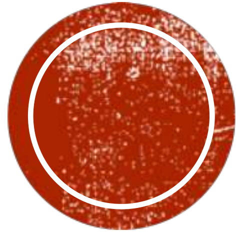
POLICY

POLICY AND FUNDING

- $26 million to Title V MCH Block Grant, which included:
  - $3 million to support the Alliance for Innovation on Maternal Health program (known as AIM)
  - $23 million for new maternal health innovation grants, which have been awarded through nine cooperative agreements to assist states in addressing disparities in maternal health and improving maternal health outcomes, with an emphasis on preventing and reducing maternal mortality and SMM.
- $12 million in Healthy Start funding
- Additional $12 million at CDC for Safe Motherhood, which has been awarded under the new Enhancing Reviews and Surveillance to Eliminate Maternal Mortality (ERASE MM) Program to states for supporting their maternal mortality review committees
- We are currently awaiting final negotiations on FY20 appropriations, but were thrilled to see that the House passed version of the Labor, Health and Human Services appropriations bill proposed a $34 million increase to Title V, again recognizing the importance of increasing support to maternal and child health programs
- Seen the creation of the Black Maternal Health Caucus led by Reps. Underwood and Adams

MATERNAL AND CHILD HEALTH BUREAU
FY 2019 TOTAL BUDGET: $1.33 BILLION

Maternal and Child Health Bureau Programs	FY2019 Enacted	+/- from FY18 Enacted
Maternal and Child Health Block Grant	$677.7	+$26.0
Maternal, Infant and Early Childhood Home Visiting	$400.0	---
Healthy Start	$122.5	+$12.0
Autism and Other Developmental Disabilities	$50.6	+1.5
Emergency Medical Services for Children	$22.3	---
Universal Newborn Hearing Screening	$17.8	---
Heritable Disorders	$16.4	+$0.5
Pediatric Mental Health Care Access	$10.0	---
Family-to-Family Health Information Centers	$6.0	---
Screening and Treatment for Maternal Depression	$5.0	---
Sickle Cell service Demonstration Program	$4.5	---



PLAN

OUR CHALLENGES

LACK OF EVIDENCE

56%
of persons working in maternal and child health-related program areas (including WIC) indicated awareness of evidence-based public health practice.

CARE FOR CYSHCN

84%
of children with special health care needs do not receive care in a well-functioning system.

SHRINKING WORKFORCE

54%
of people plan to leave the state public health workforce in five years.

CHASING ZERO

0 Drive down maternal and infant deaths

2002

INSUFFICIENT INVESTMENT

Our nation's most emergent public health issues are particularly impacting MCH populations, yet federal funding for some core MCH public health programs remains lower than it was 20 years ago.

STRATEGIC PLAN 2019-21

A Bridge for Action

AMCHP leads and supports programs nationally to protect and promote the optimal health of women, children, youth, families, and communities. AMCHP envisions a nation that values and invests in the health and wellbeing of all women, children, youth, families, and communities so that they may thrive.

1825 K Street NW | Suite 250 | Washington, DC 20006
Phone: (202) 775-0436 | Fax: (202) 478-5120

MOBILIZE
MCH ECOSYSTEM

EVIDENCE

Build Capacity Through Training and Technical Assistance to Achieve Optimal Health Outcomes.

AMCHP increases the capacity of states and territories to optimize the use of evidence to shape and champion equitable health policies and programs.

- Encourage the creation of social and physical environments that promote good health for all
- Provide training and technical assistance to MCH workers in states and territories in obtaining, interpreting, and utilizing quality, timely data
- Increase awareness of and ability to use community-driven strategies proven to work
- Promote a continuum of integrated, coordinated services that improve health outcomes for women and their families, as well as children and youth with special health care needs

WORKFORCE

Attract and Retain Highly Competent People in the MCH Public Health Workforce.

AMCHP fosters the development of a skilled, flexible, and diverse workforce that serves the MCH population.

- Advance leadership competency across the MCH workforce
- Integrate the experience and skills of families and youth and build their capacity as leaders in the MCH workforce
- Provide opportunities for professional growth and skill-building, enhancing workforce readiness and capabilities
- Cultivate program leadership and a workforce that is diverse, culturally competent, and mirrors the diversity of the communities that MCH serves

INVESTMENT

Increase Visibility of MCH Issues and Advocate for Policies that Support the Health of Women and Children.

AMCHP promotes investment in MCH programs.

- Develop effective messages to convey the MCH story and the value of MCH investments
- Build and sustain a well-informed network of MCH advocates
- Cultivate MCH champions among federal policymakers
- Raise the visibility of the MCH field

IMPACT

Support Innovation and Strategic Partnership.

AMCHP partners and aligns resources with traditional and nontraditional stakeholders to maximize our combined impact on maternal and child health.

- Identify and promote innovations that strategically leverage resources across programs
- Lead national and state stakeholders in developing innovative and effective programs and policies that address critical issues affecting the MCH population
- Build capacity of the MCH field to respond rapidly to emerging public health threats and other crises that endanger the health of women, children, youth, families, and communities

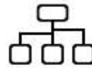
MAKE
A MAJOR IMPACT

Chasing Zero: Drive Down Maternal and Infant Deaths

- Support maternal mortality reviews and fetal and infant mortality reviews and equip members to act
- Identify what's working in women's and infant health and scale up effective practices
- Promote women-centered, community-driven, respectful, and equitable care
- Support and defend programs and policies that reinforce the mother-baby dyad and empower families and communities to thrive

Optimize Health for Children and Youth with Special Health Care Needs (CYSHCN)

- Support comprehensive, coordinated systems of care that enable all children and youth to live their best life
- Create opportunities for families to be engaged in improving systems
- Support the implementation of National Standards for Systems of Care for CYSHCN



Support and Model Youth and Family-Engaged Work

Youth

- Implement the Positive Youth Development framework in AMCHP's related programming, organizational functions, and Board operations
- Prepare and train the MCH workforce to connect with youth and build youth leadership

Family

- Lead MCH with proactive and innovative policies, programming, and training
- Convene subject matter experts and thought leaders
- Develop and disseminate leading practices, tools, resources, and data to support family engagement

Reduce the Burden of Substance Abuse and Unmet Mental Health Needs on Women, Children, Families, and Communities

- Develop effective, culturally appropriate prevention and treatment services for women with substance use and mental health disorders
- Convene MCH and mental health thought leaders to identify and implement sustainable solutions and address challenges/barriers in providing services

Identify and Address Critical Issues for Our Members

- Keep informed about emerging and priority issues (Listen and Learn)
- Find sustainable funding to support new areas of need (Fund and Sustain)
- Elevate issues to leadership, determine our role (Lead, Follow, Refer), and mobilize resources to meet needs and fill gaps (Plan and Act)

AMCHP Embraces the Core Values:

Leadership • Collaboration • Health Equity and Social Justice
Inclusion • Integrity • Excellence • Stewardship

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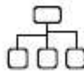

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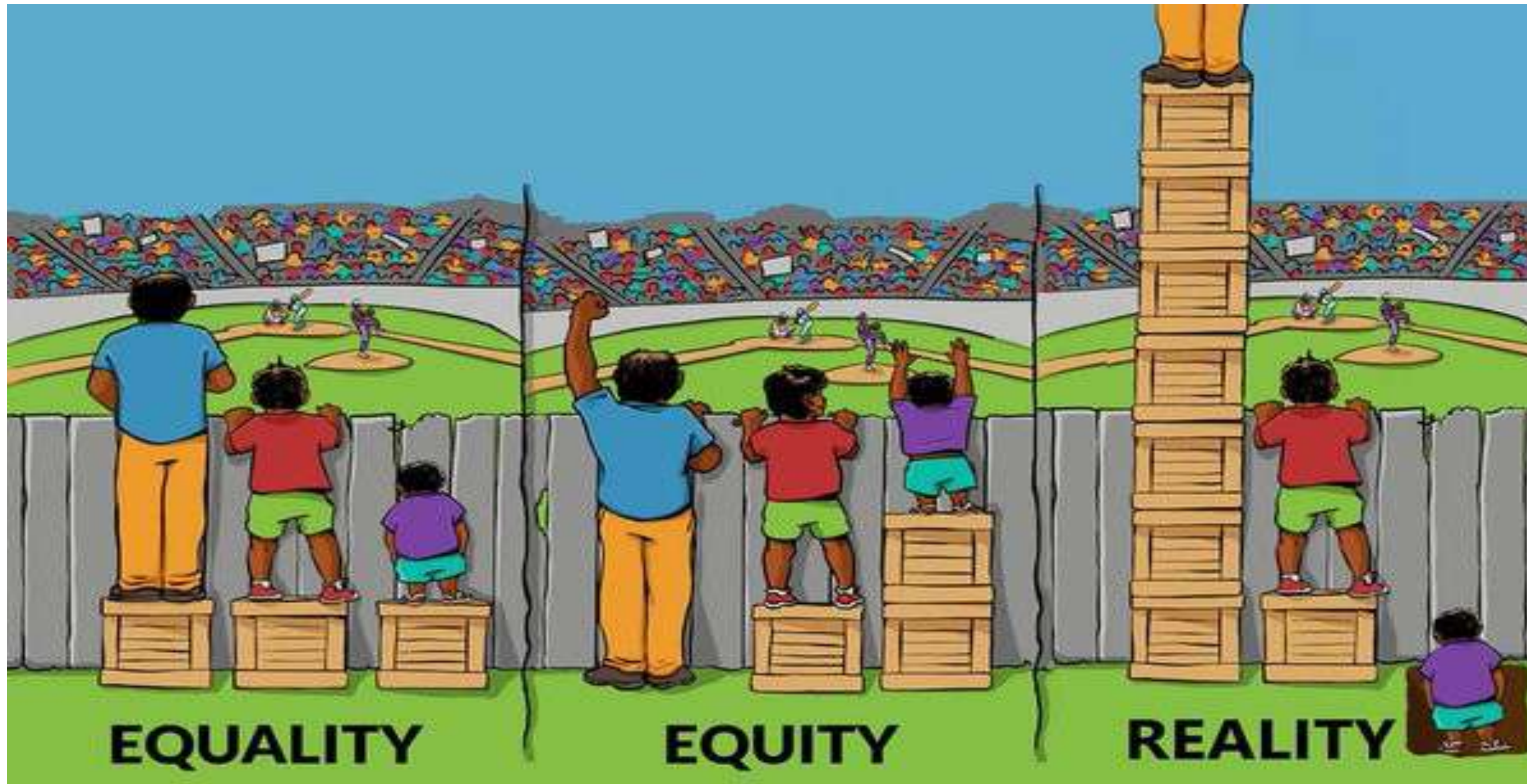
AMCHP

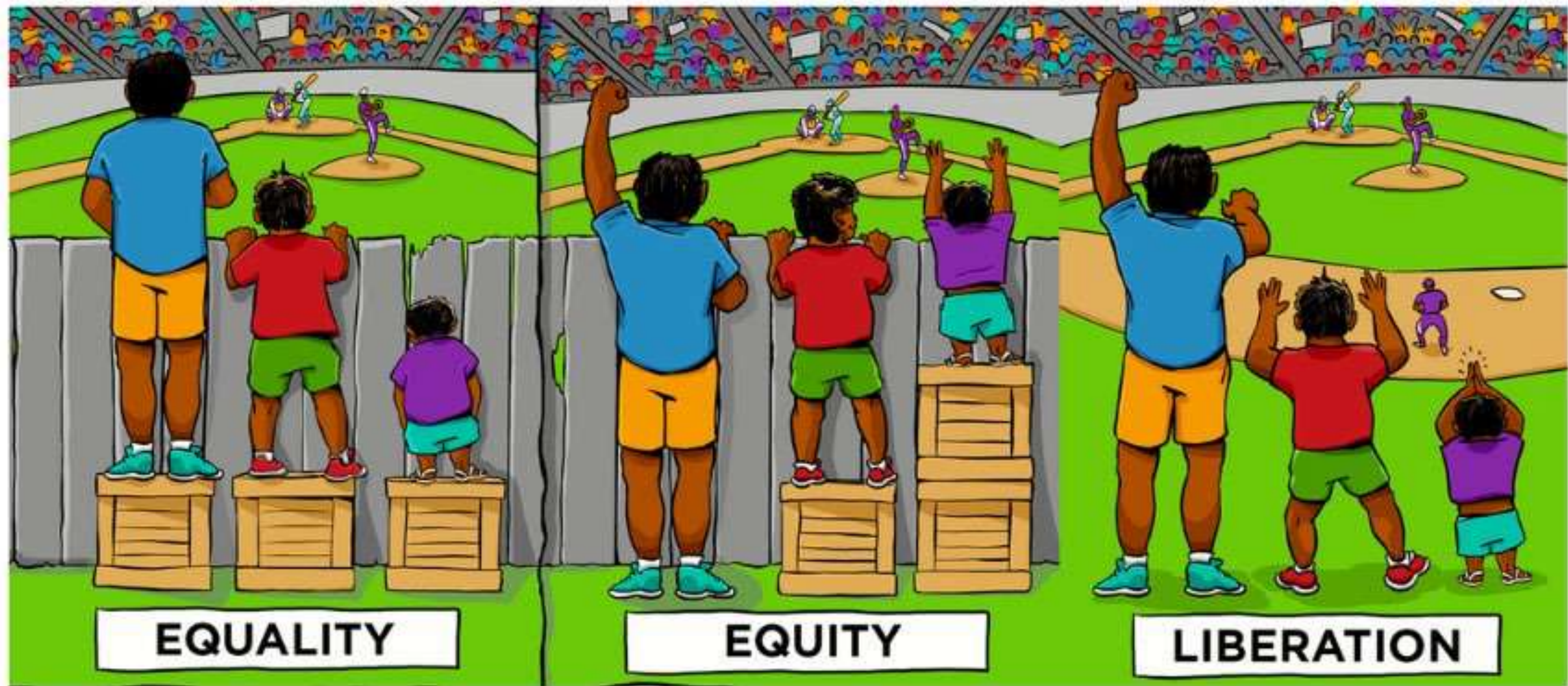
BE INTENTIONAL

- Engage the End User
- Identify the Problem/"Pain Point"
- Determine what you can realistically impact
- Set Key Milestones
- Track Progress
- Quality Improvement – what must we do differently/do better?

HEALTHY EQUITY VS. REALITY

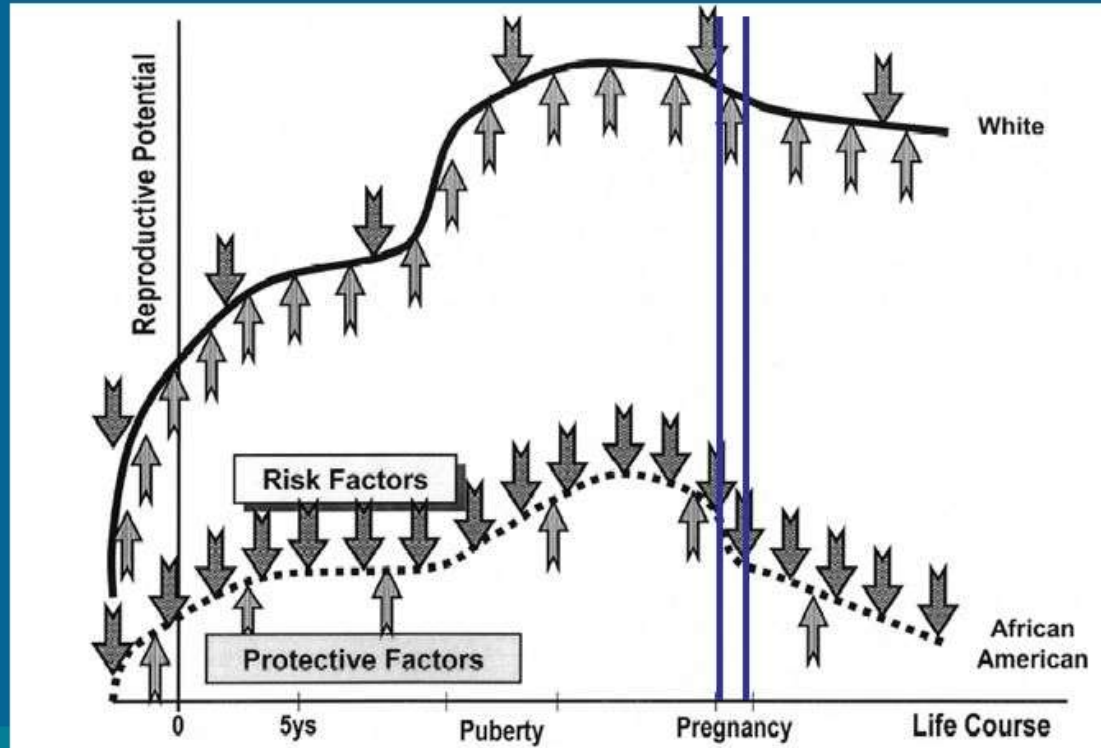


EQUITY TO LIBERATION…HOW TO GET THERE?



State Plan to Center Moms Include the Life Course Theory

Racial and Ethnic Disparities in Birth Outcomes: A Life Course Perspective



Lu MC, Halfon N. Racial and ethnic disparities in birth outcomes: a life-course perspective. Matern Child Health J. 2003;7:13-30.

SOCIAL DETERMINANTS OF HEALTH

12 POINT PLAN TO CLOSE THE BLACK-WHITE GAP IN BIRTH OUTCOMES

- Provide interconception care to women with prior adverse pregnancy outcomes
- Increase access to preconception care to Af. Am. Women
- Improve the quality of prenatal care
- Expand health care access over LC
- Strengthen fatherhood involvement in Af. Am. Families
- Enhance coordination and integration of family support services
- Create reproductive social capital in Af. Am. Communities
- Invest in community building and urban renewal
- Close the education gap
- Reduce poverty among Af. Am. families
- Support working mothers and families
- Undo racism

Source:
Lu et al. Adapted with permission of ISHIB, publisher of Ethnicity & Disease

RACISM AS A ROOT CAUSE OF INEQUITY

- "The United States intentionally structured its systems to (repeatedly) exclude certain groups of people from full participation and representation, based on their race and ethnicity. Even so-called race-neutral policies enacted in recent times (and today) have deleterious effects on communities of color because of ingrained biases and hierarchies built to favor those who are seen as white. The system is not broken—it works as it was intended. The current visible and invisible hierarchies were erected to benefit whiteness, to the detriment of those seen as "other."

Source: M. Gabriela Alcalde "Zip Codes Don't Kill People – Racism Does" Health Affairs. November 29, 2018

A GROUNDING IN STRUCTURAL RACISM…

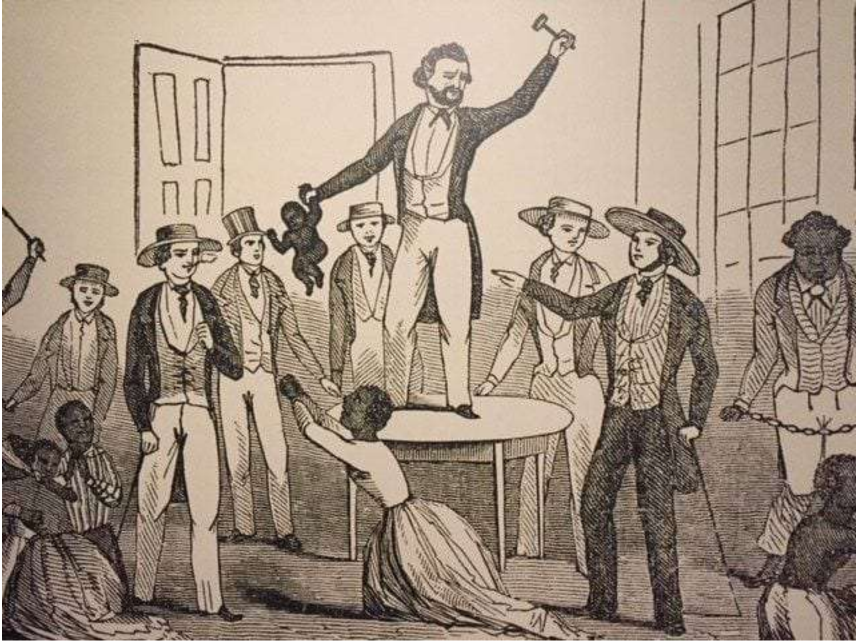
COST OF SLAVERY

- The present value of U.S. slave labor in 2009 dollars is estimated to range from $5.9 to 14.2 trillion.

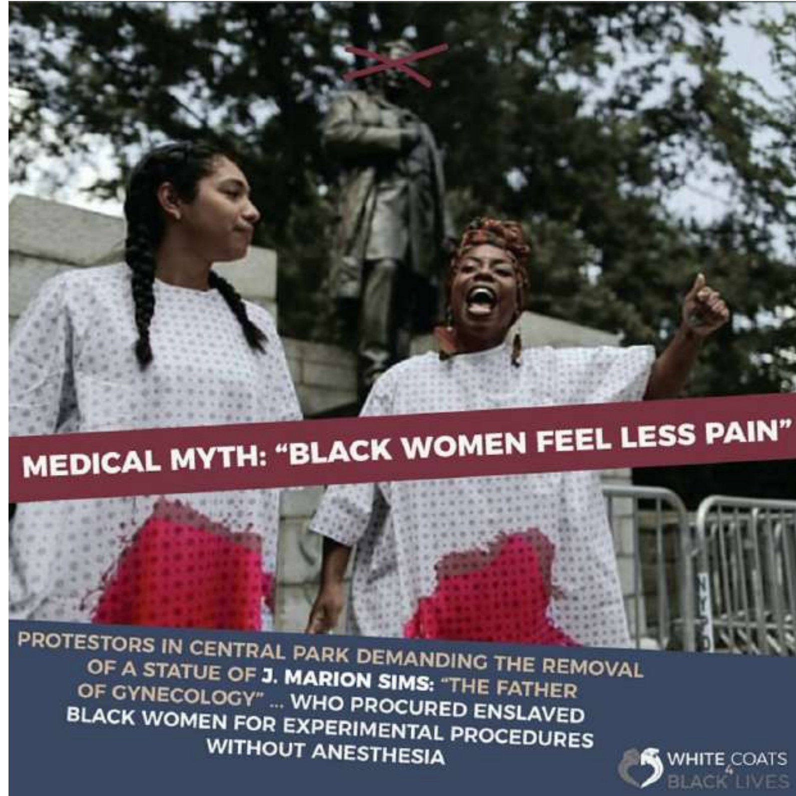
Source: T. Craemer, "Estimating Slavery Reparations: Present Value Comparisons of Historical Multigenerational Reparations Policies. Social Science Quarterly, Apr. 21, 2015

FAMILY IMPACT/LOSS OF CULTURAL IDENTITY

SOCIAL AND COMMUNITY CONTEXT



DEHUMANIZATION OF BLACK WOMEN



MEDICAL BIASES AND MISTRUST

Percentage of white medical learners endorsing beliefs about biological differences between blacks and whites

Item	General	1st year	2nd year	3rd year	Residents
Blacks age more slowly than white	23	21	28	12	14
Blacks' nerve endings are less sensitive than whites'	20	8	14	0	4
Black people's blood coagulates more quickly than whites	39	29	17	3	4
Whites have larger brains than blacks	12	2	1	0	0
Whites have a better sense of hearing than blacks	10	3	7	0	0
Blacks' skin is thicker than whites	58	40	42	22	25
Blacks have a more sensitive sense of smell than whites	20	10	18	3	7
Whites have a more efficient respiratory system than blacks	16	8	3	2	4
Black couples are significantly more fertile than white couples	17	10	15	2	7
Blacks are better at detecting movement than whites	18	14	15	5	11
Blacks have stronger immune systems than whites	14	21	15	3	4

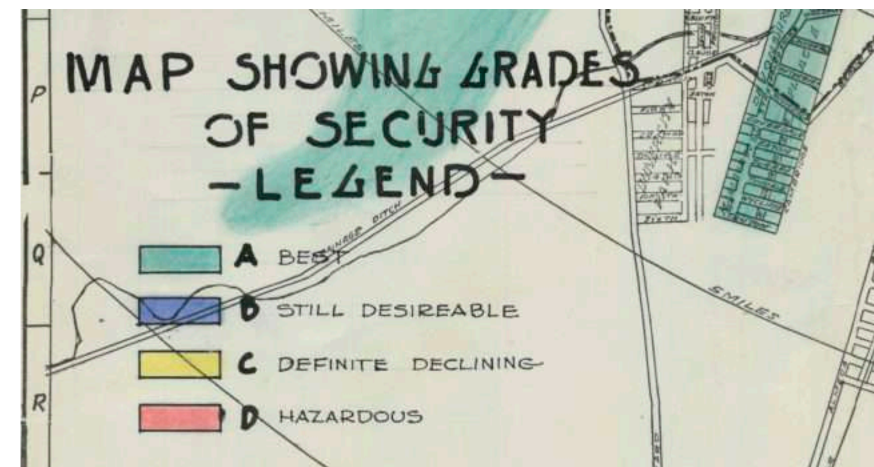
Source: Racial bias in pain assessment, Kelly M. Hoffman, Sophie Trawalter, Jordan R. Axt, M. Norman Oliver,Proceedings of the National Academy of Sciences Apr 2016, 201516047; DOI:10.1073 /pnas.1516047113

CRIMINAL JUSTICE IMPACT

- "Black Codes" – post-emancipation laws designed to force freed blacks to work again on plantations, and make up for the lost slave workforce; i.e. vagrancy laws
  - Written evidence of employment
  - Restriction on land ownership for Blacks
  - Jim Crow segregation policies
- Convict Leasing
  - Between 1884 – 1928 – state-run prisons profited from contracting with private parties from plantations to corporations to provide them with convict labor
- Lynching
  - Example crimes:
    - Gambling
    - Arguing with a white man
    - Attempting to vote
    - Flirting with a white woman
    - Quarreling

TRANSITION FROM SOUTH TO NORTH…AND REDLINING…

- 1932 – 1968
  - FHA would only insure loans in white areas
  - Black home ownership in areas would make areas uninsurable
  - Black families weren't able to get back loans
  - Black soldier couldn't take advantage of GI bill benefits after WWII
  - Generational wealth gap created as white suburban home prices appreciated and blacks were forced to live in disinvested areas
  - Impact on Housing, Education, and Access to Care



TODAY'S IMPACT

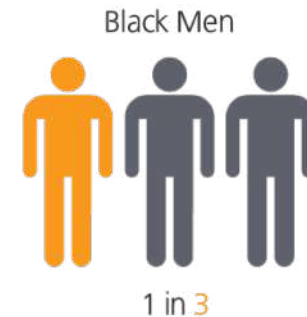
- Mass Incarceration
- Higher Education Still Has Wealth Gaps
- Earnings Gap Among Women
- African American in Hiring
- Racial Wealth Disparity

look

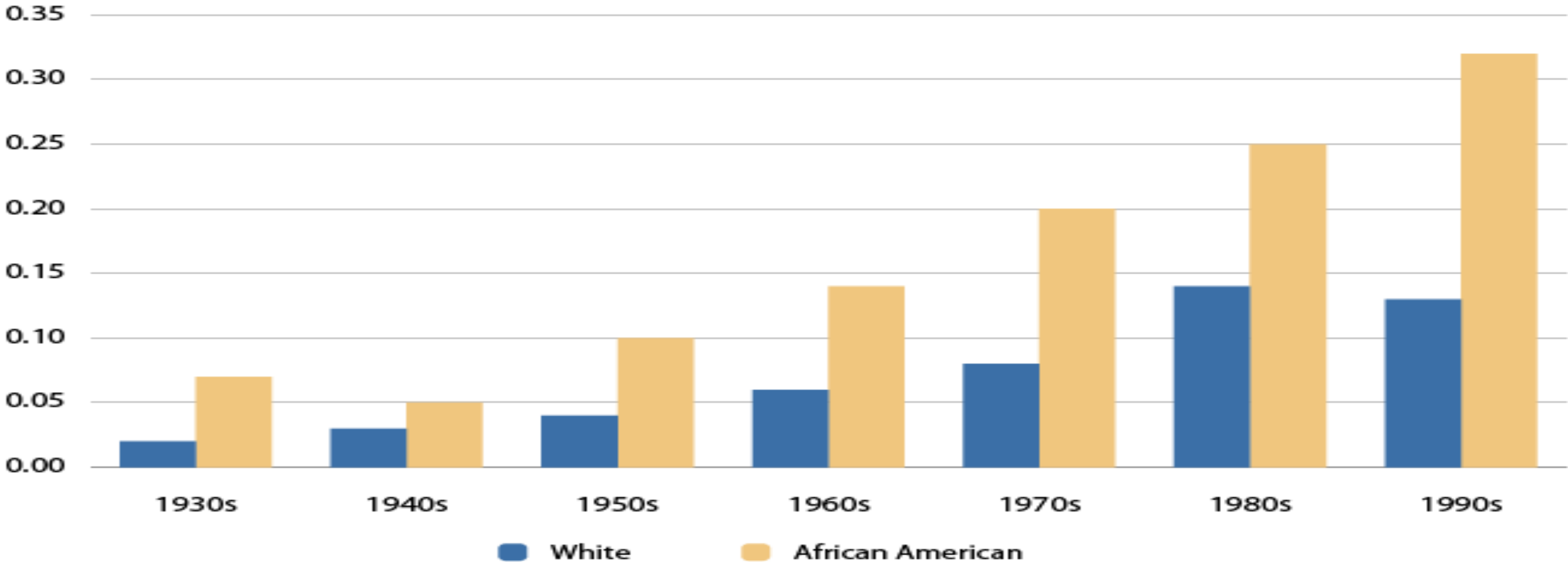
what's happening today

MASS INCARCERATION

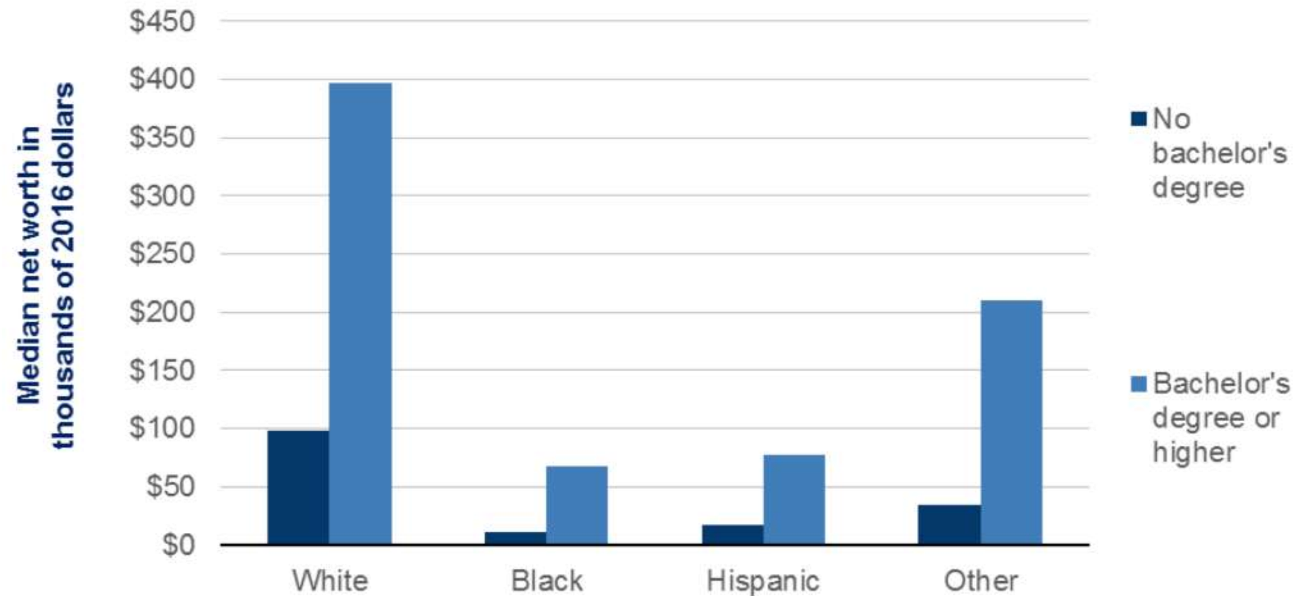
- Blacks and whites use pot at about the same rate, but blacks have been nearly four times more likely than whites to be arrested for marijuana possession
- More African Americans under correctional control (prison, jail, etc.) today than were enslaved in 1850
- Due in large part to mass incarceration of black fathers, a black child born today is less likely to be raised by both parents than a black child born during slavery. - the New Jim Crow, by Michelle Alexander



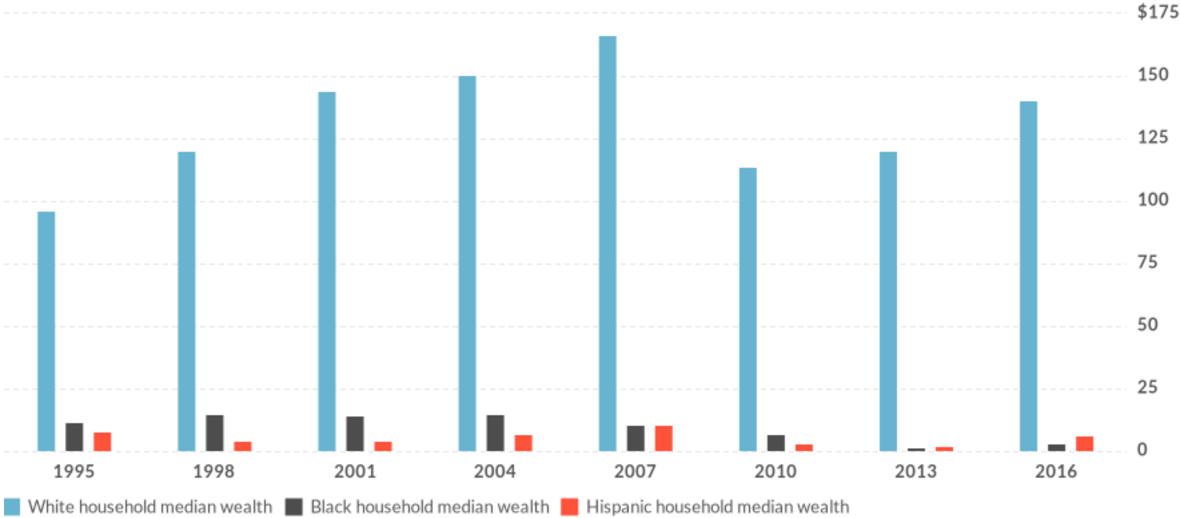
IMPACT TO FAMILIES



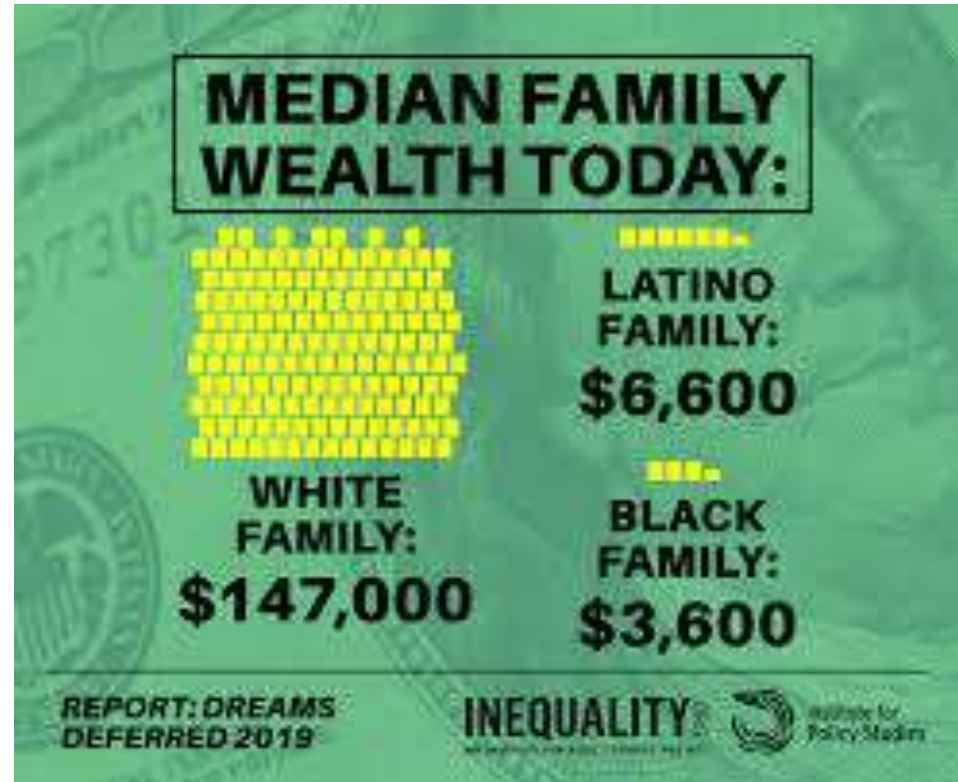
EDUCATION ISN'T THE CURE



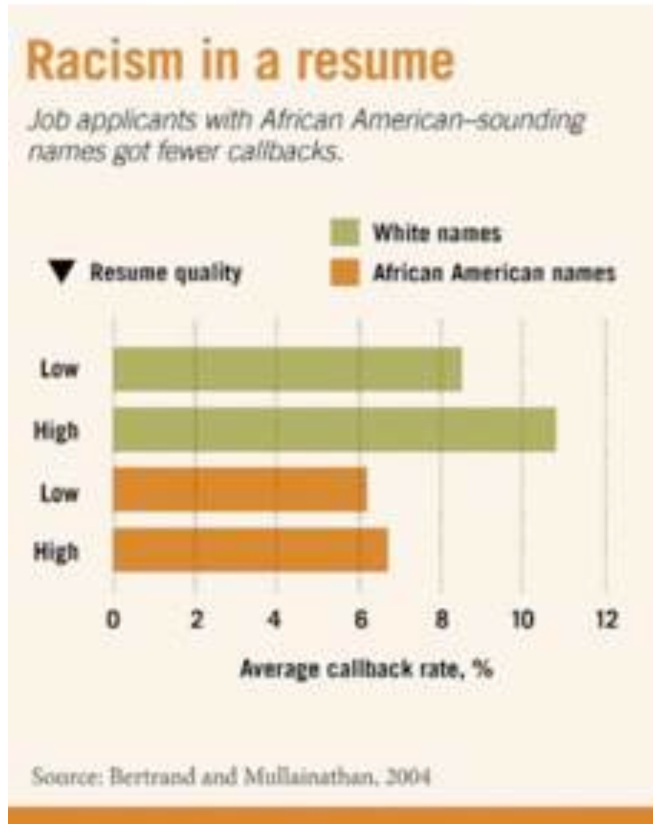
RACIAL WEALTH GAP

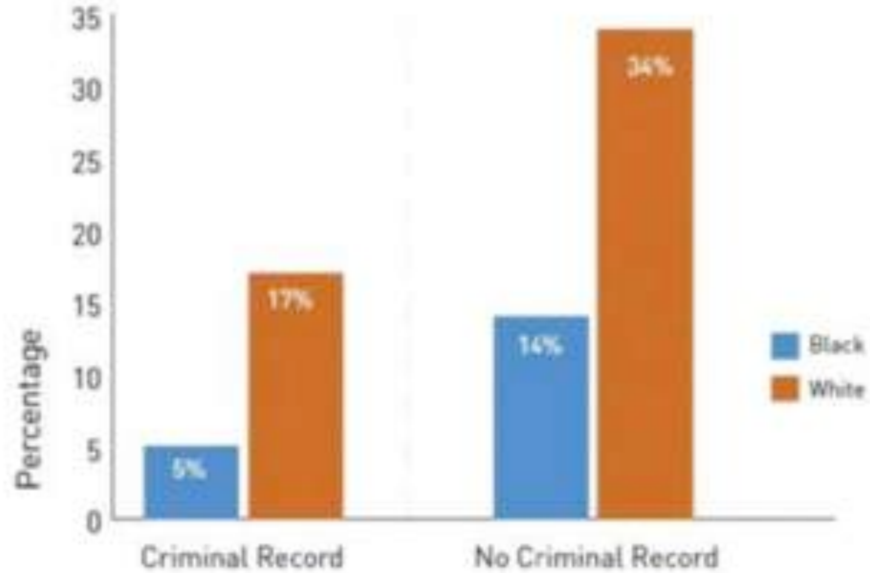


RACIAL WEALTH GAP *(CONT'D.)*



DISCRIMINATION IN HIRING





RACISM AS A ROOT CAUSE OF INEQUITY

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Source: M. Gabriela Alcalde "Zip Codes Don't Kill People – Racism Does" Health Affairs. November 29, 2018

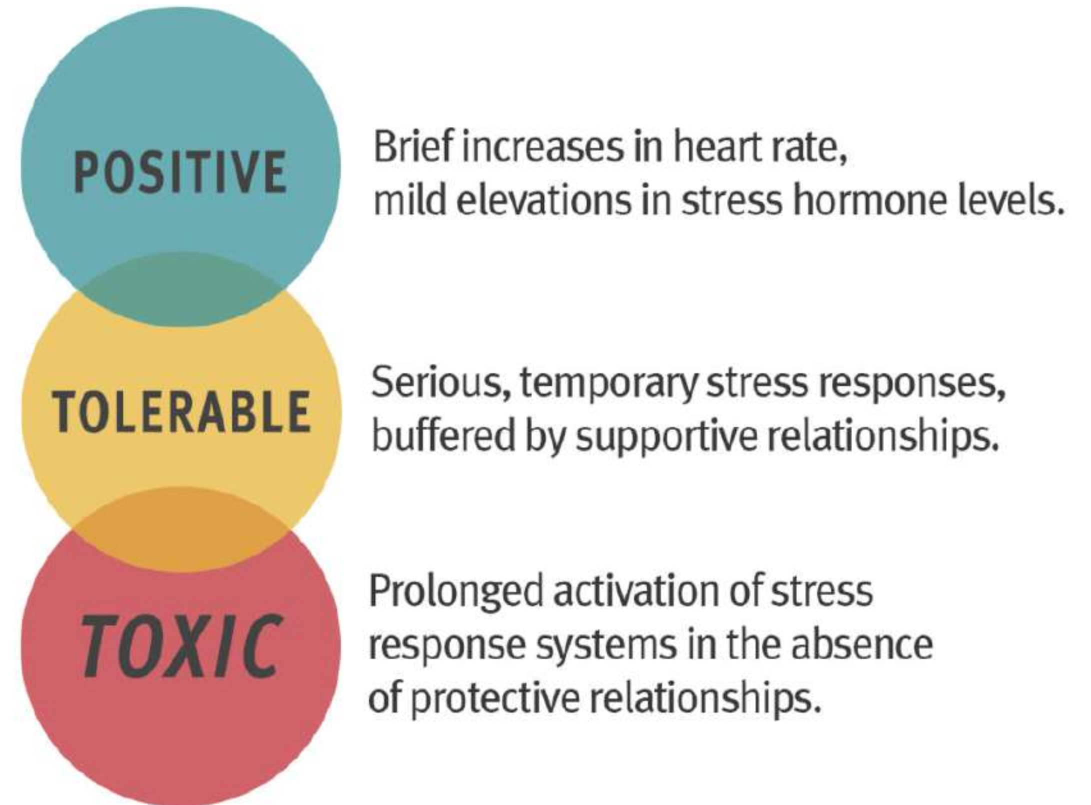
THE NATIVE AMERICAN EXPERIENCE

- Urban American Indians, like African Americans, still feel the legacy of the U.S. mistreatment of American Indian and Alaska Native (AI/AN) communities – genocide, forced migration, and cultural erasure.
- AI/AN communities have high rates of poverty, housing challenges, job discrimination, and social isolation.
- AI/AN adults are twice as likely as NH white adults to experience psychological stress; one in four Native Americans live in poverty
- Although recent attention has been placed on Afr. Am women, much more attention needs to focus on the AI/AN communities, as research shows suggests parallels to African American women's experience.

Source: Truschei, L. and Novoa, C. "American Indian and Alaska Native Maternal and Infant Mortality: Challenges and Opportunities" *Center for American Progress*; July 9, 2018

TOXIC STRESS

- Chronic stress can cause wear and tear on the body's regulatory systems, which over time can lead to decline in health and function. The impact of biological, behavioral and social risk factors build up over time, resulting in "weathering" or the gradual degradation of health.
- Maternal stress during pregnancy could program the fetal brain in a way that influences the way the infant's system regulates stress over the life course; elevating risk for ADHD, future chronic health conditions, infectious diseases and preterm birth in that infant's future offspring.



Source: Lu, M., Verbiest, S., Dominguez, T. "Life Course Theory: An Overview", *Moving Life Course Theory Into Action*, 2018; (1) 4,7
Ronald A, Pennell CE, Whitehouse AJ. Prenatal maternal stress associated with ADHD and autistic traits in early childhood. *Front Psychol.* 2010; 1:223

WHY DOES THIS HISTORY MATTER?

- It's important to understand the circumstances that those you are serving have experienced
- Re-frame the narrative; Partner vs. Project
- Solution must be targeted
- Don't want to perpetuate the same disparity unintentionally
- Build trust

WHAT CAN BE DONE?

- Must call out the problem, so the solution is appropriate
- While programs are great, we need to examine the system elements that we can address

SYSTEM CHANGE IS NEEDED…

WHAT CAN BE DONE?

- Must call out the problem, so the solution is appropriate
- While programs are great, we need to examine the system elements that we can address
- Build a roadmap to success
- Work from your strength
- Strategically Partner

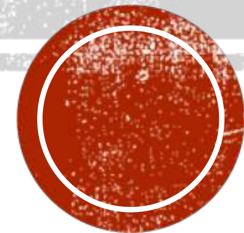
STRONGER TOGETHER

- These challenges are too big for one organization or entity
- Must look at partners outside of the box; engage the people
- Align to a long term actionable plan
- Identify and lead from your strength; Share power
- Identify milestones
- Work your plan
- Communicate and share successes/challenges

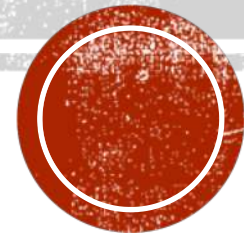
LESSONS LEARNED FROM GLOBAL MCH

- Important to build trust and gain understanding/historical context
- Community asset mindset
- Avoid being paternal; engage the community
- Follow the learning
  - Community Asset Mapping
  - Barrier Analysis

DEMONSTRATION PROJECT – PROGRAM CENTERING WOMEN'S VOICES IN MATERNITY CARE QUALITY IMPROVEMENT



“YOU CAN’T BUNDLE THIS”



PATIENT SAFETY BUNDLE

Reduction of Peripartum Racial/Ethnic Disparities

READINESS

Every health system

- Establish systems to accurately document self-identified race, ethnicity, and primary language.
  - Provide system-wide staff education and training on how to ask demographic intake questions.
  - Ensure that patients understand why race, ethnicity, and language data are being collected.
  - Ensure that race, ethnicity, and language data are accessible in the electronic medical record.
  - Evaluate non-English language proficiency (e.g. Spanish proficiency) for providers who communicate with patients in languages other than English.
  - Educate all staff (e.g., inpatient, outpatient, community-based) on interpreter services available within the healthcare system.
- Provide staff-wide education on:
  - Peripartum racial and ethnic disparities and their root causes.
  - Best practices for shared decision making.
- Engage diverse patient, family, and community advocates who can represent important community partnerships on quality and safety leadership teams.

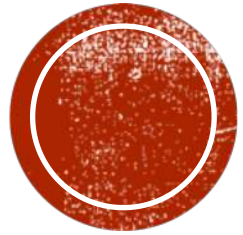
BUNDLE OPPORTUNITIES

- Tension around role of disparities bundle in relation to other bundles
- Conceptualizing action in a bundle ≠ action
  - No toolkit
  - Builds capacity to understand, but not necessarily to intervene
  - Who initiates bundle? What is the team?
- Scope of bundle
  - How might a bundle *reinforce* institutional factors contributing to disparities?
- Where are the people who birth and the community-based organizations that serve them in this process?

IDENTIFYING EQUITY LEADERSHIP

Hospitals and public health agencies often share they don't know how to find community partners. This project….

- Sought bi-directional, sustained relationships (not intermittent)
- Approach was 'agenda-less', allowing for emerging nature of the relationship
- Sought leaders that were trust-brokers among community stakeholders and understood services from the consumer perspective
- Reside and directly provide services and supports to pregnant people, especially women of color



COMING TOGETHER

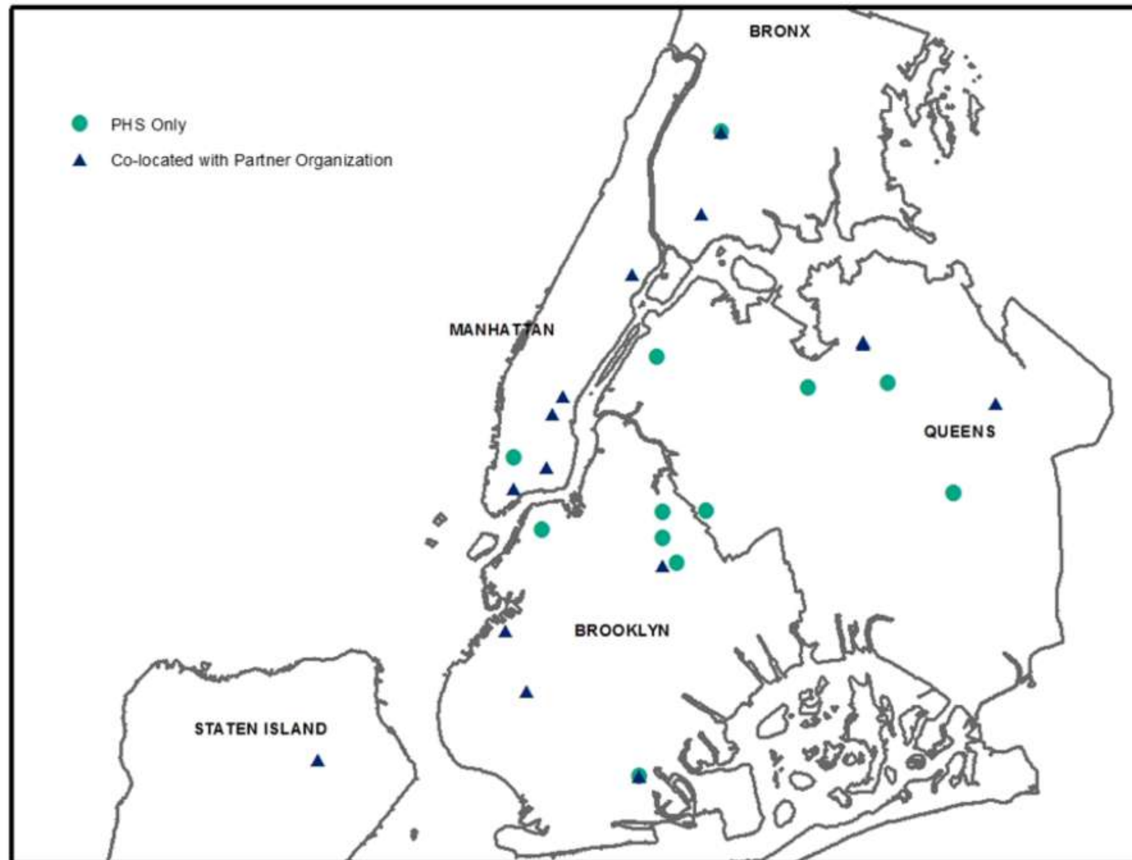
CO-PARTNERS AND LEADERS

- Specializes in full spectrum doula services for marginalized communities and communities of color
- Large volume of clients gave birth at LIJMC
- Addresses racism and implicit bias and lifts up reproductive justice
- Former consultant to NYC DHMH
- Connected to national network of individuals and organizations rooted in reproductive justice

- Long Island Jewish Medical Center (LIJMC) is situated on the border of Queens and Long Island in New York
- Part of Northwell Health – New York State's largest health care provider and private employer (11 maternity programs)
- LIJMC is the state's largest birthing facility – 9,056 births in 2018

PUBLIC HEALTH SOLUTIONS (PHS)

Our programs reach 80,000 individuals and families annually at over 25 community sites. Staff speak more than 30 languages.



QUEENS HEALTHY START (QHS)

- QHS is a collaboration between Public Health Solutions, DOHMH Nurse Family Partnership, Community Healthcare Network, and Sheltering Arms Healthy Families New York and Jamaica Hospital Medical Center
- QHS is a federally funded through U.S. Health Resources Services Administration to reduce racial and ethnic gaps, and improve perinatal health outcomes

DEMONSTRATION PROJECT GOALS

1. To identify the **resources and processes** required to implement practices that address key factors modifiable by hospitals and providers contributing to racial and ethnic disparities in maternal outcomes

2. Identify **strengths and weaknesses** of the Reduction of Peripartum Racial/Ethnic Disparities Bundle in addressing patient-/community-centered outcomes

3. Inform a **toolkit** for the implementation of the bundle across a health system, jurisdiction, or state

THE PROCESS: SETTING A STRONG FOUNDATION

- LIJMC "bought in" on January 24, 2018 through a presentation of the bundle to hospital staff; but the pieces weren't all in place yet
- The work must begin with the voices of the people who birth at LIJMC with the leadership of our project partners
- So…what's been happening the last 20 months?

Agreed on **equitable funding arrangement**; co-wrote consulting agreements

What are the racial/ethnic disparities in maternal morbidity at LIJMC? **Calculated SMM, confirmed with chart reviews**

All partner launch call in September 2018; **share SMM disparities data**

October 30, 2018: First **partner site visit** to LIJMC

Hosted planning calls designing focused conversations (set spirit and intention)

Wrote and deliberated **conversation guide**; determined **expressions of gratitude** for participants

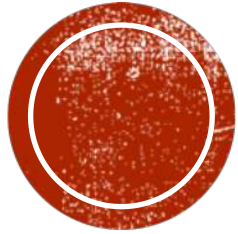
Scheduled conversations and recruited participants (delivered at LIJMC since 2016) December 2018 & March 2019

Reflect on findings to inform **systems of accountability**, prepare for toolkit development

Share Press Ganey survey results; deliberate accountability

August 19: Second **partner site visit** to LIJMC; discussion of project with administrative leaders

Key Takeaways



1. MOVING AT A SLOWER PACE IS OFTEN ANTITHETICAL TO HOSPITAL CULTURE, BUT IT WAS IMPORTANT IN TRUST BUILDING AND BRINGING INTENTION TO THE WORK.

2. NEED A WILLINGNESS TO BE A BIT VULNERABLE

THE PROCESS: THE CONVERSATIONS

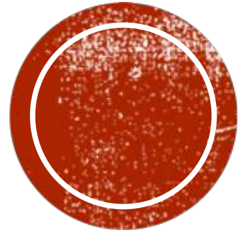
- Method needs to put consumer at the center
  - Community can guide the conversation where it needs to go
- Informal, supportive, genuine
  - Potential to (re)traumatize so environment matters
- The environment
  - Who was in the room matters

THE PROCESS: THE CONVERSATION LOGISTICS

- Recruitment
  - All those doing outreach are aware of purpose and can answer questions
  - Lean on partners in recruitment
  - Receptive to concerns (fear of backlash)
- Food (local, good, consistent with values)
- Transportation (two-way MetroCard)
- $100 gift card to express gratitude
- Childcare

COMMON THEMES FROM CONVERSATIONS

- Lack of communication
- Treatment based on insurance type
- Support can be essential, protective, and empowering
- Clinicians not obtaining consent before touching a patient and not trusting the patient as an expert on their body
- People who birth are knowledgeable on birth and maternal mortality and seek autonomy and to be seen and heard
- Participating mothers did their due diligence in vetting the hospital
  - Asked for recommendations from family and friends on which hospital was best



QUOTES FROM PARTICIPANTS

“

Now they're trying to tell me they want to give me Pitocin, yada-yada-yada. I'm like, "No, I have 24 hours." Talk about knowing your rights. I have 24 hours before I can deliver, so, no, you're not gonna rush me. That was about nine hours in. You're not gonna rush me to deliver this baby. We're still fresh. Let the body take its course. No, this is my third go around. I know my rights. I know what's going on with my body. I don't need it. You guys are just trying to rush it along so the next person could come in this bed. No, I wanna do it my way, and there's no risk at this time. ”

“They were rushing me to walk. They wanted me to use the bathroom so that they could clear the bed, as you said, so that they can do someone else, which was unfair to me because I can’t walk. You just put something in my back that numbed my whole lower half.”

A clients quote about receiving a cerclage

"

The pumping and stuff like that, it took me a while to get my breast milk in, and I felt bad because they're like, "Oh, look at other moms. They're coming and they're pumping, and then you're not bringing any milk. We're gonna force feed the baby. We need more milk." I would sit there and cry. The breastfeeding, the teacher, the lactation consultant, she actually helped me to get my milk to come in. She was like, "You have to calm down. Don't stress and massage. Just take warm, hot showers and massage." She actually sent me home—when they discharged me and kept my daughter, she sent me home with a breast pump. They gave me like a whole kit, and that was how I was able to bring in milk. Then they decided they were gonna add powder to my breastmilk because they said my breastmilk didn't have enough calories, but I think it was just them trying to push forward.

"

“

I didn’t have lactation come to me either. I had one of the nurses try to help me at the time. She tried to get him to latch on, and then she brung me the breast pump so I could try to do it by myself, but that experience was crazy in itself cuz I just felt so helpless. I was just like, this is something I really, really want to do, and here I am stuck giving my freakin’ child formula, but I didn’t get no help while I was there trying to do that. I didn’t get no help whatsoever while I was there trying to do that, which made me discouraged cuz I was just like, why can’t I? You know what I’m saying? Why can’t I? Yeah, it was horrible. I would never go back though. If God sees it fit that I have another child, I’m not going back to Katz. It’s not happening.

”

“

Interviewer: What else? You brought up the issue of race. Do you think that race played a factor in the care that you received?

Client: It's a half and half for me because being in the waiting room that long, when certain moms come up, and they're like, "Oh, I need to be rushed to the back," they get rushed to the back.

Interviewer: Okay. When you say certain moms, you mean moms that—

Client: Are Caucasians…They just know that most people want to go with their flow. I feel like, yeah, it's very different for them to actually get a black woman that has her husband and her doula inside the room pressuring, that's telling you X, Y, and Z, telling you facts, telling you statistics, telling you real stuff, and you're telling me in in the ninth hour, you're gonna give me Pitocin. I'm like, "No, I have 24 hours." They're just looking dumbfounded, like, "What are you talking about?" Like, oh, she knows what she's talking about.

”

“

I was speaking to them for a good, maybe like 10 minutes. It wasn’t until my husband jumped in and said, “Listen, my wife and I have made that child. Ain’t nobody gonna take my child up out of here,” is when they hushed up and cut all that noise out and finally left my room. I was like, why did it take him to speak? I’m the patient.

”

THE IMPACT – WHAT EXCITES US

ASDS

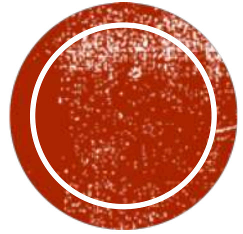
- Institutions not just being in the community but of the community
- How communities and institutions can work collaboratively to advance better birth outcomes
- Coming to a full understanding of how racism and implicit bias impact not just the birth experience but the reproductive life course and how people parent their children

PHS

- The potential changes in policy, practice, and mindset of physician and community
- PHS and Northwell have built trust and an avenue to discuss and resolve client issues

LIJMC

- Transforming how we can integrate and prioritize people's voices into processes to improve the care and birth experience for families



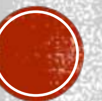
WHAT'S NEXT?

ACCOUNTABILITY

SPECIAL THANK YOU!

A special thank you to:

- The women who birthed at LIJMC and shared their stories
- The Alliance for Innovation in Maternal Health (AIM) administered by the American College of Obstetricians and Gynecologists



TOGETHER, WE CAN IMPROVE HEALTH OUTCOMES
OF WOMEN AND CHILDREN AND BE CHAMPIONS
FOR HEALTH EQUITY

AND HOW ARE THE MOTHERS AND CHILDREN?

…ALL THE MOTHERS AND CHILDREN ARE WELL!

THANK YOU!...QUESTIONS?

Jonathan Webb, MPH, MBA

Email: jwebb@amchp.org

Website: www.amchp.org

Phone: 202-366-3040

Twitter: @AMCHP_CEO

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