COLLABORATIVE APPROACHES TO ACCELERATING PROGRESS IN EQUITY AND REDUCING PRETERM BIRTHS

Lisa Waddell, MD, MPH
Senior Vice President MCH & NICU Innovation
March of Dimes
The following personal financial relationships with commercial interests relevant to this presentation existed during the past 12 months:

No relationships to disclose
MARCH OF DIMES LEADS THE FIGHT FOR THE HEALTH OF ALL MOMS AND BABIES.
Puerto Rico is not included in the United States total. Preterm is less than 37 completed weeks of gestation, based on obstetric estimate of gestational age.

Source: Preterm birth rates are from the National Center for Health Statistics, 2017 final natality data. Grades assigned by March of Dimes Perinatal Data Center.
Gestational age is based on obstetric estimate.
Race categories include only women of non-Hispanic ethnicity.
Source: National Center of Health Statistics, 2014-2016 natality data
Prepared by March of Dimes Perinatal Data Center, November 2018
DISPARITIES IN PREMATURITY

Percentage of live births in 2014-2016 (average) born preterm

- Asian/Pacific Islander: 8.6%
- White: 8.9%
- Hispanic: 9.2%
- American Indian/Alaska Native: 10.8%
- Black: 13.4%

In United States, the preterm birth rate among black women is 49% higher than the rate among all other women.

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

Preterm birth rates are increasing for everyone, especially women of color.

Preterm birth rates by maternal race/ethnicity, U.S.

- White: 9.1% in 2014, 13.6% in 2016 (2% increase)
- Black: 9.4% in 2014, 13.6% in 2016 (3% increase)
- Hispanic: 8.8% in 2014, 11.3% in 2016 (5% increase)
- Asian / Pacific Islander: 8.8% in 2014, 11.3% in 2016 (5% increase)
- American Indian / Alaska Native: 11.3% in 2014, 11.3% in 2016 (9% increase)

Percent change between 2014 & 2016

Premature/preterm is less than 37 weeks of gestation. Preterm birth rate is defined as the percentage of live births born preterm.
Maternal rate based on "bridged" race; race categories exclude Hispanics.
Source: National Center for Health Statistics, 2014 and 2016 natality data.
Prepared by March of Dimes Perinatal Data Center, February 2018.
TO ACHIEVE EQUITY AND IMPROVEMENTS IN PRETERM BIRTH

We must:
1. Accelerate the use of evidence-based interventions
2. Address social determinants
3. Advance research
4. Harness collective action and partnerships to drive results

How will we accomplish all of that?

We build a Collaborative!
GOALS & PURPOSE

GOAL: To achieve equity and demonstrated improvements in preterm birth

PURPOSE: To engage and convene a wide array of organizations, drawing on their unique expertise to problem solve together, create solutions and drive improvements in preterm birth and equity using our collective action and shared strategy and metrics.
<table>
<thead>
<tr>
<th>A</th>
<th>B</th>
<th>C</th>
<th>D</th>
<th>E</th>
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<tbody>
<tr>
<td><strong>Increase effective use of evidence-informed clinical and public health practice</strong></td>
<td><strong>Expand discovery and accelerate translation and innovation</strong></td>
<td><strong>Align multi-level support to improve health equity</strong></td>
<td><strong>Develop and implement messaging, policy &amp; practice strategies</strong></td>
<td><strong>Secure the funding and resources required for success</strong></td>
</tr>
<tr>
<td>The Clinical and Public Health Practice Workgroup has the following objectives:</td>
<td></td>
<td>The Research Workgroup has the following objectives:</td>
<td>The Health Equity Workgroup has the following objectives:</td>
<td>The Funding and Resources Workgroup has the following objectives:</td>
</tr>
<tr>
<td>1</td>
<td><strong>Optimize public health systems and strategies to improve the health of women and adolescents</strong></td>
<td>Implement public health/community-based research and program evaluation</td>
<td>Foster and support community/place-based leadership and engagement</td>
<td>Tell the right story to each audience in a compelling way</td>
</tr>
<tr>
<td>2</td>
<td><strong>Optimize clinical practices to improve the health of women and adolescents</strong></td>
<td>Expand basic, translational, clinical and health services research</td>
<td>Foster and support population-based solutions</td>
<td>Coalesce partners to support common messaging</td>
</tr>
<tr>
<td>3</td>
<td><strong>Support strategies to increase the intentionality of pregnancy</strong></td>
<td>Research effective adaptation and implementation of evidence to improve precision</td>
<td>Align federal, tribal, state, territorial, local and community policy initiative</td>
<td>Integrate messaging with other campaign/efforts</td>
</tr>
<tr>
<td>4</td>
<td><strong>Ensure all women receive high quality prenatal care</strong></td>
<td>Provide career support for multi-level/multi-degree investigator goals</td>
<td>Partner across sectors to impact the root causes of inequity</td>
<td>Engage partners to advocate policies supporting preterm birth goals</td>
</tr>
<tr>
<td>5</td>
<td><strong>Ensure appropriate care for all women with prior preterm birth</strong></td>
<td>Foster collaborative community learning</td>
<td>Establish a federal home for preterm birth efforts</td>
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<tbody>
<tr>
<td><strong>Emphasize the health of women and adolescents</strong></td>
<td>Engage families, communities and other strategic partners across sectors through a collaborative infrastructure</td>
<td>Optimize the use of data and evaluation to drive learning and success</td>
</tr>
</tbody>
</table>
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 TIMELINE (2016-2017)

- **Feb. 2016:** Clarion Group begins to facilitate planning
- **April 2016:** Key informant interviews & collected surveys
- **June 2016:** Prematurity Collaborative Strategic Map developed
- **May 2016:** In-person strategic planning meeting with partners
- **Feb. 2017:** 1st Clinical Public Health Practice & Health Equity work group meetings held
- **Nov. 2016:** 1st Steering Committee Meeting
- **July 2017:** 1st Communications Workgroup convenes in person
- **Sept. 2017:** 1st Policy Workgroup meeting
March 2018: Members of the Research Work Group convene to discuss a scientific consensus statement

Spring 2018: 1st workgroup projects posted to www.marchofdimes.org/collaborative

May 2018: Release of The Guiding Principles to Achieving Equity in Preterm Birth

May 2018: 1st in-person Full Collaborative Meeting. Prematurity Prevention Summit: Building a Birth Equity Movement and Prematurity Collaborative announces move to shared measures & collective action

July 2018: 1st Joint workgroup meeting held resulting in 1st joint work plan

Aug. 2018: Full Collaborative meeting features 3 local collaboratives focused on equity & birth outcomes

Sept. 2018: Finalized 2018/2019 workgroup work plans
CONSIDERATIONS & NEXT STEPS

1. To build a shared vision to drive equity and demonstrated improvements in preterm birth prevention.

2. To define our shared strategy and essential next steps to continue the momentum.

3. To have workgroups develop shared activities based on an open process, allowing for national spread and both national and local implementation.

4. To develop shared measures including population indicators and performance metrics to hold us all accountable for driving improvements and changing lives.

5. To engage and incorporate local leaders and local collaboratives on every level of the work.

6. To continue process improvement within the Collaborative to maintain a smooth operation and adjust for any changes.
POLICY WORKGROUP CO-CHAIRS

Andrea Kane, MPA
Vice President Policy & Strategic Partnerships, Power to Decide

Cindy Pellegrini
Senior Vice President, Public Policy & Government Affairs, March of Dimes
POLICY GOALS AND STRATEGY

Goal: Develop and implement messaging, policy & practice strategies

The Work Group has the following objectives to help meet this goal:

• Integrate messaging with other campaigns/efforts
• Engage partners to advocate policies supporting preterm birth goals
• Establish a federal home for preterm birth efforts
HISTORY, ACCOMPLISHMENTS & LESSONS LEARNED

• Launched initially in September 2017; the group meets monthly
• Currently, 165 Policy Work Group Members
• Early meetings focused on:
  1. Identification of issues members were working on and where members would like to work together
  2. Prioritization of advocacy initiatives that address social determinants of health and highlighting promising approaches
• Through work group meetings, surveys and consensus building, a work plan was created
• LESSONS LEARNED:
  • Consensus building and an open, transparent process are important
  • Leveraging existing efforts across the collaborative is critical
  • Engaging all Collaborative members to extend and spread work will be tested
  • Continuous integration of work with other work groups further is a goal
2018/2019 WORK PLAN

1. Create, implement and secure collective action across the Collaborative for three policy initiatives:
   a) Funding/support for group prenatal care in Medicaid
   b) Postpartum Medicaid coverage extension
   c) Medicaid expansion

2. Create a portal for members to share advocacy materials on a range of policies to prevent preterm birth and improve equity.

3. In partnership with the Clinical Public Health Practice and Health Equity work groups, create a toolkit or resource guide for group prenatal care-including integration of doulas and community health workers.
JOIN THE PREMATURITY COLLABORATIVE!

USE ONE OF TWO WAYS TO SIGN UP FOR A WORKGROUP:

1. Complete the sign-up form on our website at: marchofdimes.org/collaborative

2. Email us at: collaborative@marchofdimes.org
Clinical & Public Health Practice (CPHP) Workgroup

Vanessa Lee, MPH, Infant Mortality CoIIN Coordinator, Co-Chair, Clinical & Public Health Practice Workgroup

Division of Healthy Start and Perinatal Services
Maternal and Child Health Bureau (MCHB)
Health Resources and Services Administration (HRSA)
Clinical and Public Health Practice (CPHP) Workgroup Co-Chairs

- **Vanessa Lee, MPH**
  Infant Mortality CoIIN Coordinator, HRSA/MCHB

- **Christopher Zahn, MD**
  Vice President, Practice Activities, ACOG
Overall GOAL: Increase effective use of evidence-informed clinical and public health practice

- **Objectives to help meet this goal:**
  - Optimize Public Health Systems and Strategies, and Clinical Practices, to Improve the Health of Women and Adolescents
  - Support Strategies To Increase The Intentionality Of Pregnancy
  - Ensure All Women Receive High Quality Prenatal Care
  - Ensure Appropriate Care For All Women With Prior Preterm Birth
CPHP Work Group History

• Launched in February of 2017; the group meets every other month
• Currently, over 260 Clinical & Public Health Practice Work Group Members
• Early meetings focused on sharing best practices, identifying priority focus areas, and establishment of a work plan
  ✓ 17P and Low Dose Aspirin prioritized for Year 1
AIM #1: Increase access to & utilization of 17P

- SUPPORT STATES WITH LEGISLATIVE STRATEGIES TO IMPROVE ACCESS AND UTILIZATION OF 17P
- REDUCE BARRIERS TO PRIOR-AUTHORIZATION, AS SELF-REPORTED BY HEALTH CARE ORGANIZATIONS
- PROVIDING SUPPORT TO STATES ON ALTERNATIVE MODELS OF MEDICATION DELIVERY AND PATIENT EDUCATION STRATEGIES

AIM #2: Increase access to & utilization of low dose aspirin (LDA) to Prevent Preeclampsia

- INCREASE AWARENESS OF USPSTF & ACOG RECOMMENDATIONS FOR LDA TO PREVENT PREECLAMPSIA
Early Accomplishments & Lessons Learned

YEAR 1 ACCOMPLISHMENTS

• Conducting Webinars/Learning Series on 17P & LDA
• Developing and publishing 17P resources on patient education and model legislation at marchofdimes.org/collaborative
• Membership from all levels: national, state, local, and community
YEAR 1 LESSONS LEARNED

• Need for more focus on equity within our strategies/priority topic areas
• There is still more work that can be done in access to, and use of, 17P and LDA
• Time and resources are needed to apply learnings/information from Year 1 into action
• “Magic mix” of clinical providers, public health and community/consumers
<table>
<thead>
<tr>
<th>ACTIVITY/AIM</th>
<th>STRATEGIES</th>
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<tbody>
<tr>
<td>Advocate for PTB prevention clinical best practices to be quality measures</td>
<td>Optimize clinical practices to improve the health of women and adolescents. Ensure all women have appropriate prenatal care.</td>
</tr>
<tr>
<td>Develop a preterm birth prevention bundle</td>
<td>Optimize Clinical practices to improve the health of women and adolescents. Ensure all women receive high quality prenatal care. Ensure appropriate care for women with a previous preterm birth.</td>
</tr>
<tr>
<td>Identification or creation of a universal screening tool to identify social risk factors that may influence birth outcomes</td>
<td>Optimize Clinical / Public Health systems and Practices to improve the health of women and adolescents. Ensure all women receive high quality prenatal care. Foster and support population based solutions.</td>
</tr>
<tr>
<td>Toolkit or resource guide related to Group Prenatal Care- including integration of doulas and CHW’s</td>
<td>Optimize Clinical / Public Health systems and Practices to improve the health of women and adolescents. Ensure all women receive high quality prenatal care. Foster and support population based solutions.</td>
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• Advocate for PTB prevention clinical best practices to be quality measures
• Develop a preterm birth prevention bundle

**JOINT HEALTH EQUITY, POLICY, AND CLINICAL & PUBLIC HEALTH PRACTICE WORK PLAN ACTIVITIES**

• Identification or creation of a universal screening tool to identify social risk factors that may influence birth outcomes
• Toolkit or resource guide related to Group Prenatal Care-including integration of doulas and CHW’s
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Public Health Analyst
Division of Healthy Start and Perinatal Services
Maternal and Child Health Bureau (MCHB)
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Fleda Mask Jackson, PhD, Founder, Save 100 Babies
President and CEO, Majaica, LLC
University Affiliate, Columbia University
Co-Chair, Health Equity Work Group
PRESENTER DISCLOSURES

The following personal financial relationships with commercial interests relevant to this presentation existed during the past 12 months:

No relationships to disclose
HEALTH EQUITY WORKGROUP

GOAL: Align multi-level support to improve health equity

The Work Group has the following objectives to help meet this goal:

• Foster and support community/place-based leadership and engagement
• Foster and support population-based solutions
• Align federal, tribal, state, territorial, local and community policy initiative
• Partner across sectors to impact the root causes of inequity
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
Associate Clinical Professor, Dept OB/GYN,
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
WORK GROUP HISTORY

• Launched in February of 2017; the group meets every other month
• Currently, there are over 252 Health Equity Work Group Members
• Hired Health Equity Director, Kweli Rashied-Henry, to coordinate activities of the Health Equity Work Group
• Early meetings focused on sharing best practices and establishment of a work plan:
  • Soliciting best and promising practices
  • Highlighting Best Babies Zone- a place based initiative to improve birth outcomes and
  • Moms2Be a community based program to improve infant mortality and preterm birth in Ohio
LESSONS LEARNED

• Critical to set clear definitions and set a level playing field
• Important to develop guiding principles for use across the collaborative into other work groups to always emphasize equity
• Collaboration and communications across work groups is important for the health of the collaborative and to drive action
• It is important to have a designated administrator (backbone staff) to coordinate and participate in the production of workgroup products
• It is important to have co-chair dedication and support for each activity set forth in the work plan
1. **COMPLETE: Guiding principles:** Principles that will assist other workgroups towards ensuring that “equity” is at the forefront of thinking as they consider their work.

2. **COMPLETE: Glossary:** Definition of terms and concepts for all collaborative participants and workgroups.

3. **COMPLETE: Consensus statement:** A published document recognizing the many sciences contributing to equity and birth outcomes. The statement will address the valuable contribution that can be made by different forms of inquiry (biomedical sciences, social sciences, community-based participatory research, etc.).

4. **COMPLETE: Identify and spread best practices.** Hosted a number of organizations on work group meetings to share their success stories.
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.

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
CONTRIBUTING AUTHORS

FledaMask Jackson, PhD (Lead)
Martha R. Boisseau, MPH, CHES
Paula Braveman, MD, MPH
William Darity, PhD
Arthur R. James, MD, FACOG
Gina Legaz, MPH

Noble Maseru, PhD, MPH
Tyan Parker-Dominguez, PhD, MSW, MPH
Diana Ramos, MD, MPH, FACOG
Kweli Rashied-Henry, MPH
Lisa Waddell, MD, MPH
Donald Warne, MD, MPH
ADDITIONAL IMPETUS FOR THE CONSENSUS STATEMENT ON BIRTH EQUITY

- March of Dimes and Polio among African Americans
- President’s Franklin Roosevelt’s Economic Bill of Rights
- First Lady Eleanor Roosevelt and the Universal Declaration of Human Rights
CORE VALUES: WHAT WE BELIEVE IN

1. Health as a human right therefore quality, affordable and accessible healthcare should be available to all

2. All moms and babies should have every opportunity for optimal health

3. Equity is a directive for addressing social inequities that contribute to negative disparate birth and maternal health outcomes

4. Racial and gender discrimination, exclusionary practices and implicit bias must be undone
CORE VALUES: WHAT WE BELIEVE IN

5. Inclusion of the authoritative knowledge from communities of interest is paramount for equitable research, policy and practice

6. Social science disciplines and research methods should be used to examine root causes of birth and maternal health inequities in addition to exploring the community assets that promote health

7. Scientific pursuits should utilize equity frameworks for investigating root causes of racial and ethnic disparities in birth and maternal health outcomes

8. Knowledge and experience of historically underrepresented minorities should be prioritized including commensurate funding levels for their research
CALL TO ACTION: TRANSLATING CORE VALUES INTO ACTION STEPS

1. Collective will and resources are needed to achieve birth equity
2. Must end racism and discrimination to address needs of women and children
3. Advance equity-informed approaches to research and evaluation
4. Actively participate in social change to eliminate policies that are harmful to moms and babies and promote those that can address the social determinants of health
## OPPORTUNITIES AND CHALLENGES TO INTEGRATE RECOMMENDATIONS

<table>
<thead>
<tr>
<th>OPPORTUNITIES</th>
<th>CHALLENGES</th>
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<tbody>
<tr>
<td>Core values as benchmarks for measuring progress towards achieving goals</td>
<td>Incorporating measures using Results Based Accountability framework</td>
</tr>
<tr>
<td>Call to action recommendations to support Collaborative goal and workgroup’s charge</td>
<td>Tracking equity advancements across and beyond Collaborative members</td>
</tr>
<tr>
<td>Collective impact model conducive for action learning and leadership</td>
<td>Workgroup ownership leading to siloes</td>
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</tbody>
</table>
2018/2019 WORK PLAN

HEALTH EQUITY WORKGROUP WORK PLAN

1. Develop, publish and secure sign-on support for a consensus statement recognizing the many sciences contributing to equity and birth outcomes. The statement will address the valuable contribution that can be made by different forms of inquiry (biomedical sciences, social sciences, community-based participatory research, etc.).

In partnership with the Clinical Public Health Practice Workgroup, we will focus on:

2. Identification or creation of a universal screening tool to identify social risk factors that may influence birth outcomes.

In partnership with the Clinical Public Health Practice and Policy workgroups, we will focus on:

3. Creation of a toolkit or resource guide on group prenatal care integrated with doulas and community health workers.
Racial-Ethnic Disparities in Preterm Birth: The Role of Stress, Resilience & Social Determinants

Michael C. Lu, MD, MPH
Senior Associate Dean for Academic, Faculty & Student Affairs
Professor, Department of Prevention & Community Health
Milken Institute School of Public Health
George Washington University

2018 American Public Health Association Meeting & Expo
Accelerating Progress in Reducing Preterm Births: National, State and Local Collaborative Solutions
San Diego, CA
November 13, 2018
Personal Disclosure

The following personal financial relationships with commercial interests relevant to this presentation existed during the past 12 months:

No relationships to disclose
Reducing disparities and achieving equity in birth outcomes in our Nation will require building resilience downstream, fighting injustice upstream, and creating the social conditions in which women and families can be healthy across the life course.
Chronic Stress
Allostasis & Allostatic Load

Allostasis: Maintaining Stability through Change

Allostasis Load: Wear & Tear from Chronic Stress

Weathering

How does stress get inside the womb?

- Hypothalamus
- Pituitary
- Adrenal

CRH
ACTH

Maternal Cortisol
Norepinephrine

Mother

Placenta

CRH

Fetal Cortisol
DHEA-S

11-B HSD II

Fetus

Hypothalamus

Pituitary

Adrenal
HOW STRESS CHANGES A CHILD’S BRAIN

3-YEAR-OLD CHILDREN

- Prolonged exposure to trauma triggers physiological changes in the brain.
- Neural circuits are disrupted, causing changes in the hippocampus, the brain’s memory and emotional centre.

- This can cause brain shrinkage, problems with memory, learning and behaviour.
- A child does not learn to regulate emotions when living in state of constant stress.
- Associated with greater risk of chronic disease and mental health problems in adulthood.
Developmental Origins of Health & Disease

How the Nine Months Before Birth Shape the Rest of Our Lives

ORIGINS

Annie Murphy Paul

How the first nine months shape the rest of your life

The new science of fetal origins

By Annie Murphy Paul
Prenatal Programming of the Hypothalamic-Pituitary-Adrenal Axis

Fig. 1. Schematic representation of the hypothalamic-pituitary-adrenal (HPA) axis. GR, glucocorticoid receptor; MR, mineralocorticoid receptor; PVN, paraventricular nucleus; CRH, corticotropin-releasing hormone; AVP, arginine vasopressin; ACTH, adrenocorticotropic hormone.

Environmental exposures, stresses, diet, and lifestyle can all induce epigenetic changes that determine whether genes are turned on or off.

Life Course Perspective

Life-Course Perspective

• Birth outcomes are the end product of not only the nine months of pregnancy, but the entire life course of the woman
  • Disparities in birth outcomes are the consequences of not only differential exposures during pregnancy, but differential early life experiences and cumulative weathering over the life course

• Improving birth outcomes and reducing disparities will first require improving women’s health not only during pregnancy, but before and between pregnancies and across the life course.
  • Improving birth outcomes will take more than improving healthcare; it will take improving social conditions for girls and women across their life course

Racial and ethnic disparities in preterm birth: The role of stressful life events

Michael C. Lu, MD, MPH, Belinda Chen, MPH

Department of Obstetrics and Gynecology, David Geffen School of Medicine at UCLA, Department of Community Health Sciences, and the Center for Healthier Children, Families and Communities, UCLA School of Public Health, Los Angeles, Calif

Received for publication January 7, 2004; revised March 10, 2004; accepted April 23, 2004

KEY WORDS
Preterm birth
Racial-ethnic disparity
Stressful life event

Objective: The purpose of this study was to examine racial-ethnic disparities in stressful life events before and during pregnancy and to assess the relationship between stressful life events and racial-ethnic disparities in preterm birth.

Study design: Using data from the Pregnancy Risk Assessment Monitoring System, we conducted a retrospective cohort analysis of a sample of 33,542 women from 19 states who were delivered of a live-born infant in 2000. Principal component analysis was used to group 13 stressful life events into 4 stress constructs: emotional, financial, partner-related, and traumatic. Racial-ethnic disparity...
Maternal Lifetime Exposure to Interpersonal Racism In 3 or More Domains and Infant Birth Weight

(Collins et al, AJPH, 2004)
Closing the Black-White Gap in Birth Outcomes:
A 12-Point Plan

1. Provide interconception care to women with prior adverse pregnancy outcomes
2. Increase access to preconception care for African American women
3. Improve the quality of prenatal care
4. Expand healthcare access over the life course
5. Strengthen father involvement in African American families
6. Enhance service coordination and systems integration
7. Create reproductive social capital in African American communities
8. Invest in community building and urban renewal
9. Close the education gap
10. Reduce poverty among Black families
11. Support working mothers and families
12. Undo racism

Resilience
How to Build Resilience

- **Individual**
  - Mindfulness, meditation, exercise
  - Cognitive-behavioral therapy
  - Trauma-informed care

- **Interpersonal**
  - Partner or family support
  - Social support (e.g. group prenatal care)

- **Community**
  - Social capital
  - Address institutionalized racism

---

**WHERE IS THE F IN MCH? FATHER INVOLVEMENT IN AFRICAN AMERICAN FAMILIES**

**Objectives:**
1. Review the historical contexts and current profiles of father involvement in African American families;
2. Identify barriers to, and supports of, involvement; and
3. Evaluate the effectiveness of father involvement programs;
4. Recommend directions for future research.

**Methods:**
Review of observational and interventional studies on father involvement.

**Results:**
Several historical developments (e.g., declining employment for Black men and increases in the participation of Black women, and welfare policies that favored single mothers) led to father absence from African American families. Today, more than two thirds of Black infants are born to unmarried mothers. Even if unmarried fathers are actively involved, controlling for parental education, income and other factors, less is known about the male partner’s influence on maternal health. In ethnographic studies, pregnant African American women identified their male partner as a vital source of support or stress. A growing body of literature suggests that maternal psychosocial stress is an important risk factor for poor pregnancy outcomes.

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# Preventing Maternal & Infant Mortality: Improving Social Conditions

## The Five Conditions of Collective Impact

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<thead>
<tr>
<th>Condition</th>
<th>Description</th>
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<tbody>
<tr>
<td>Common Agenda</td>
<td>All participants have a shared vision for change including a common understanding of the problem and a joint approach to solving it through agreed upon actions.</td>
</tr>
<tr>
<td>Shared Measurement</td>
<td>Collecting data and measuring results consistently across all participants ensures efforts remain aligned and participants hold each other accountable.</td>
</tr>
<tr>
<td>Mutually Reinforcing Activities</td>
<td>Participant activities must be differentiated while still being coordinated through a mutually reinforcing plan of action.</td>
</tr>
<tr>
<td>Continuous Communication</td>
<td>Consistent and open communication is needed across the many players to build trust, assure mutual objectives, and create common motivation.</td>
</tr>
<tr>
<td>Backbone Support</td>
<td>Creating and managing collective impact requires a separate organization(s) with staff and a specific set of skills to serve as the backbone for the entire initiative and coordinate participating organizations and agencies.</td>
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</tbody>
</table>

Preventing Maternal & Infant Mortality: Going Upstream

As much as we like to fix MCH problems with MCH programs and services, tackling the root causes of maternal & infant mortality will require political and policy change.
Preventing Maternal & Infant Mortality: Going Upstream

President’s Budget 2019

- Cuts Medicaid by $1.4 trillion over 10 years
- Cuts SNAP (food stamps) by 17.2B in FY2019, and $213.5B over 10 years
- Cuts TANF by $21B over 10 years
- Cuts HUD budget by $6.8B, including $1B from Section 8
- Eliminates Low Income Heat and Energy Assistance Program ($3.4B)

Deregulation of Environmental Protection

- White House Cuts NASA Climate Monitoring Program
  May 9, 2018
- Threatened Species Protection Rule Under Review
  April 2, 2018
- EPA Starts Rollback of Car Emissions Standards
  April 2, 2018
- Trump Proposes Cuts to Climate and Clean-Energy Programs
  February 12, 2018
- Report: Trump Mulling Major Cuts to Clean Energy Research
  January 31, 2018
- **EPA LOOSENS REGULATIONS ON TOXIC AIR POLLUTION**
  January 25, 2018
- Most of National Parks Advisory Board Resigns in Protest
  January 15, 2018
- Report: Climate Change Web Sites ‘Censored’ Under Trump
  January 10, 2018

Preventing Maternal & Infant Mortality: Going Upstream
Rates of low birth weight (LBW) before and after Postville Raid by mother's ethnicity/nativity

2006-2008

Comparison period 2006
Comparison period 2007
37 weeks after raid 2008

Time Period

% LBW

Non-Latina White Mother
Foreign Born Latina Mother
US Born Latina Mother

2018/2019 WORK PLAN

1. Create, implement and secure collective action across the Collaborative for three policy initiatives:
   a) Funding/support for group prenatal care in Medicaid
   b) Postpartum Medicaid coverage extension
   c) Medicaid expansion

2. Create a portal for members to share advocacy materials (e.g. toolkits, model bill language, policy statements, white papers, testimony, etc.) on a range of policies to prevent preterm birth

2018/2019 JOINT WORK PLAN

The Policy Work Group plans to collaborate with both the Health Equity Work Group and Clinical Public Health Practice Workgroups to produce:

1. A toolkit or resource guide related to group prenatal care-including integration of doulas and community health workers. The Policy Workgroup will help provide sample policies, testimony, factsheets related to group prenatal care as well as support enhanced payment for group prenatal care.
State and Local Collaborative Solutions to Accelerate Progress in Reducing Preterm Births

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Presenter Disclosures

Connie Mitchell, MD, MPH

• The following personal financial relationships with commercial interests relevant to this presentation existed during the past 12 months:

• Dr. Mitchell has no relationships to disclose.
Outline of Presentation

- Share data regarding disparities in California maternal/infant health population indicators
- Provide additional insight on disparities and perinatal health from state MIHA Data
- Share how we have begun to talk differently about disparities in California
- Share how we have begun to act differently with examples from state and local level.
Disparities in Maternal Mortality Rate by Race/Ethnicity, 1999-2013

SOURCE: State of California, Department of Public Health, California Birth and Death Statistical Master Files, 1999-2013. Maternal mortality rates for California (deaths ≤ 42 days postpartum) were calculated using ICD-10 cause of death classification (codes A34, O00-O95,O98-O99). Produced by California Department of Public Health, Center for Family Health, Maternal, Child and Adolescent Health Division, May, 2015.
Disparities in Infant Mortality Rate by Race/Ethnicity, 2000-2015

Data Sources: California Birth Cohort Files, 2000-2015
Prepared by the Epidemiology, Surveillance and Federal Reporting, Maternal, Child and Adolescent Health Division, Center for Family Health
Disparities in Low Birthweight Births by Race/Ethnicity, 2007-2016

Note: Includes California resident live births with known birthweight. Low Birthweight is ≤2500 grams.
Source: California Department of Public Health, 2007-2016 Birth Statistical Master Files
Prepared by the Epidemiology, Surveillance and Federal Reporting, Maternal, Child and Adolescent Health Division, Center for Family Health
Disparities in Preterm Singleton Births by Race/Ethnicity, 2007-2016

Note: Includes California resident live births with gestational age range 17-47 weeks. Preterm is <37 weeks gestation.
Gestational age is based on obstetric estimate.
Source: California Department of Public Health, 2007-2016 Birth Statistical Master Files
Prepared by the Epidemiology, Surveillance and Federal Reporting, Maternal, Child and Adolescent Health Division, Center for Family Health
Disparities in Perinatal Health

HOW HAVE WE BEGUN TO TALK DIFFERENTLY?
Chronic worry about racial discrimination and Preterm Birth

- Stress may play an important role in PTB.
- Studies have linked racial discrimination to birth outcomes, presumably via stress.
- Racial discrimination can be experienced and measured in many different ways.
- Maternal and Infant Health Assessment survey:
  - Investigated worry about racial discrimination during her life, among women with a recent live birth;
  - Found that 37% of Black women with a recent live birth reported chronic worry about racism.
Chronic worry about racial discrimination was associated with preterm birth among Black women.

Reported chronic worry: 12.5% with preterm birth
Did not report chronic worry: 7.2% with preterm birth

Data source: Maternal and Infant Health Assessment (MIHA) 2011-2014.
Maternal health risks around the time of pregnancy were not rare.

- Poverty: 43%
- Food insecurity: 17%
- Homeless/No regular place to sleep: 3%
- Intimate partner violence: 8%
- Smoking 3 mo before pregnancy: 12%
- Binge drinking 3 mo before pregnancy: 14%

Data source: Maternal and Infant Health Assessment (MIHA) 2011-2014.
HOUSEHOLD WEALTH IS UNEVENLY DISTRIBUTED ACROSS RACIAL/ETHNIC GROUPS IN CALIFORNIA

Percentage

51.7%  15.7%  12.0%  6.4%  2.9%  1.9%

White  Latino  Asian  African American  Other

Households  Household Wealth

FIGURE 5: Percentage of California’s households and household wealth (net worth), by race/ethnicity, California, 2010.

Sources: U.S. Census Bureau, Census 2010, Summary File 2; and Survey of Income and Program Participation (Panel 2008, Wave 7).

Source: California Department of Public Health “Portrait of Promise” August 2015
AFRICAN AMERICANS AND LATINOS ARE MORE LIKELY TO SPEND MORE THAN 30% OF THEIR INCOME ON HOUSING THAN OTHER RACIAL/ETHNIC GROUPS

FIGURE 12: Percentage of housing cost burden, by tenure and race/ethnicity, California, 2006-2010.


Cost burdened is defined as households spending more than 30% of monthly household income on housing costs.

Housing costs include monthly, gross rent (rent and utilities) or selected, housing costs (mortgage, utilities, property tax, insurance and, if applicable, home association fees).

Source: California Department of Public Health “Portrait of Promise” August 2015
MORE THAN 40% OF LOW-INCOME ADULTS ARE UNABLE TO AFFORD ENOUGH FOOD

Percentage of low-income adults

<table>
<thead>
<tr>
<th>Group</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Multi-Race</td>
<td>54.6%</td>
</tr>
<tr>
<td>African American</td>
<td>46.3%</td>
</tr>
<tr>
<td>Latino</td>
<td>46%</td>
</tr>
<tr>
<td>American Indian and Alaska Native</td>
<td>45.7%</td>
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<tr>
<td>White</td>
<td>35.9%</td>
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<tr>
<td>Asian</td>
<td>28.6%</td>
</tr>
<tr>
<td>Native Hawaiian and Other Pacific Islander</td>
<td>21.5%*</td>
</tr>
<tr>
<td>Women</td>
<td>42.3%</td>
</tr>
<tr>
<td>Men</td>
<td>41%</td>
</tr>
<tr>
<td>California</td>
<td>41.7%</td>
</tr>
</tbody>
</table>

Source: University of California, Los Angeles, California Health Interview Survey, 2011-2012.

* Statistically unreliable data.

Source: California Department of Public Health “Portrait of Promise” August 2015
Disparities in Perinatal Health

HOW HAVE WE BEGUN TO ACT DIFFERENTLY?
Understanding social disadvantage and impact on health across the life course and across generations

SOCIOLOGY

Social Context

Policy Context

INIVIDUAL

Social position by race & class

1. Social stratification

2. Differential exposure

Specific exposure

3. Differential vulnerability

Disease

4. Differential consequences

Social consequences of ill health

5. Further social stratification

Increase exposures

Decrease vulnerability

Prevent unequal consequences

Decrease exposures

Slide Courtesy of Dr. P. Braveman, University of California San Francisco; Adapted from Finn Diderichsen, U. Copenhagen
Acting Differently at State Level

- Health in All Policies State Agency Task Force
- Public Health Office of Health Equity
  - “Portrait of Promise” (August 2015)
- Government Alliance on Race and Equity
  - CDPH Racial and Health Equity Plan
- MCAH Black Infant Health
  - Group Model focus on support and empowerment
- MCAH Perinatal Equity Initiative (July 2018)
Acting Differently at Local Level

- Best Baby Zone (UC Berkeley + Kellogg Foundation)
- Preterm Birth Initiative (University of California San Francisco + Benihoff Foundation)
- Community Birth Plan (California Department of Public Health + March of Dimes)
- Los Angeles County Disparities in Infant Mortality Initiative (Center for Health Equity)
- California Maternal Quality Care Collaborative focus on disparities in outcomes at hospital level
Eliminating Disparities in Health Requires Change on Multiple Levels

- Individual & Population Change
- Program/Intervention Change
- Community/Neighborhood Change
- Institutional Change
- Social and Policy Change
• California faces many challenges related to perinatal health disparities
• The disparity gap has been persistent and unchanged by previous healthcare and public health interventions;
• New public health strategies are needed to
  – Decrease exposure
  – Decrease vulnerability
  – Prevent unequal consequences
  – Influence social stratification
• Change will be necessary at all levels in order to reduce gaps in health disparities