MARCH OF DIMES

ADVANCING HEALTH EQUITY TO IMPROVE MATERNAL AND NEONATAL OUTCOMES

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Director of Health Equity

A SHARED DESTINY

- Prematurity costs U.S. at least $26 billion/year
- Medicaid covers 1/3 of birth-related costs
- U.S. spends most, but has worse health
- Countries with greater social equity enjoy better health

2018 PREMATURE BIRTH REPORT CARD

Premature birth and its complications are the largest contributors to infant death in the U.S., and a major cause of long-term health problems in children who survive. March of Dimes aims to reduce preterm birth rates and increase equity, and monitors progress through Premature Birth Report Cards. Report Card grades are assigned by comparing the 2017 preterm birth rate in a state or locality to March of Dimes' goal of 8.1 percent by 2020. Report Cards provide county and race/ethnicity data to highlight the importance of addressing equity in areas and populations with elevated risk of prematurity. March of Dimes is working to expand solutions to help all mothers and babies have healthy, full-term births.

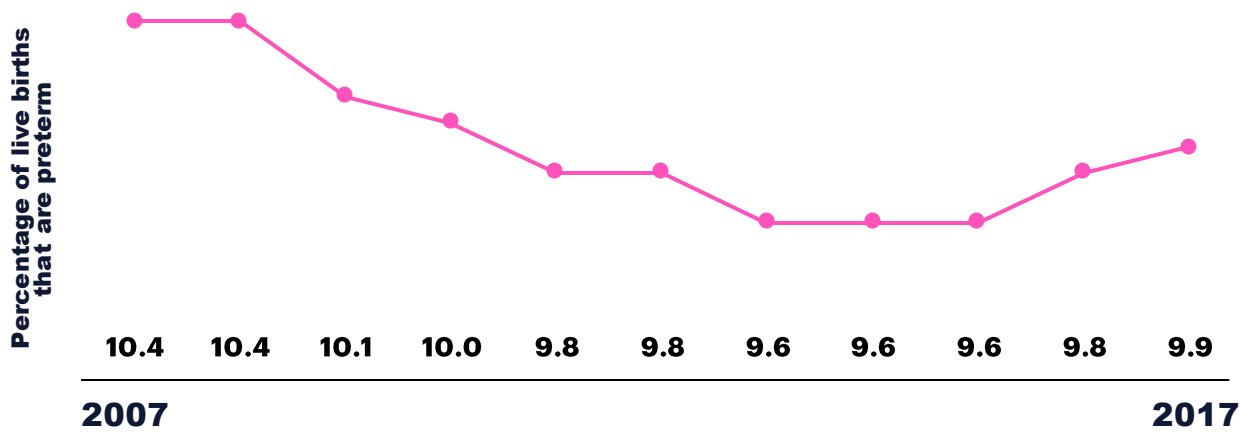
UNITED STATES

GRADE

C

PRETERM BIRTH RATE

9.9%



Grade and Range	A 8.1 or less	B 8.2 – 9.2	C 9.3 – 10.3	D 10.4 – 11.4	F 11.5 or greater

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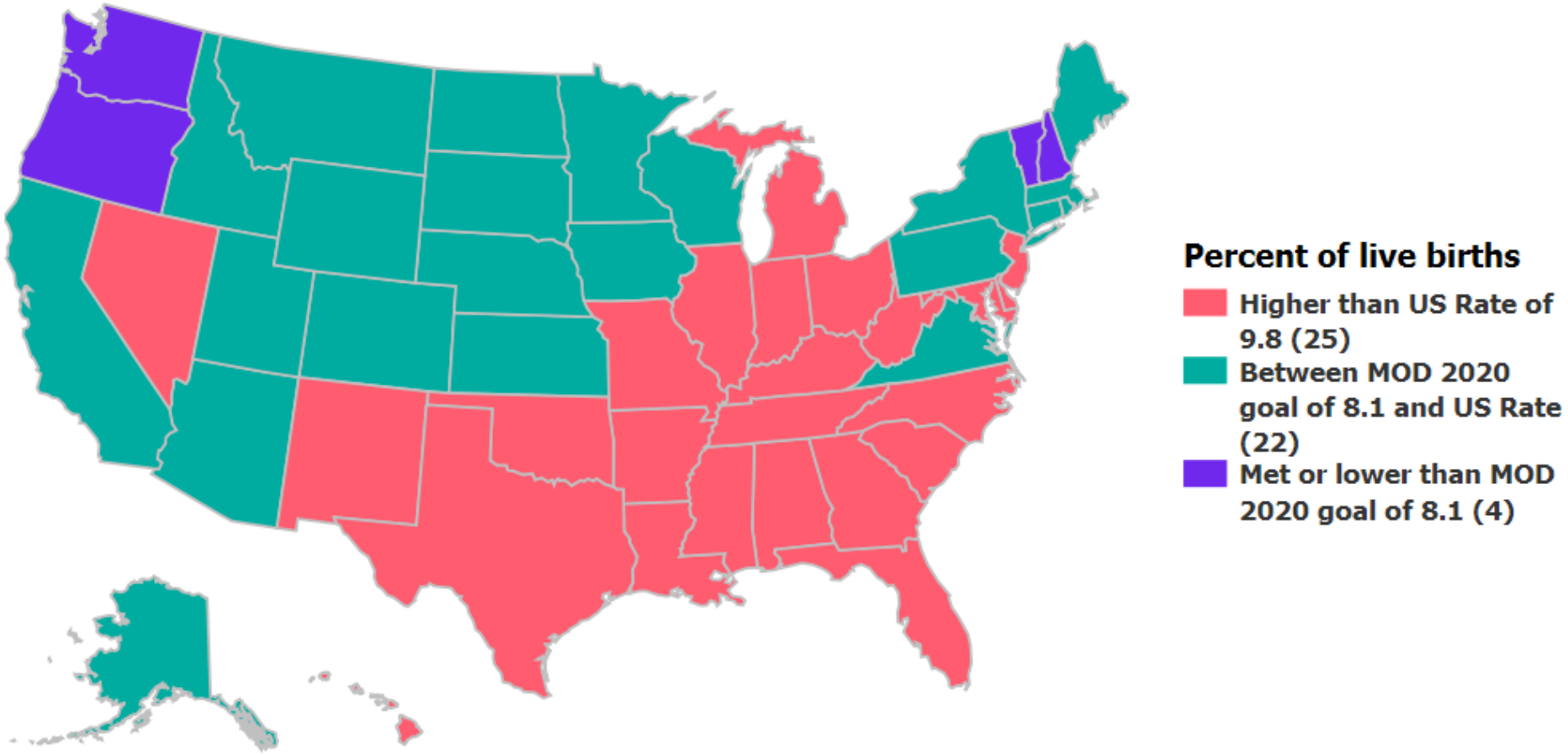
Preterm is less than 37 weeks gestation based on obstetric estimate.
Source: National Center for Health Statistics, 2007-2017 natality data

PRETERM BIRTH

UNITED STATES, 2016



Preterm is less than 37 weeks of pregnancy.

Source: National Center for Health Statistics, final natality data. Retrieved October 17, 2018, from www.marchofdimes.org/peristats.

2018 PREMATURE BIRTH REPORT CARD

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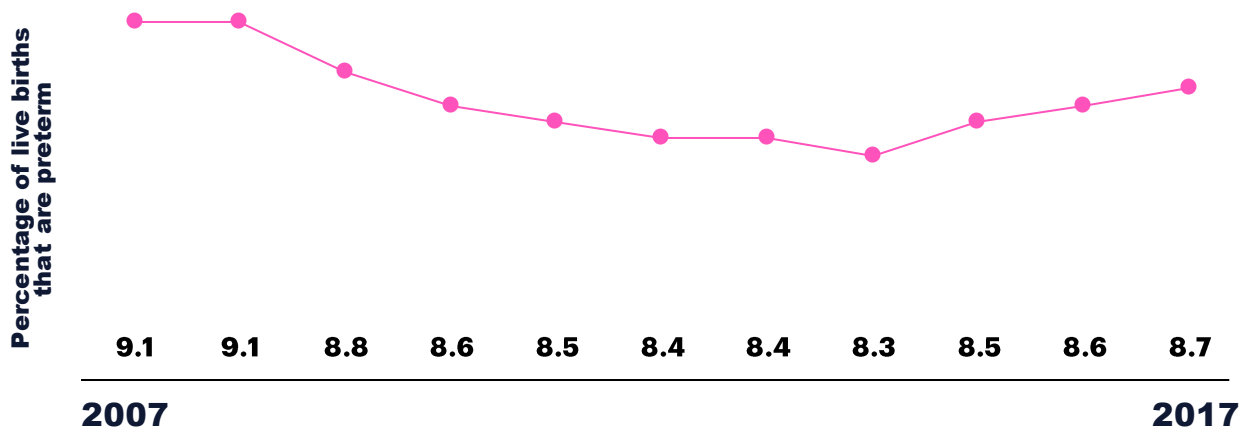
CALIFORNIA

GRADE

B

PRETERM BIRTH RATE

8.7%



Grade and Range	A 8.1 or less	B 8.2 – 9.2	C 9.3 – 10.3	D 10.4 – 11.4	F 11.5 or greater

Preterm is less than 37 weeks gestation based on obstetric estimate.
Source: National Center for Health Statistics, 2007-2017 natality data

2018 PREMATURE BIRTH REPORT CARD

COUNTIES IN CALIFORNIA

Counties with the greatest number of births are graded based on their 2016 preterm birth rates.

COUNTY	GRADE	PRETERM BIRTH RATE	CHANGE FROM LAST YEAR	COUNTY	GRADE	PRETERM BIRTH RATE	CHANGE FROM LAST YEAR
Alameda	B	8.4%	Worsened	Sacramento	B	8.5%	Worsened
Contra Costa	B	9.1%	Worsened	San Bernardino	C	9.3%	Worsened
Fresno	B	9.2%	Improved	San Diego	B	8.5%	Worsened
Kern	C	9.5%	Worsened	San Francisco	B	8.3%	Worsened
Los Angeles	B	9.0%	Worsened	San Joaquin	B	8.9%	Improved
Orange	A	8.0%	Worsened	San Mateo	B	8.2%	Improved
Riverside	B	8.5%	Worsened	Santa Clara	A	8.1%	No Change
				Ventura	A	7.5%	Improved

Grade and Range	A 8.1 or less	B 8.2 – 9.2	C 9.3 – 10.3	D 10.4 – 11.4	F 11.5 or greater

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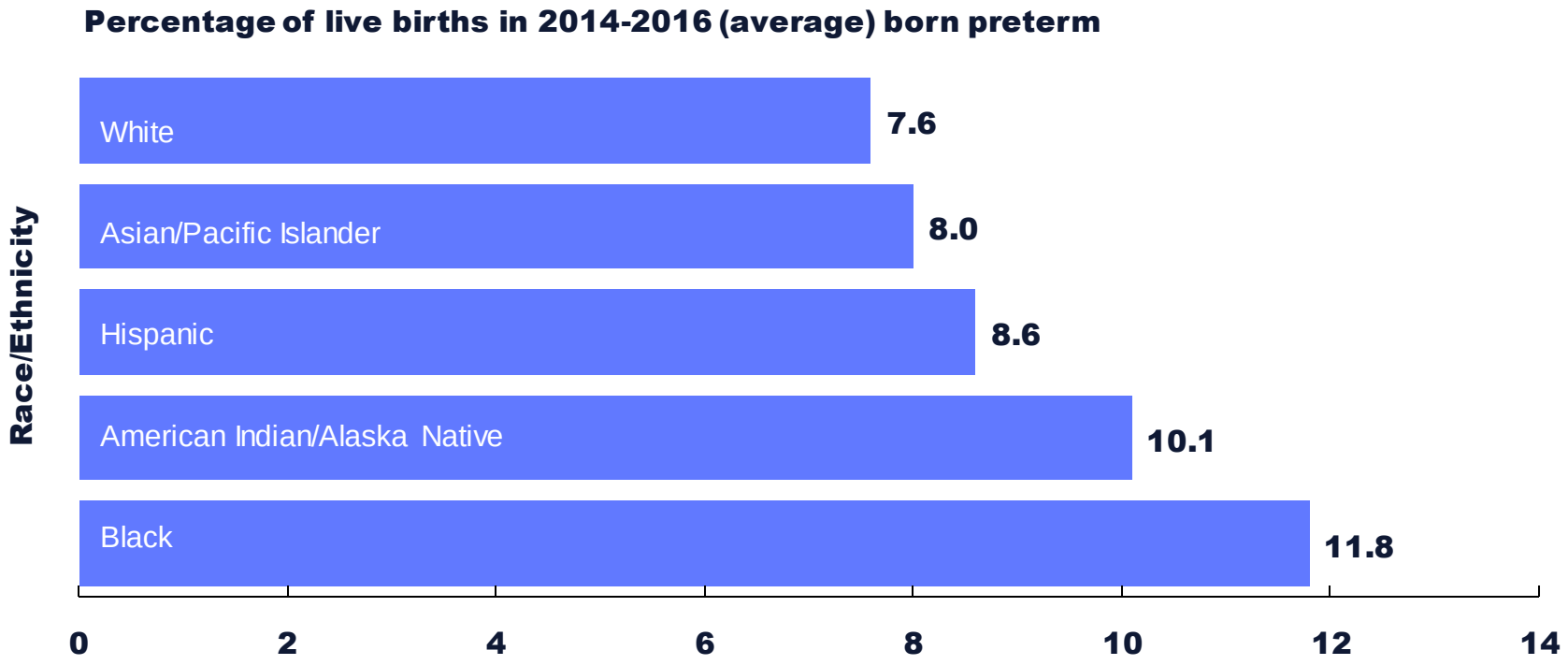
Preterm is less than 37 weeks gestation based on obstetric estimate.
Source: National Center for Health Statistics, final 2016 natality data.

MARCHOFDIMES.ORG/REPORTCARD

2018 PREMATURE BIRTH REPORT CARD

RACE & ETHNICITY IN CALIFORNIA



In California, the preterm birth rate among black women is 44% higher than the rate among all other women.

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Preterm is less than 37 weeks gestation based on obstetric estimate.
Race categories include only women of non-Hispanic ethnicity.
Source: National Center for Health Statistics, 2014-2016 natality data

NOT A “THOSE PEOPLE” PROBLEM, BUT AN “US” PROBLEM

March of Dimes Birth Equity Initiative

CONNECT AND CONVENE THOUGHT LEADERS	FACILITATE COLLECTIVE ACTION	ADVOCATE FOR POLICY AND SYSTEM CHANGES	ACCELERATE EVIDENCE-BASED PROGRAMS AND CARE INNOVATION	CONDUCT RIGOROUS DATA ANALYSES AND SUPPORT RESEARCH	TRAIN FUTURE LEADERS AND STRENGTHEN COMMUNITIES

Resources

Prematurity Collaborative	Perinatal Data Center	Center for Social Science Research
Prematurity Research Centers	Advocacy Network - OGA	#blanketchange
MCH and NICU Innovation	National Service Partners/ Volunteers	Fundraising/Donors

Using Collective Impact LOCALLY to Improve the Health of All Moms and Babies

THE CAMPAIGN

#BlanketChange is a movement committed to taking every action in preventing the tragic and preventable deaths of mothers during pregnancy and after childbirth.

Using the image of the iconic receiving blanket that hospitals swaddle newborns in, we're asking people to raise awareness of this health crisis by making their voices heard to demand **#BlanketChange** on behalf of our nation's moms and babies.

BLANKET MEMORIAL ON THE NATIONAL MALL

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NOWHERE TO GO: MATERNITY CARE DESERTS ACROSS THE U.S.

MORE THAN 5,300,000 WOMEN LIVE IN A MATERNITY CARE DESERT

53% OF U.S. COUNTIES DO NOT HAVE A HOSPITAL OFFERING OBSTETRIC SERVICES

1.1 MILLION WOMEN LIVE IN A MATERNITY CARE DESERT IN A LARGE METROPOLITAN AREA

179 RURAL COUNTIES LOST HOSPITAL BASED OBSTETRIC SERVICES BETWEEN 2004 AND 2014

48% OF U.S. COUNTIES LACK A SINGLE OB-GYN

are services for women during pregnancy, delivery and postpartum.[1,2] the U.S. each year.[3] Access to quality maternity care is a critical sitive birth outcomes, especially in light of the high rates of maternal ty in the U.S. A ***maternity care desert*** is a county in which access to d or absent, either through lack of services or barriers to a woman's begins to identify these areas by looking at the availability of hospitals, ay for that care through health insurance.

y 700 women die of childbirth[4] and more than 50,000 rbidity, a life-threatening livery.[5] Despite many countries their maternal mortality rates her than most other high-income lity rate has increased over the , a significant racial and ethnic he U.S., with black women being m pregnancy-related causes also geographical disparities,

KEY FINDINGS

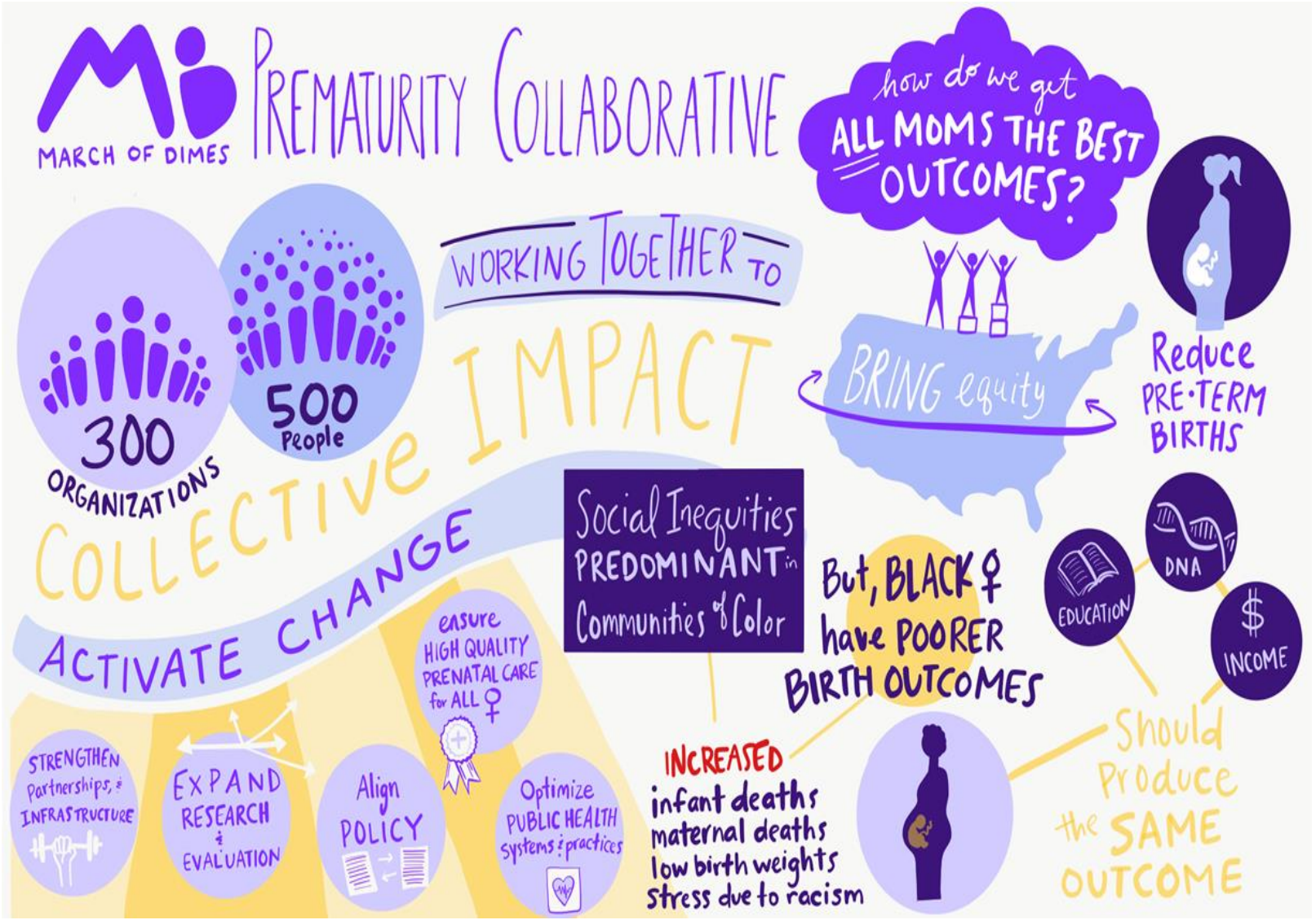
More than 5 million women live in maternity care deserts (1,085 counties) that have no hospital offering obstetric care and no OB providers.

For the first time, this report combines both of these factors to identify maternity care deserts.

PREMATURITY COLLABORATIVE

GOAL: To achieve equity and demonstrated improvements in preterm birth

PURPOSE: To engage diverse organizations, drawing on their unique expertise problem solve together using collective action, shared strategy and metrics.



PREMATURITY COLLABORATIVE CO-CHAIRS

Wanda D. Barfield, MD, MPH, FAAP,
RADM, U.S. Public Health Service

Director, Division of Reproductive Health, National Center for Chronic Disease Prevention and Health Promotion

Lisa F. Waddell, MD, MPH
March of Dimes

Senior Vice President, Maternal and Child Health/NICU Innovation & Interim Chief Medical Officer

PREMATURITY COLLABORATIVE STRATEGIC MAP

ACHIEVE EQUITY AND DEMONSTRATED IMPROVEMENTS IN PRETERM BIRTH

	A	B	C	D	E
	Increase effective use of evidence-informed clinical and public health practice	**Expand discovery and accelerate translation and innovation**	**Align multi-level support to improve health equity**	**Develop and implement messaging, policy & practice strategies**	**Secure the funding and resources required for success**
	The Clinical and Public Health Practice Workgroup has the following objectives:	The Research Workgroup has the following objectives:	The Health Equity Workgroup has the following objectives:	The Policy and Communications Workgroups have the following objectives:	The Funding and Resources Workgroup has the following objectives:
1	Optimize public health systems and strategies to improve the health of women and adolescents	Implement public health/community-based research and program evaluation	Foster and support community/place-based leadership and engagement	Tell the right story to each audience in a compelling way	Align and strengthen staffing and infrastructure
2	Optimize clinical practices to improve the health of women and adolescents	Expand basic, translational, clinical and health services research	Foster and support population-based solutions	Coalesce partners to support common messaging	Identify, cultivate relationships and prioritize potential funders/resources
3	Support strategies to increase the intentionality of pregnancy	Research effective adaptation and implementation of evidence to improve precision	Align federal, tribal, state, territorial, local and community policy initiative	Integrate messaging with other campaigns/ efforts	Improve "asks" to secure funding and coordinate where appropriate
4	Ensure all women receive high quality prenatal care	Provide career support for multi-level/multi-degree investigators	Partner across sectors to impact the root causes of inequity	Engage partners to advocate policies supporting preterm birth goals	Provide appropriate funder and partner recognition
5	Ensure appropriate care for all women with prior preterm birth	Foster collaborative community learning		Establish a federal home for preterm birth efforts	Align payment/ funding with desired outcomes
F	**Emphasize the health of women and adolescents**				
G	**Engage families, communities and other strategic partners across sectors through a collaborative infrastructure**				
H	**Optimize the use of data and evaluation to drive learning and success**				

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HEALTH EQUITY WORKGROUP CO-CHAIRS

Fleda Mask Jackson, PhD
Founder, Save 100 Babies
President and CEO, Majaica, LLC
University Affiliate, Columbia University

Arthur R. James, MD, FACOG
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Wexner Medical Center
The Ohio State University

Diana Ramos, MD, MPH, FACOG
Associate Clinical Professor in
Obstetrics and Gynecology,
Keck University of Southern California
School of Medicine
Co-Chair National Preconception Council

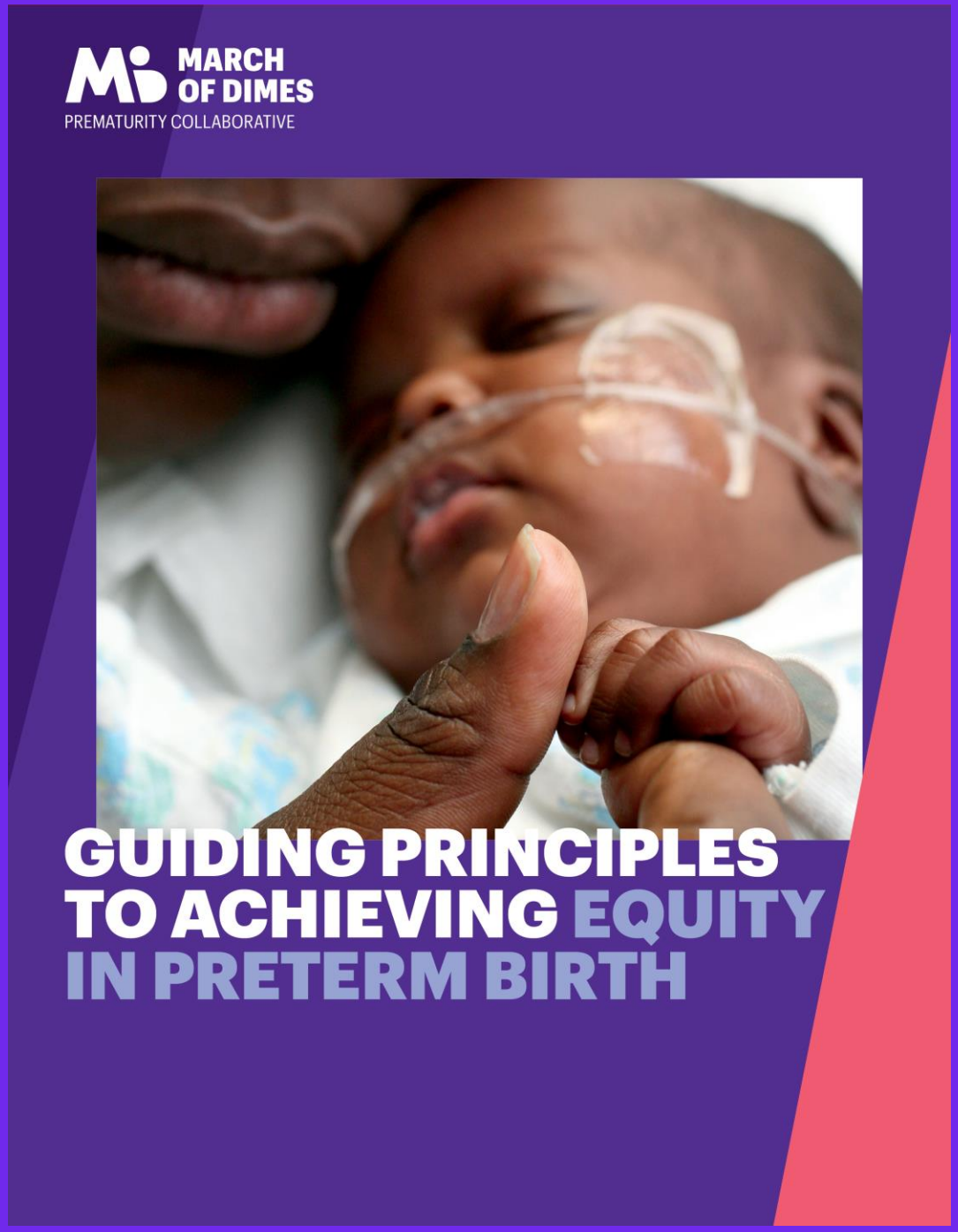
GUIDING PRINCIPLES

MARCHOFDIMES.ORG/COLLABORATIVE

GOAL: Establish key equity terms and concepts for all Collaborative members to use to guide their work

Subgroup of Health Equity workgroup convened to discuss structure, content and format of document.

Document builds on 2017 Robert Wood Johnson Foundation report, “What is Health Equity?”



CONSENSUS STATEMENT

GOAL: Share the value and contributions of the social sciences to understanding and potential solving the problem of birth inequities.

Subgroup of Health Equity Workgroup convened to discuss structure, content and format of consensus statement.

Small writing team assembled to develop content based on initial outline.

Document includes:

1. Core values
2. Call to Action

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PREMATURITY COLLABORATIVE

CONSENSUS STATEMENT

BIRTH EQUITY FOR MOMS AND BABIES

Advancing social determinants pathways for research, policy and practice

BACKGROUND

Founded by President Franklin D. Roosevelt in 1938 to drive the discovery of a polio vaccine, March of Dimes succeeded in this mission and provided all children with access to this lifesaving therapy. Throughout his 12 years in the White House, President Roosevelt continued his crusade to improve the lives of children by proposing economic solutions across the nation to ensure fair wages, decent housing, appropriate medical care and quality education (Franklin D. Roosevelt Presidential Library and Museum, no date). President Roosevelt's pursuit of economic and social equality and the human rights work of First Lady Eleanor Roosevelt offer critical insight for the current work of March of Dimes (Glendon, 2001).

The mission of March of Dimes today is to lead the fight for the health of all moms and babies. Nearly half a million babies in the U.S. are born prematurely each year. Women of color are up to 50 percent more likely than white women to give birth prematurely, and their children can face a 130 percent higher infant death rate than children born to white women (March of Dimes Perinatal Data Center, 2018). In this country, black women have maternal death rates over three times higher than women of other races (Callaghan, 2012). In addition to the human toll, the societal cost of premature birth is at least $26 billion per year (Institute of Medicine, 2007).

APPROACH TO GENERATING CONSENSUS

In response to the rising rates of preterm birth as well as persistent racial and ethnic disparities, the March of Dimes Prematurity Collaborative (Collaborative) was formed in 2017 to achieve equity and demonstrated improvements in premature birth. Equity is justice and fairness (Braveman, Arkin, Orleans, Proctor & Plough, 2017; March of Dimes, 2018).

It implies equal rights, but it is not the same as equality. Equity requires directing more resources to groups that have greater needs due to a history of exclusion or marginalization (March of Dimes, 2018). In 2018, the Collaborative expanded its focus to include the health of moms because strategies used to address premature birth and its associated disparities can help prevent other maternal health problems.

Recent trends in prematurity and maternal death demand a deeper examination into causes and contributors of disparities for Native American and African-American women, the groups of women with the most disparate birth and maternal outcomes (Centers for Disease Control and Prevention, 2018 a,b). Psychosocial and economic factors, along with physical environments that affect maternal and birth outcomes, should be considered in any examination into root causes of birth and maternal disparities (Schroeder, 2007). This consensus statement examines social factors that contribute to birth and maternal health outcomes, including prematurity and offers guidance to:

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Thank you!

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