



Preconception CoIN

Preconception IM CoIN Webinar

Achieving health and equity for women
Strategies for meaningful connections between clinical
care and public health



Preconception
Health+Health Care Initiative

A National Public-Private Partnership

Kay Johnson
September 11, 2020 3-4pm ET

This webinar is being recorded.

- This webinar will be archived on BeforeandBeyond.org, under Program > “Preconception IM CoIIN” tab.
- Stay tuned for information about accessing this recording and the next webinar in this series.
- Please provide feedback to today’s webinar **at the link provided**

WOMEN-CENTERED CLINICIAN-ENGAGED COMMUNITY-INVOLVED



OUR GOAL: This Preconception CollN will develop, implement, and disseminate a

woman-centered,
clinician-engaged,
community-involved

approach to the well woman visit to improve the preconception health status of women of reproductive age, particularly low-income women and women of color.



Kay Johnson

Achieving health and equity for women:

Strategies for meaningful connections between clinical care and public health



ACHIEVING HEALTH AND EQUITY FOR WOMEN

Strategies for meaningful connections
between clinical care and public health

Kay Johnson

Johnson Group Consulting, Inc.

Presentation for webinar September 11, 2020

Hosted by UNC Center for Maternal and Infant Health



Starting perspective...What I believe

- ❖ Equity in health or life depends upon strong and well-implemented public policies.
- ❖ Every person should have the freedom to decide if and when to be a parent and raise a family.
- ❖ Reproductive justice will be attained when all people have the economic, social, and political power and the means to make decisions about their bodies, sexuality, health, and families.
- ❖ The challenges we face won't be remedied by clinical practice changes, quality improvement, or individual behavior change alone.
- ❖ To have equitable impact on the greatest number of women, children, and families, we must ensure effective public policies, programs, and services.
- ❖ Data are not and never have been neutral. (Kreiger doi: 10.2307/3342531)



The bad old days

❖ In 1981:

- Family planning was available for 4.6 million women through the Title X program (peak funding 1980 in constant dollars).
- Medicaid programs in 19 states did not cover for prenatal care for first-time pregnant women because they were not considered mothers.
- Medicaid was paying for 12% of delivery costs and women/families were generally expected to be the principal source of payment.
- Among married women, 52% had insurance to help pay for prenatal care and 65% had coverage for birth/hospital care in 1972. (Unmarried not counted)
- No laws barred pregnancy coverage exclusions at state or federal levels.



So, what is not happening that should be?

- ❖ Barriers limit health and health care for many women.
- ❖ Many low-income young adults still uninsured.
- ❖ Primary care is discontinuous (no medical home).
- ❖ Low reproductive health awareness or no “reproductive life plan” evolving for most men and women.
- ❖ Many providers are not focused on reproductive risks.
- ❖ Most women have coverage for well visits with preconception care, but they and their providers are not aware, not using benefit.
- ❖ Perinatal HIV, opioid use, mental health marginalized.
- ❖ Racism, unequal treatment, access barriers, and other inequities drive racial/ethnic and income disparities.



The tension between W and M

- ❖ A longstanding tension exists between women's health (W) and maternal health (M) policy
- ❖ Since the 1960s, divergent policies, programs, and initiatives have increased separation, tension
 - Family planning Title X administrative separation
 - Medicaid seen as a welfare program (with racist underpinnings and history)
 - Policies limiting Medicaid/public funding for abortion
 - Medicaid expansions of maternity and child coverage
 - Preconception health initiative seen as pro-natalist
- ❖ Leaders must be aware of how their actions fit into this larger picture



Many targets for advocacy over time

Well women

Healthy babies

Access to care

Reproductive Justice

Access to abortion & contraception

Planned pregnancies

Quality care

Maternal mortality

Infant mortality

Health coverage

Lifting families out of poverty

Equity



Learning from Herstory: Foundations of Maternalist State in the Progressive Era

Grace Abbott

Edith Abbott

Jane Addams

S. Josephine Baker

Julia Lathrop

Florence Kelley

Lilian Wald

❖ Progressive Era—from 1870s-1920s—was a time of political mobilization of American middle-class white women, who agitated for maternalist social measures to protect children and mothers and to address poverty in an industrial and urban society.

- Led to creation of the Children's Bureau, child care, child labor laws, juvenile courts, child welfare, kindergarten, and “mother's pensions”
- Against “welfare” programs for the poor alone, more universalist
- Did not work against racism or xenophobia
- Spread a model of public health and MCH (starting with Sheppard-Towner Act)

To learn more, see: Skocpol. *Protecting Soldiers and Mothers: The political origins of social policy in the United States*. 1992.



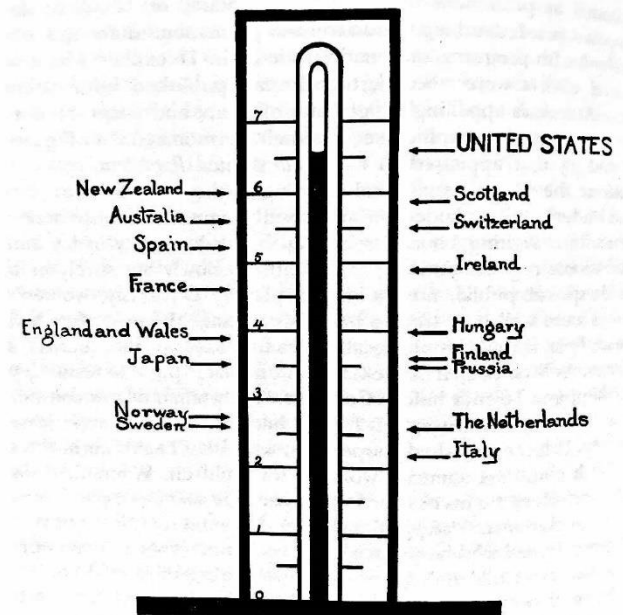
Sheppard Towner funding led to change

- ❖ With federal funds going to states for MCH between 1921 & 1927, “...*at least some work was reaching [people of color], who had been virtually ignored up to this time.*”
 - MN and NB targeted their Native American populations for special support.
 - AZ, NM, and TX employed Spanish speaking nurses to make home visits.
 - The South, although keeping its programs segregated, for the first time made an effort to extend public health services to Black people.
- ❖ All states were pushed by Children’s Bureau to channel resources to areas with high rates of maternal and infant mortality.
- ❖ Roots of the Title V MCH program.

MATERNAL MORTALITY RATES

per 1000 births

Latest available figures up to 1917



The United States lost over 23,000 women in 1918 from childbirth. We have a higher maternal death rate than any other of the principal countries.

CHILDREN'S BUREAU, U.S. DEPARTMENT OF LABOR.



Shaping the Vision for Preconception Health and Health Care

Hani Atrash
 Jeanne Conry
 Denise D'Angelo
 Ann Dunlop
 Dan Frayne
 Jessie Hood
 Brian Jack
 Kay Johnson
 Lorraine Klerman
 Milt Kotelchuck
 Michael Lu
 Merry-K Moos
 Diana Ramos
 Cheryl Robbins
 Sarah Verbiest
 Lauren Zapata
 Laurie Zephyrin

❖ CDC Recommendations for Preconception Health and Health Care in 2006

- *“Preconception care aims to promote the health of women or reproductive age before conception and thereby improve pregnancy-related outcomes.”*¹
- *“To improve the health of women and any children they may choose to have.”*²

❖ Skepticism and criticism arose

- Washington Post: *“Forever Pregnant”*
- Ms. Magazine: *“Warning: You Could be Pre-Pregnant”*
- A forward looking agenda to improve the health of women and children OR a backward looking pro-natalist idea?³

1. Johnson et al. *Recommendations to improve preconception health and health care—United States: A report of the CDC/ATSDR Preconception Care Work Group and the Select Panel on Preconception Care*. MMWR. 2006. 55(RR-6), 1–23.
2. Johnson & Baluff. *Summary of Findings from the Reconvened Select Panel on Preconception Health and Health Care*. 2015
3. Waggoner MR. *The Zero Trimester: Pre-pregnancy care and the politics of reproductive risk*. University of California Press. 2017.



Shaping the Vision for Well-Woman Care

Claire Brindis
Haywood Brown
Cynthia Chuang
Jeanne Conry
Angela Dias
Rebekah Gee
Kimberly Gregory
Arden Handler
Marianne Hillemeier
Arthur James
Susan Kendig
Maureen Phipps
Diana Ramos
Kweli Rashied-Henry
Alina Salganicoff
Ana Sanchez-Birkhead
Carol Weisman
Christopher Zahn

❖ Women's Clinical Preventive Services

- Aim: Every woman, every time
- Content of care defined + federal regs
- Clinicians willing to implement?
- Focus on reproductive and health overall
- Access and quality varies by race-ethnicity, income, and insurance status
- Need attention to life course, reproductive justice, SDOH
- GYN, FP/GP, NP, other provider types

Women's Preventive Services Guidelines (HRSA, US HHS) <https://www.hrsa.gov/womens-guidelines-2016/index.html> ; Institute of Medicine. *Clinical Preventive Services for Women: Closing the Gaps*. doi.org/10.17226/13181; Women's Preventive Services Initiative (WPSI)

<https://www.womenspreventivehealth.org/about/> ; WPSI Well-Women Chart.

doi:10.1097/AOG.00000000000003368 ; The Well-Woman Project: Listening to Women's

Voices. doi:10.1089/heq.2018.0031 ; Recommendations of the IOM Clinical Preventive Services for Women Committee: implications for obstetricians and gynecologists. doi:10.1097/GCO.0b013e32834cdcc6



Shaping the vision for reduced maternal mortality

Wanda Barfield
Linda Blount
William Callaghan
Charlene Collier
Joia Crear Perry
Lekisha Daniel-Robinson
Eugene Declercq
Elizabeth Howell
Katy Kozhimannil
Michael Lu
Claire Margerison
Jeanne Mahoney
Elliott Main
Fleda Mask Jackson
Kate Menard
Lisa Waddell
Serena Williams

- ❖ Accelerated movement led by Black women
- ❖ Many focused on measurement
- ❖ Advocates call for
 - access and quality in birth services
 - postpartum care
 - extended Medicaid coverage
 - more culturally congruent workforce
- ❖ Advancing care models
 - Focus on care teams, including doulas, community health workers, and navigators
- ❖ National expert panels, state review teams, and other entities





NATIONAL
QUALITY FORUM

Framework Adapted from Dr. Elizabeth Howell

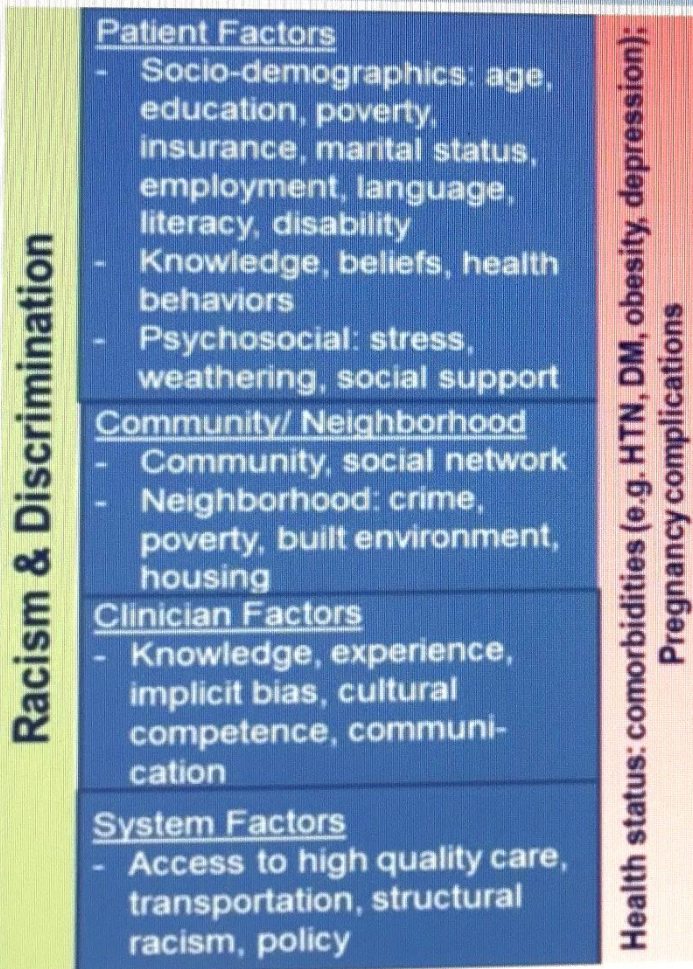
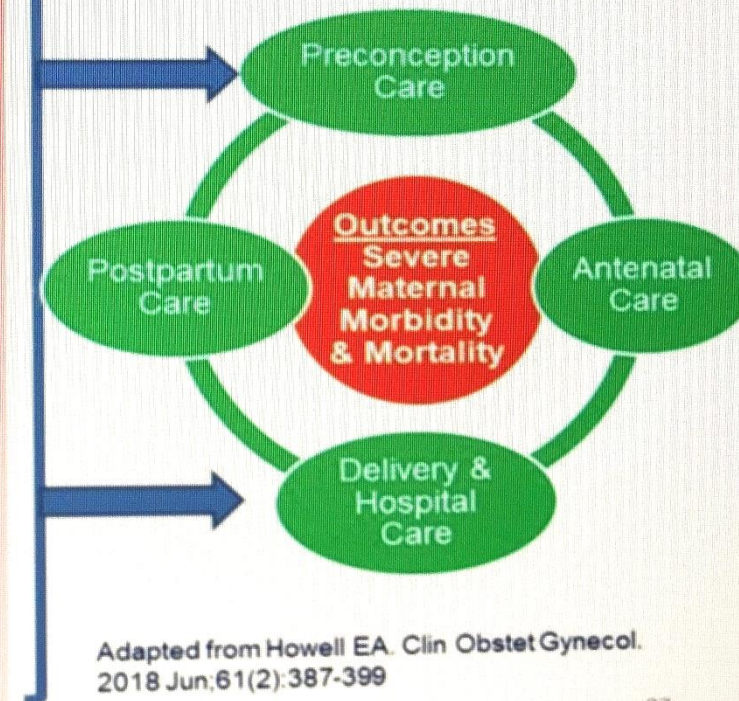


Figure 1: Pathways to Racial and Ethnic Disparities in Severe Maternal Morbidity & Mortality



Adapted from Howell EA. Clin Obstet Gynecol. 2018 Jun;61(2):387-399



Shaping the Vision for Reproductive Justice

Byllye Avery
Osub Ahmed
Monifa Bandele
Joia Crear-Perry
Kimberly Crenshaw
Dazon Dixon Diallo
Angela Doyinsola Aina
Lisa Fortuna
Elizabeth Dawes Gay
Christy Gamble
Marlene Gerber Fried
Elena Gutierrez
Marcela Howell
Kwajelyn Jackson
Zakiya Luna
Priscilla Ocen
Kimala Price
Loretta Ross
Jael Silliman
Monica Simpson

- ❖ Reproductive justice – the human right to maintain personal bodily autonomy, have children, not have children, and parent children in safe and sustainable communities.
 - Beyond the limits of reproductive health and reproductive rights movement.
 - Understanding intersectionality.
 - Centering the most marginalized.
 - Addressing historical and current systemic racism in policies and practices.

See: Ross et al. *Undivided rights: Women of color organizing for reproductive justice*. Haymarket Books, 2016; Sister Song <https://www.sistersong.net/>



LET'S TALK COVERAGE: AFFORDABLE CARE ACT AND MEDICAID

Improving women's health coverage in multiple ways



Implementation of ACA benefits

❖ **Eight years ago on August 1, 2012, an estimated 47 million insured women (enrolling in new health plans or renewing their existing policies) gained coverage for the clinical preventive health services without cost-sharing.**

- Insufficient attention has been given to effective implementation of this coverage.

Learn more from: Federal website with guidelines: <https://www.hrsa.gov/womens-guidelines/index.html>

Women's Preventive Services Initiative <https://www.acog.org/About-ACOG/ACOG-Departments/Annual-Womens-Health-Care/Womens-Preventive-Services-Initiative> ; IOIM/NAS Women's Clinical Preventive Services.

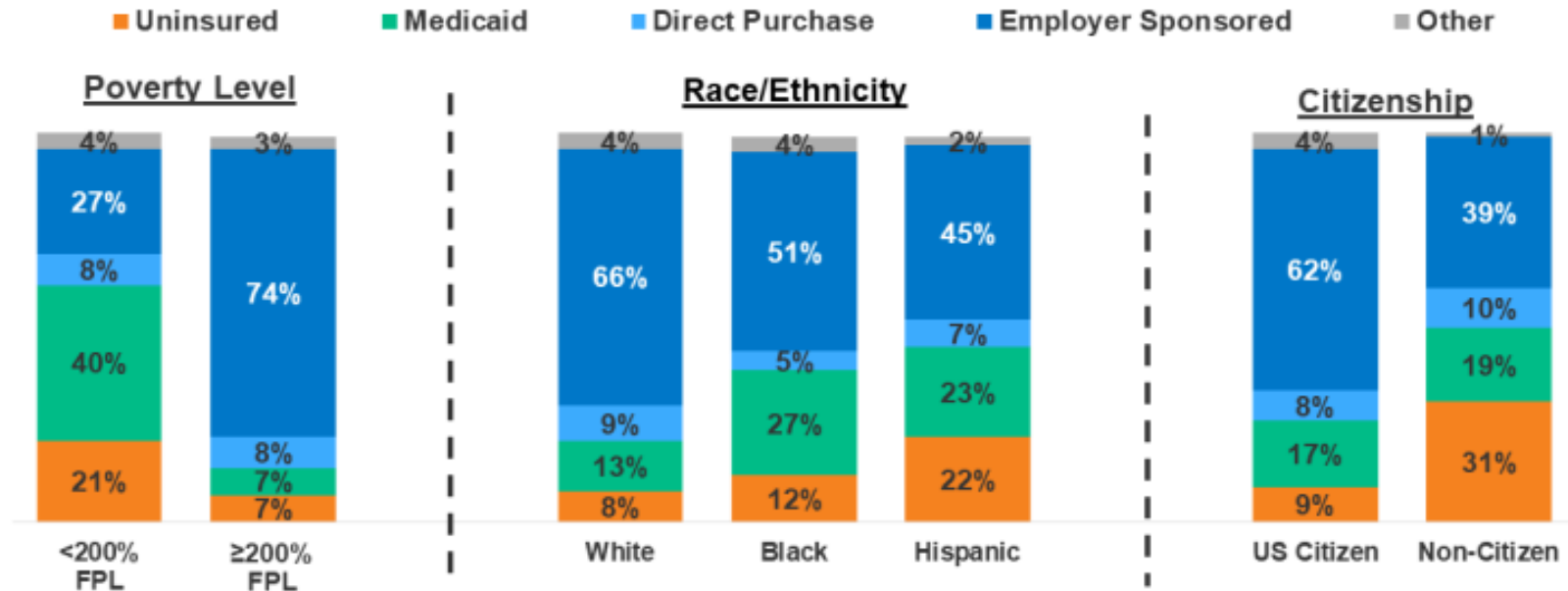
<http://nationalacademies.org/hmd/Reports/2011/Clinical-Preventive-Services-for-Women-Closing-the-Gaps.aspx>

Gee et al. Recommendations of the IOM Clinical Preventive Services for Women Committee. doi:

10.1097/GCO.0b013e32834cdcc6



Health Insurance Coverage, Women 18-64, 2018

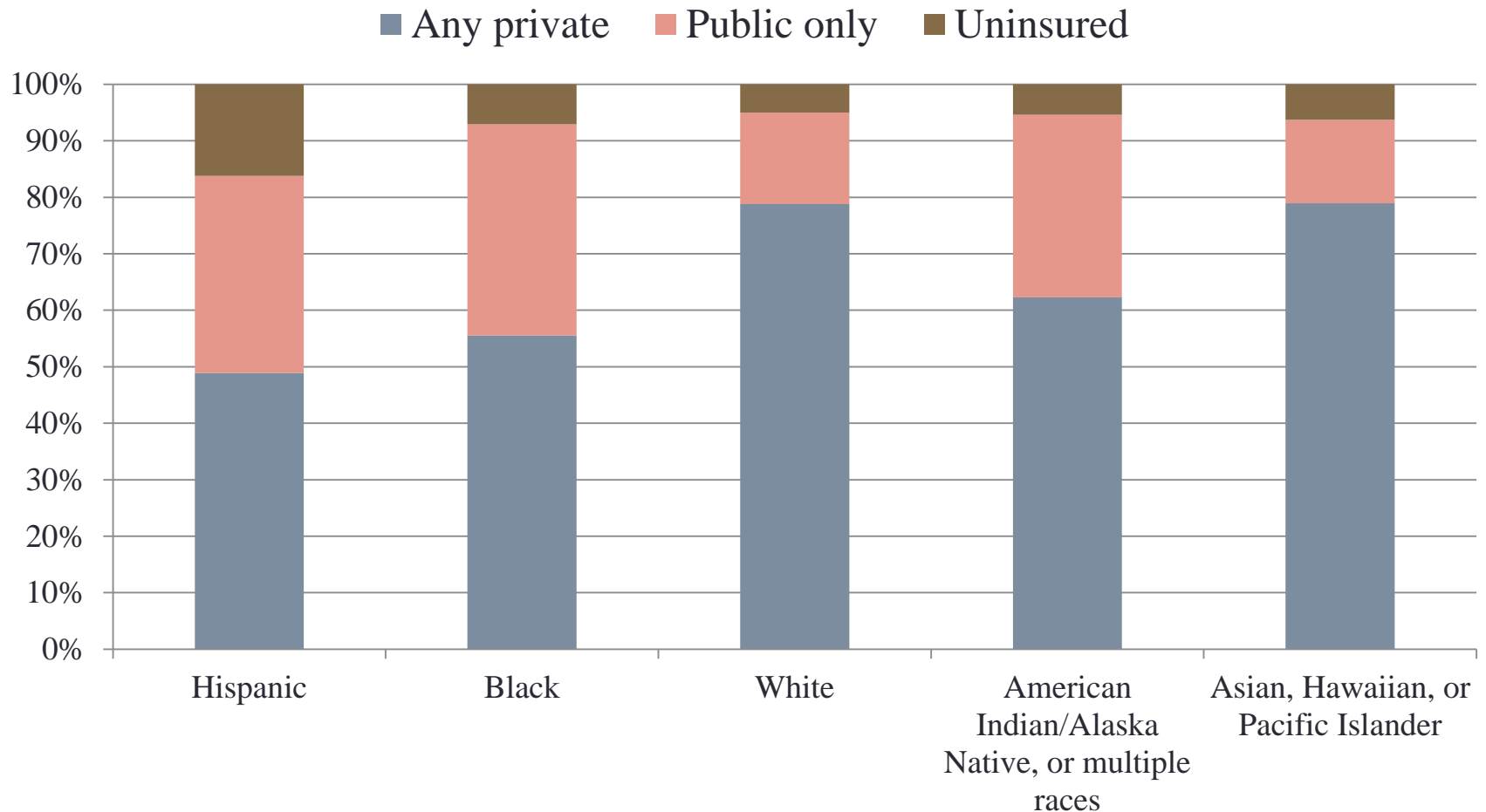


NOTES: Among non-elderly women 19-64. The Census Bureau Federal Poverty Level was \$13,064 for a nonelderly individual. "Other" includes those covered under the military or Veterans Administration as well as nonelderly Medicare enrollees.

SOURCE: KFF estimates based on 2018 Census Bureau's American Community Survey



Health Coverage Status for Women < 65, By Race/ Ethnicity, US, 2016

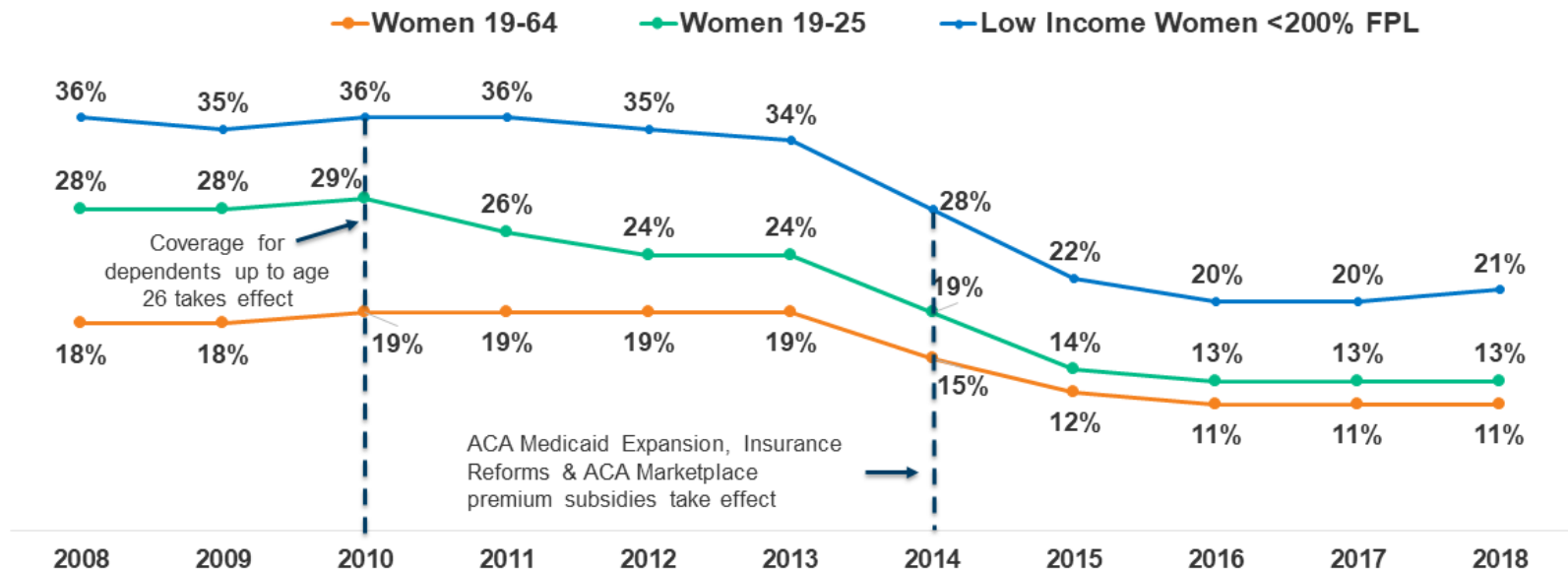


Source: Agency for Healthcare Research and Quality (AHRQ). Percentage of people by race by sex and insurance coverage, <65, United States, 2016. Medical Expenditure Panel Survey (MEPS). Data generated interactively by Johnson: 10/20/2018. Also see: Gunja, et al. *How the Affordable Care Act Has Helped Women Gain Insurance and Improved Their Ability to Get Health Care: Findings from the Commonwealth Fund Biennial Health Insurance Survey, 2016*, Commonwealth Fund, 2017.



Women <26 and women with incomes below 200% FPL had significant declines in uninsured rates under ACA. Decline in rate has stalled since 2016.

Uninsured Rate Among All Women, Low income Women and Younger Women, 2008-2018

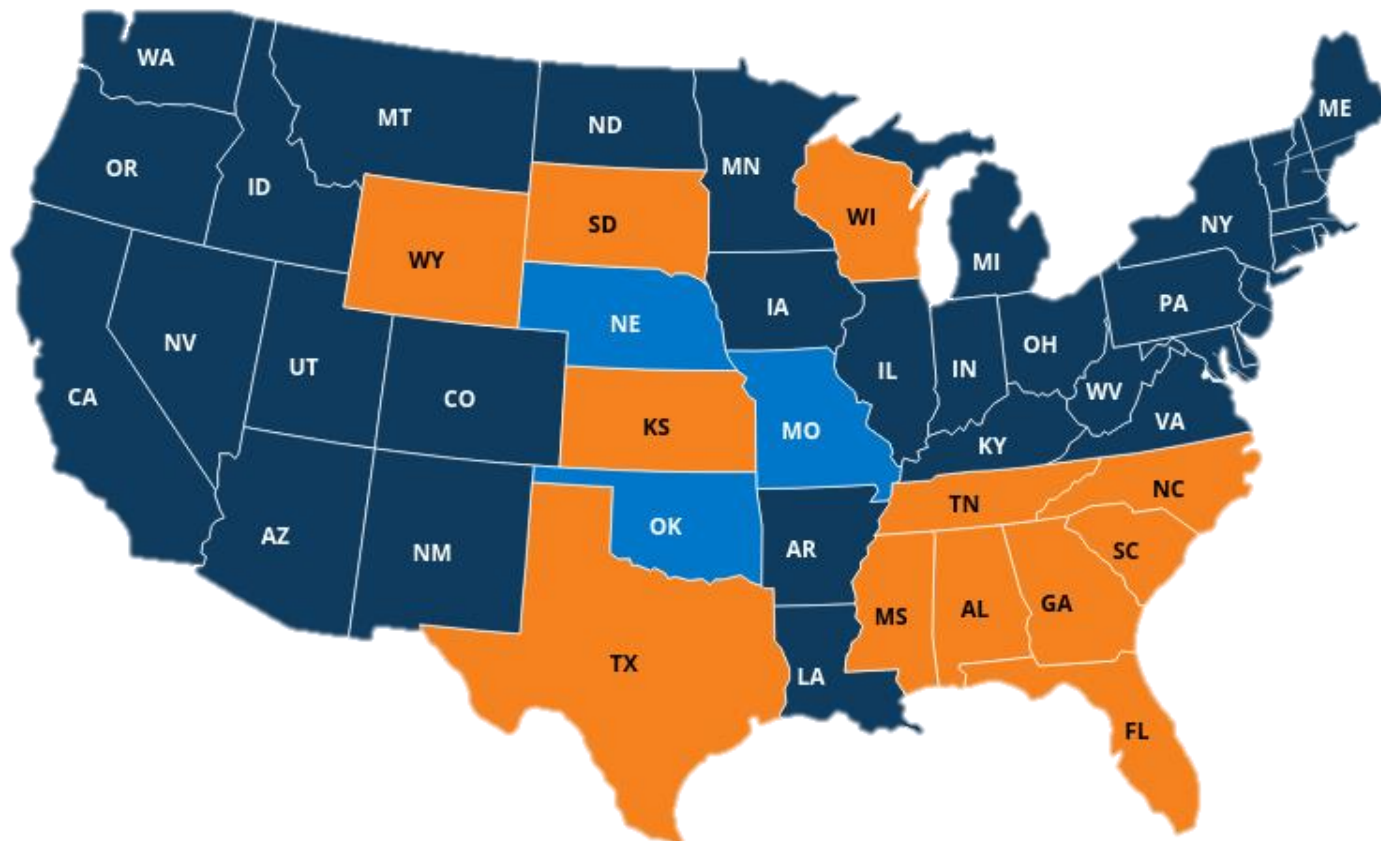


NOTES: 200% of the federal poverty level (FPL) in 2018 was \$26,128 for a non-elderly individual.

SOURCE: KFF estimates based on 2008-2018 Census Bureau's American Community Survey



Status of State Medicaid Expansion Decisions



Expanded Medicaid coverage resulted in more than 14 million additional people covered.

- Adopted (39 States including DC)
- Adopted but not implemented (3 States)
- Not adopted as of 8/15/20 (12 States)

SOURCE: Status of State Action on the Medicaid Expansion Decisions. KFF State Health Facts, updated August 15, 2020.

<https://www.kff.org/medicaid/issue-brief/status-of-state-medicaid-expansion-decisions-interactive-map/>

Medicaid and Women of Color

Sources:

- National Partnership factsheet. <http://www.nationalpartnership.org/research-library/repro/the-house-republican-repeal-bill-threatens-reproductive-justice-for-women-of-color.pdf>
- NAPAWF calculations based on American Community Survey (ACS) 2015.
- National Women's Law Center. Affordable Care Act Repeal Threatens the Health and Economic Security of 5.1 Million Women of Color Who Recently Gained Insurance Coverage. 2017.
- National Women's Law Center. Medicaid and Reproductive Justice, 2018.

- ❖ 15 million women of reproductive age are enrolled in Medicaid
- ❖ Women of color are more likely to have low income and thus are disproportionately likely to be covered by Medicaid
 - Nearly one-third (31%) of Black/African American women
 - Over one quarter (27%) of Latinas
 - About one in five (19%) of AAPI women, particularly Southeast Asian and Pacific Islander women.



Medicaid and Childbearing



Prenatal services

- Prenatal care
- Case management
- Smoking cessation
- Prenatal vitamins & prescriptions
- Home visiting
- Genetic services
- Substance use treatment



Birth services

- Birth facility and providers for labor, delivery, & newborn
- Care for maternal or infant complications (including maternal safety bundles)
- Doula services



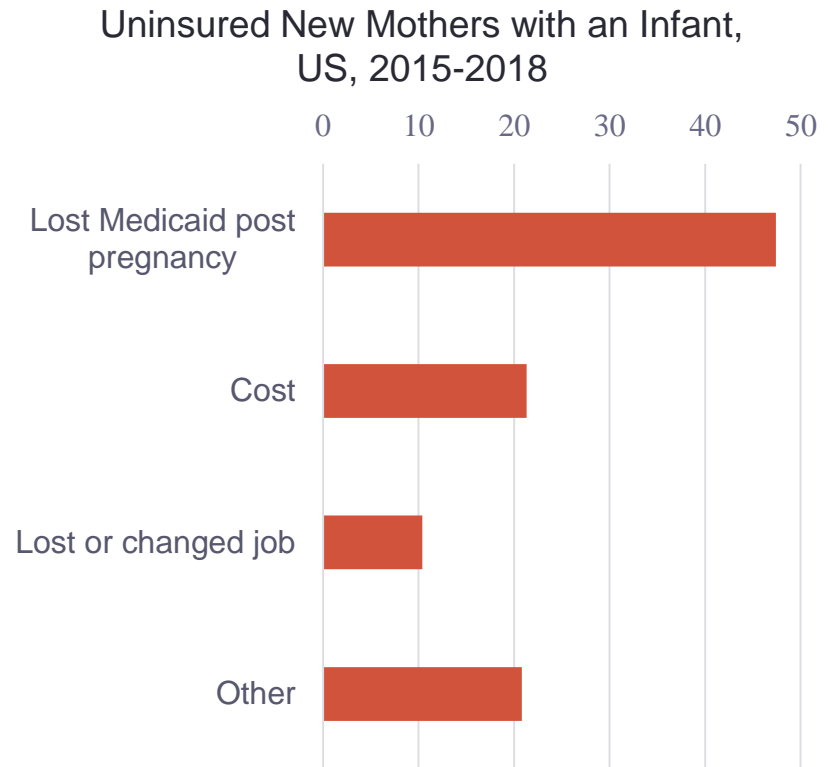
Postpartum & interconception services

- Postpartum visits
- Family planning
- Breastfeeding support
- Maternal depression
- Interconception care for high risk



Women Losing Coverage Postpartum

- ❖ Half with income below 100% of poverty level
- ❖ Half are Latinas / Hispanic
- ❖ About 2/3 are citizens (62%)
- ❖ More than half are married, and another quarter live with a partner
- ❖ While about one-third are employed, 59% are not in labor force



Sources: McMorrow et al. Uninsured New Mother's Health and Health Care Challenges Highlight the Benefits of Increasing Postpartum Medicaid Coverage. Urban Institute, 2020. (NHIS data). Also see: Zephyrin & Nuzum. Caring for Moms During the COVID-19 Pandemic. Commonwealth Fund Blog, April 15, 2020; Eckert. It's Past Time to Provide Continuous Medicaid Coverage for One Year Postpartum. Health Affairs Blog, February 6, 2020



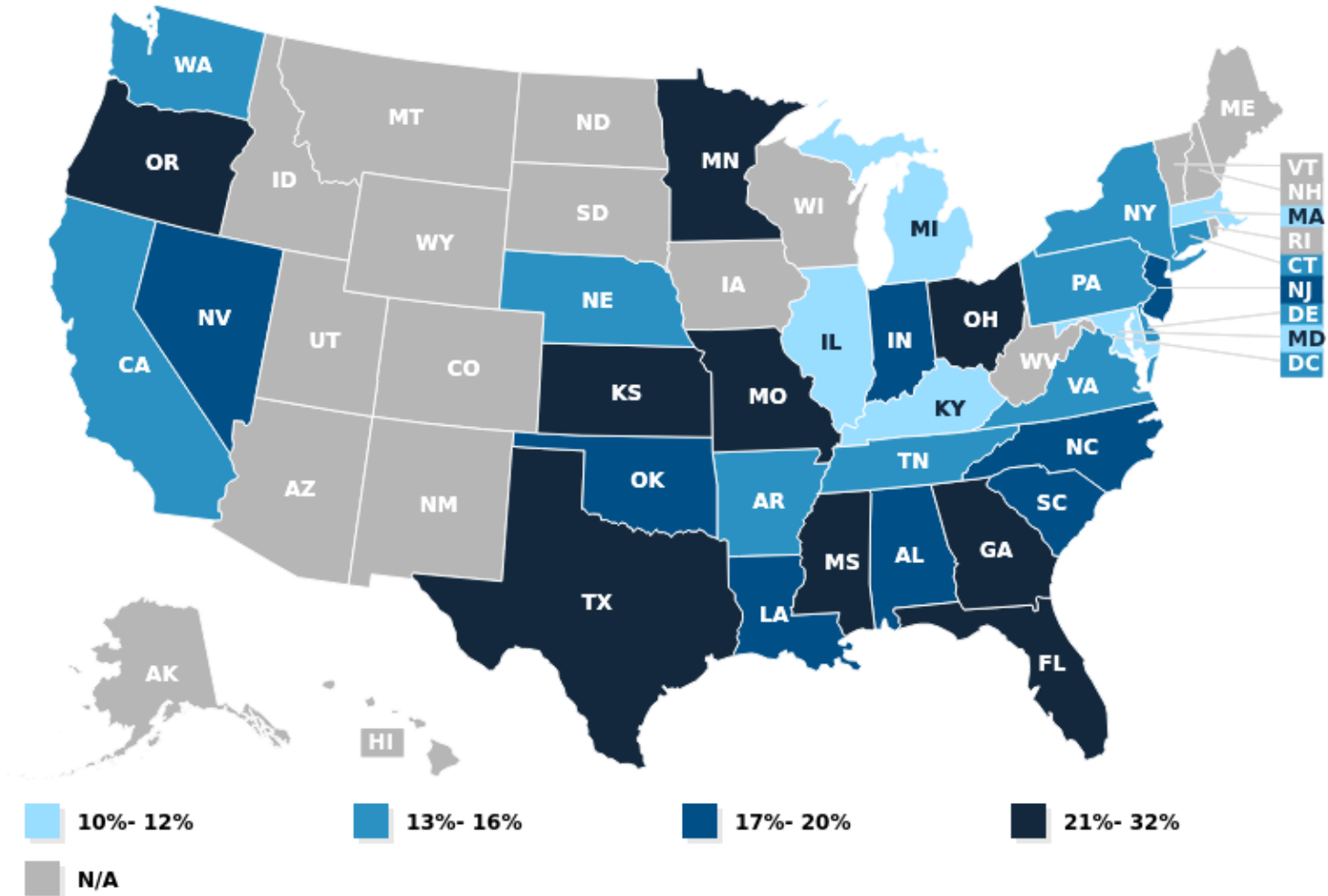
Coverage for whom? What impact?

- ❖ Racial/ethnic coverage disparities decreased but not eliminated by ACA.¹
- ❖ ACA closed coverage the gaps for BIOPC age 19-25, with boosts in having regular source of care and having health care visits.²
- ❖ ACA associated with significant reductions in delayed care, increases in health care visits.³
- ❖ Medicaid expansions for low-income parents reduced costs and stress.⁴
- ❖ Among childless adults, Medicaid expansion impact on access to care better for whites.⁵

1. Buchmueller & Levy. doi:10.1377/hlthaff.2019.01394; 2. Lipton et al. doi:10.1177/1077558717706575; 3. Chen et al. doi:10.1097/MLR.0000000000000467; 4. McMorro S, et al. doi:10.1111/1475-6773.12432; 5. Lee & Porrell. doi:10.1177/1077558718808709



Black/African American Women Age 18+ Who Report Having No Personal Health Care Provider, 2016-2018

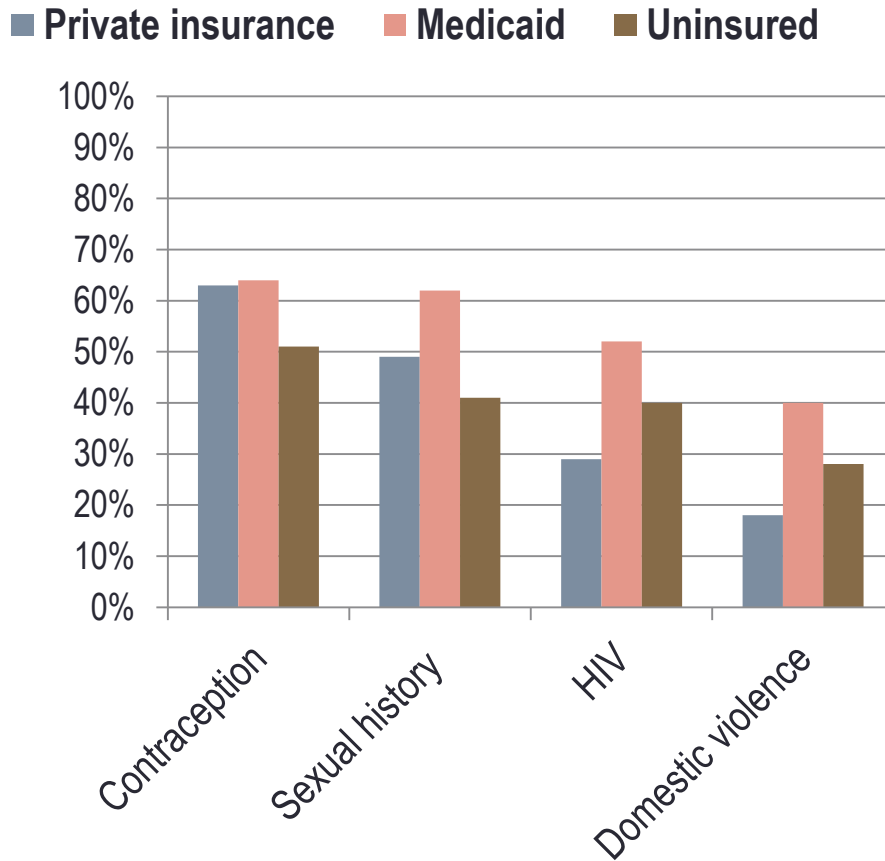


Kaiser Family Foundation analysis of the Center for Disease Control and Prevention (CDC)'s Behavioral Risk Factor Surveillance System (BRFSS) 2016-2018 Survey Results.



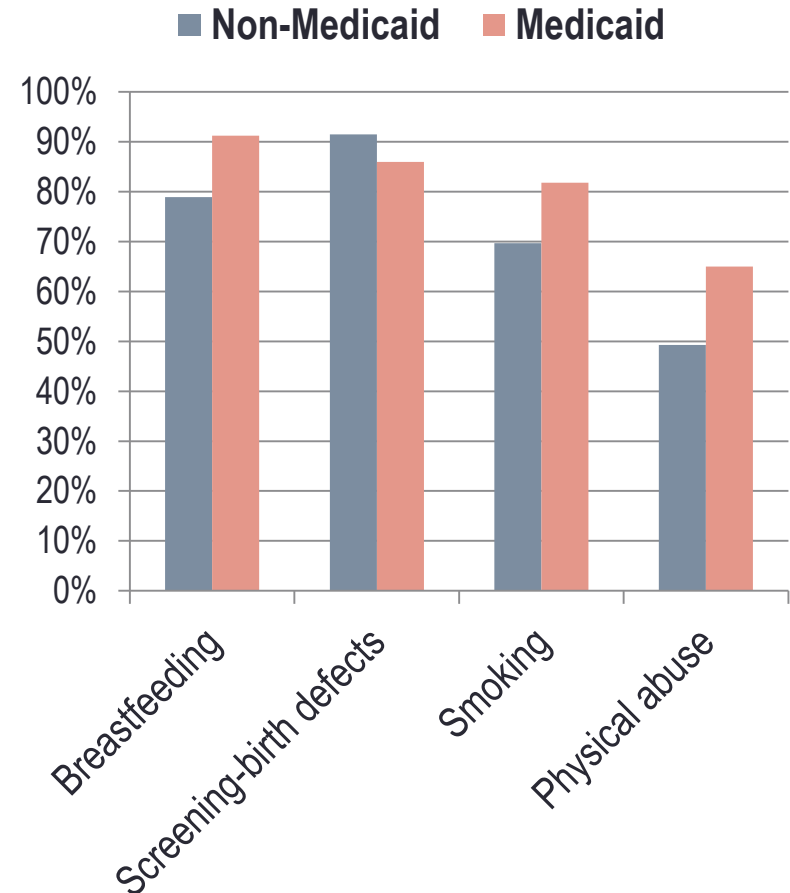
Unequal treatment?

US Women Ages 15-44, Kaiser Survey, 2013



Source: Kaiser Family Foundation. *2013 Kaiser Women's Health Survey*. Provider Counseling on Sexual Health Topics Among Women, By Insurance Coverage, 2013.

Sample State PRAMS, 2011



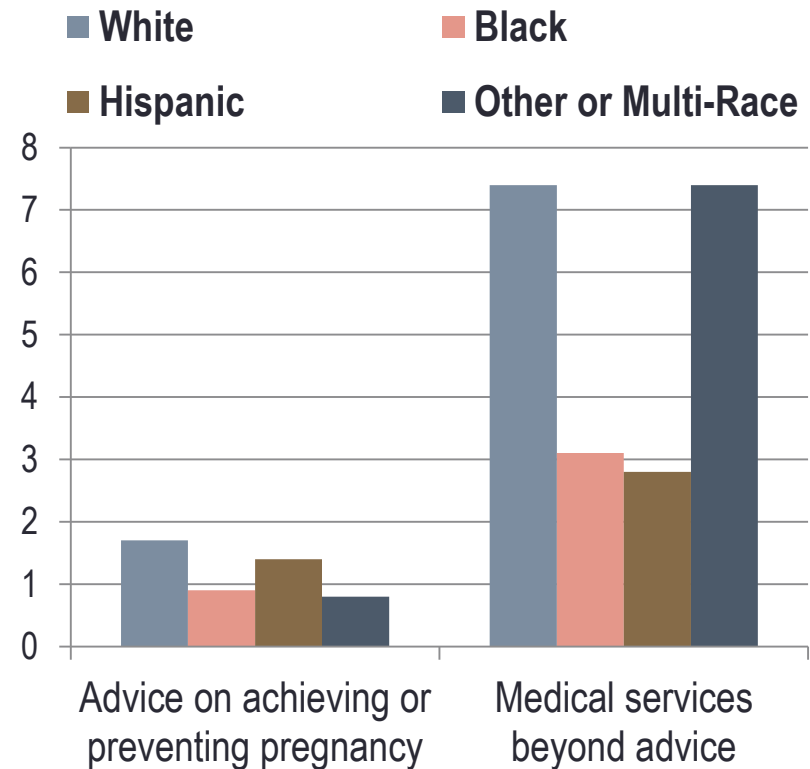
Source: PRAMSTAT. Percent of Women Who Recently Gave Birth Who Reported Health Education Discussions with Health Providers, By Medicaid Status, PRAMS Sample State

Unequal access?

❖ Need layers of change

1. Recognition of the role of racism in access to care for BIOC.
2. Improvement in coverage, benefits, and cost.
3. Implementation of practice guidelines.
4. Adoption of anti-racist, anti-bias approaches by all types of providers.
5. Design of QI approaches that use an equity lens, not just measure disparities at the end.

Preconception/ Pre-Pregnancy Advice and Services, US, 2011-2013



Source: Pozol et al. CDC. MMWR. 2017;66(20)



Shaping the agenda for access

- ❖ Access to quality, appropriate, unbiased services
- ❖ Access to full array of reproductive health services (e.g., ART, abortion, birth centers, doulas)
- ❖ Access to culturally appropriate and unbiased education about reproductive options and services, including providers and birth preferences
- ❖ Shared decision making, patient-centered
- ❖ No coercion
- ❖ No criminalization of reproduction (e.g., women addicted to substances)



Closing Knowledge Gaps

- ❖ Move from measuring to understanding root causes to eliminating disparities.
- ❖ Use an equity lens to design QI projects, not just count disparities at the end.
 - *Require this change in perinatal quality collaboratives*
- ❖ Health care system measures that focus on care process, outcomes, and patient satisfaction.
- ❖ Health services research (HSR) conducted with people and communities engaged at every stage from co-design to data analysis and reporting.
- ❖ Measure/monitor SDOH, equity, and unequal treatment.



Example California CPQCC

ACCULTURATION OF OPERATION

- ❖ Signal importance of family-centered-care. Provide multi-lingual signage welcoming all families as partners in care
- ❖ Ensure families are greeted and treated respectfully.
- ❖ Deliver trainings (e.g. cultural competency, structural competency, anti-bias trainings) for all.

CONNECTIONS TO RESOURCES

- ❖ Employ personnel (e.g., social workers, family navigators) for a standardized assessment of SDOH and for tailored psycho-social support.
- ❖ Provide routine screening and support for social services needs

FAMILY LEADERSHIP

- ❖ Employ paid family advisors
- ❖ Develop peer-to-peer support program

COMMUNICATION

- ❖ Offer language assistance
- ❖ Offer varied ways to interact with care team (e.g. in person, by phone, other virtual approaches)

EDUCATIONAL SERVICES

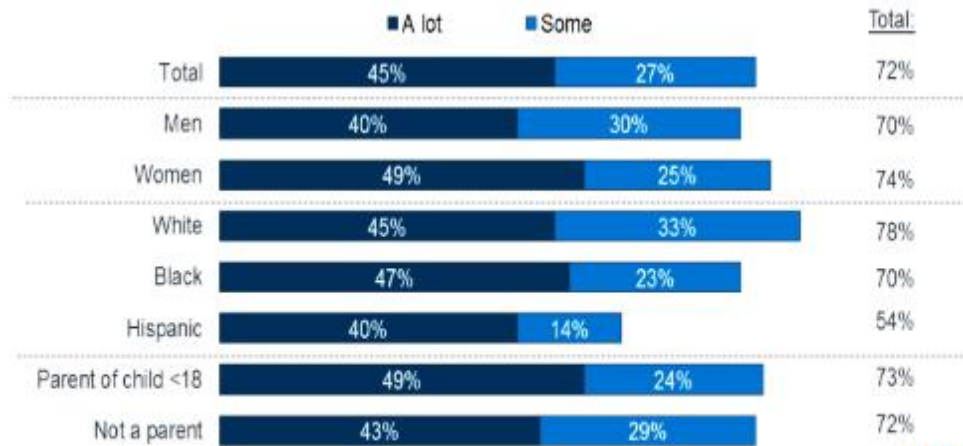
- ❖ Develop targeted multi-lingual and culturally appropriate education and support for families on the health benefits of breastfeeding and other infant care.
- ❖ Ensure staff are properly trained and use appropriate educational and support methods.



ADVANCING HEALTH AND EQUITY FOR WOMEN IN A TIME OF CHANGE



Triple crises: COVID, economy, justice



SOURCE: KFF Health Tracking Poll (conducted March 25-30, 2020). See topline for full question wording.

KFF
HEALTH TRACKING
POLL FOUNDATION

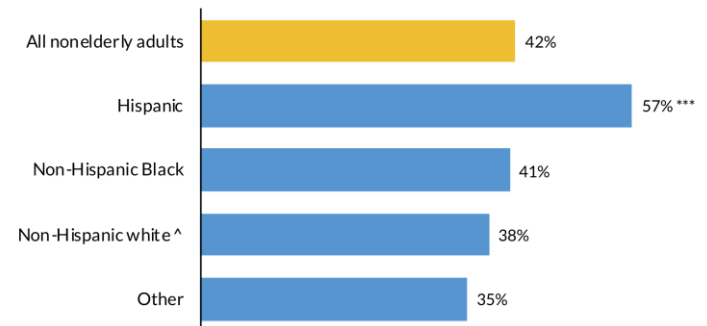


Share of young adults living with parents rises to levels not seen since the Great Depression era

% of 18- to 29-year-olds in U.S. living with a parent



Share of Adults Ages 18 to 64 Whose Families Lost Jobs, Work Hours, or Work-Related Income during the Pandemic, by Race and Ethnicity, March and April 2020



URBAN INSTITUTE

Source: The Health Reform Monitoring Survey for the first quarter of 2020. The survey was conducted between March 25 and April 10, and 74.5 percent of respondents completed the survey by March 31.

Before, during and after childbirth, all women have the right to high quality care. This includes:



#COVID19 #CORONAVIRUS

All women have the right to a safe and positive childbirth experience, whether or not they have a confirmed COVID-19 infection.



#COVID19 #CORONAVIRUS

A time to go farther, do better...

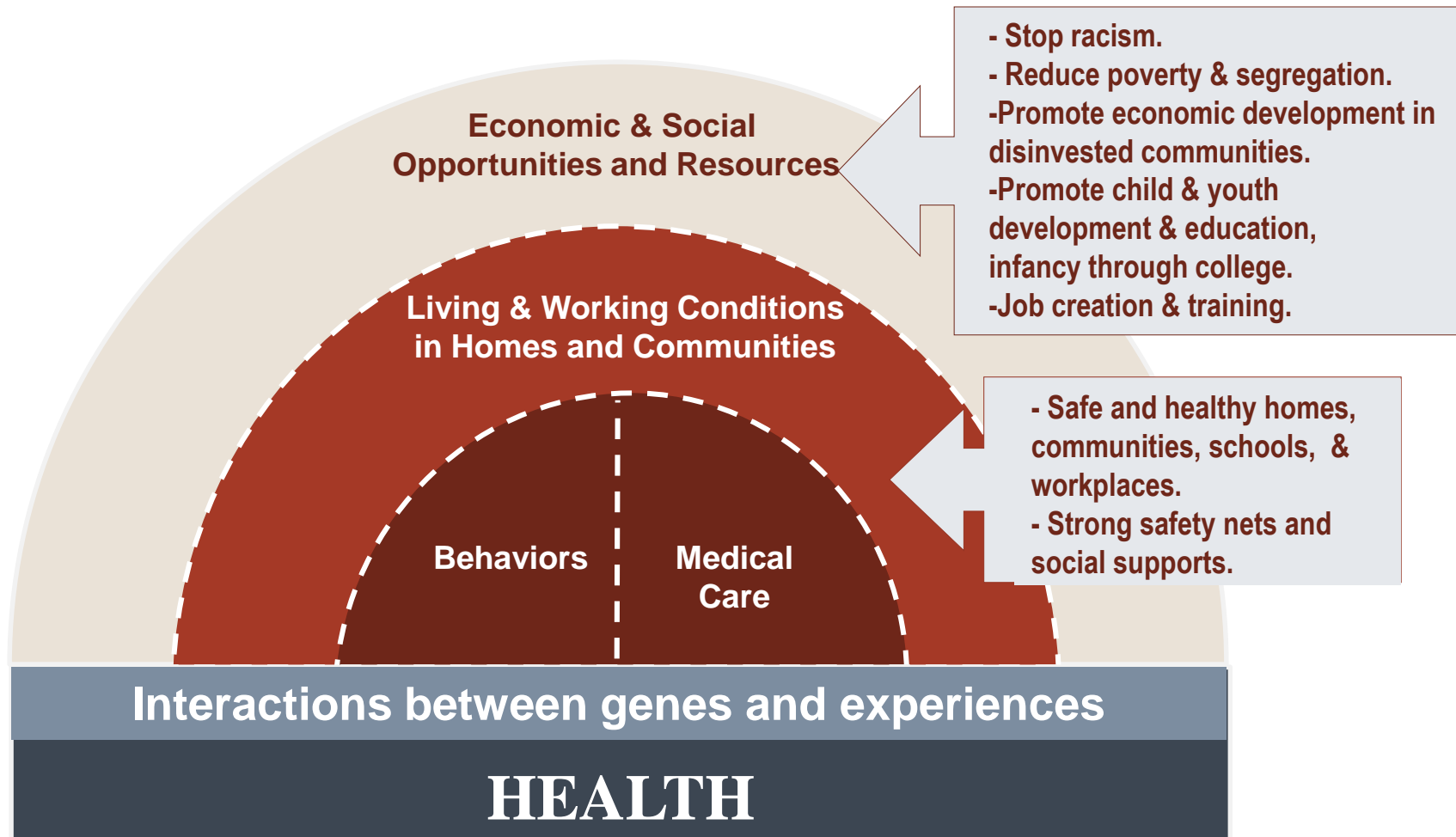
❖ What we have been doing has often been:

- Incremental
- Limited by socio-political context
- Not reflective of women's voices
- Not acknowledging or addressing bias and racism
- Not sharing power with women, families, communities

We deserve
the opportunity
to have families
regardless of financial
ability.

Consumer wall chart comment in first IM CoIIN,
Social Determinants of Health Learning Network
meeting, Boston, 2015.





Source: P. Braveman et al. University of CA., San Francisco, adapted from version originally created for: *Overcoming obstacles to health: Report from the Robert Wood Johnson Foundation to the Commission to Build a Healthier America*. Robert Wood Foundation, 2008.



Context for policy and programs today

- ❖ Women and their families need family leave, income support, and other supportive policies.
- ❖ Assuring access, quality, and equity are paramount in health care.
- ❖ ACA was very important for women's health — must be protected and better implemented.
- ❖ Medicaid expansions and improved quality and access are needed.
- ❖ Community health centers serve 1 in 10 low-income women, full range of primary care key for life long health.
- ❖ Title V provides locus for an array of programs and services, vital in every state but often underutilized leverage.
- ❖ Title X family planning is vital for low-income women, but threatened by proposed regulations and often disconnected from other health care services.
- ❖ Access to abortion threatened by judicial and legislative action and limited for low-income women already.



Existing Public Policy & Program Areas

- ❖ Income support, including tax subsidies (*expand*)
- ❖ Family and medical leave policies (*improve*)
- ❖ Affordable Care Act (*protect*)
- ❖ Medicaid (*expand*)
- ❖ Maternal morbidity and mortality bills (*enact*)
- ❖ Title V Maternal and Child Health Services (MCH) Block Grant (*enhance*)
- ❖ Healthy Start (*optimize*)
- ❖ Community Health Centers (*strengthen*)
- ❖ Title X Family Planning program (*embed*)



More related to
legislative action

Large P Policy examples

1. Adopt policies to improve SDOH and socio-economic well-being (e.g., tax credits, paid family leave, TANF option as family leave, income support).
2. Expand Medicaid eligibility to 138% of poverty level or higher for women and men, 19-64 without regard to parental status.
3. Extend Medicaid eligibility for one year postpartum following a Medicaid financed birth/pregnancy.
4. Provide first dollar coverage for ACA preventive services to all women.
5. Adequately fund safety net and community-based programs (e.g., FQHC, Healthy Start, home visiting).
6. Make federal law changes to support maternal mortality reduction (e.g., “Momnibus” bill)
7. Expand Title V with funds for development of a community-based workforce (e.g., community health workers, navigators).
8. DO NOT cut funding for services for women, children, and families as a result of current crises.



Small p policy examples

More related to
administrative action

1. Build **workforce** of community health workers, peer navigators, doulas, etc.
2. Develop Medicaid **interconception** care projects for enrolled higher risk women (*no new authority or eligibility required*).
3. Add performance **measures** for well-woman, maternity, and postpartum care to Medicaid managed care contracts.
4. Incentivize use of **team-based care** in medical homes.
5. Pay incentives for performance/**quality** in well-woman visits.
6. Provide **adequate reimbursement** for doulas, community health workers, and others who provide navigation, care coordination, and support before, during, and beyond pregnancy.
7. Use Title V funds to support **provider training** related to culturally appropriate well woman/ preconception, maternity, and postpartum care.
8. Set priority in **home visiting** for completed referrals to well-woman visits.
9. Adopt Title V **performance measure** (NPM-1) for well-woman visit as state priority and collect data/monitor performance by race, ethnicity, and insurance status.
10. Use **perinatal quality collaboratives** to advance equity and improve outcomes, including hospital and community-based providers.

Program strategies in public health

More related to
changing the culture
of PH/MCH agencies

1. Promote reproductive health and autonomy.
2. Use an equity lens to assess and modify public health & MCH policies, programs, and practices.
3. Train the public health workforce on reproductive justice principles, root causes of inequity, and anti-racism.
4. Shift the emphasis of program work from monitoring maternal behavior toward listening to and supporting women.
5. Create a strategic plan aimed at birth equity, including efforts focused before, during, and beyond pregnancy.
6. Focus on improving social determinants of health, not just individual education or behavior.
7. Partner with Medicaid to monitor performance.
8. Build respectful and meaningful alliances and partnerships with families and communities.



Practice strategies

More related to clinical practice change

1. Operate under medical home principles
 - **Deliver primary care that is: patient/family centered, comprehensive, team-based, accessible, coordinated, and committed to quality, safety, and equity.**
2. Make practice changes using professional guidance and recommendations
 - ACOG: *“combat racism, racial bias, and achieve inclusiveness in our own professional settings...”*
3. Identify and address structural and operational barriers to care.
4. Be aware of and aim to remedy practitioner bias.
5. Assist in recruitment of providers from racial/ethnic groups that reflect the community served.
6. Integrate issues related to social justice in training.
7. Engage with advocates to foster communication about equity and social justice.



A range of ideas from the field

- ❖ **Listen to, trust, and respond to women.** <https://www.cdc.gov/hearher/index.html>
- ❖ Address social determinants of health.
- ❖ Provide income support and family leave.
- ❖ Train and use a more relational, culturally congruent workforce, including doulas and community health workers.
- ❖ Use data for action, not just measuring disparities.
- ❖ Expand Medicaid coverage, including eligibility to one year postpartum.
- ❖ Continue, increase, and/or restore Title V MCH spending.
- ❖ Improve quality and safety of care.
- ❖ Shift the culture of care.
- ❖ Monitor and eliminate bias, unequal treatment, and racism in care process.
- ❖ Apply more holistic, patient-centered, strengths-based approaches.
- ❖ Use team-based care and a range of providers.
- ❖ Improve access to a range of mental health services and social support.
- ❖ Improve and reform care coordination.
- ❖ Focus home visiting on support for mothers, not just on monitoring behaviors and risk of child abuse.

HOW CAN WE KEEP FOCUS ON THE BIG PICTURE?

Sources: National Birth Equity Collaborative, March of Dimes Equity Agenda, Black Mamas Matter Alliance, Ever Thrive Illinois, Georgetown Center for Children and Families, National Partnership for Women & Families, Center for American Progress, Association for Maternal and Child Health Programs, and an array of other professional organizations, expert panels, and national leaders.



Birth Equity Agenda: Blueprint for Reproductive Health and Wellbeing

1. Reproductive health and autonomy are promoted and protected at the highest levels of government.
2. Health is a recognized right and governmental priority.
3. Individuals and institutions are held accountable for discrimination that leads to disparate health impacts.
4. No maternal death goes unnoticed or uncounted.
5. Government involvement in reproductive health does not intrude on individual reproductive freedom, agency, and autonomy.



Questions for our times

- ❖ By providing coverage and some benefit assurance, did the ACA move toward creating conditions that support health equity and reproductive justice?
- ❖ How can we keep shifting the discussion toward equitable access and quality, particularly for BIOPC and other marginalized people?
- ❖ US and global responses to COVID-19 pandemic are converging and intersecting with existing sexual and reproductive health and justice inequities, how can we best respond?



THANK
YOU



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https://unc.az1.qualtrics.com/jfe/form/SV_cXPbbX4hTbXiqPP



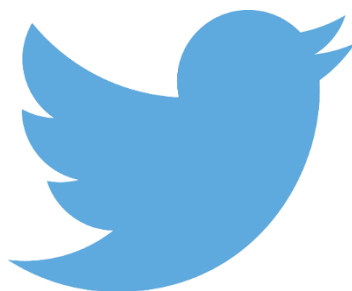
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woman-centered, clinician-engaged, community-involved

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