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NIH National Institutes of Health
Office of Disease Prevention

Prevention in Focus Webinar Series

Welcome!

We will begin shortly.

NIH National Institutes of Health
Office of Disease Prevention

Prevention in Focus Webinar Series

Addressing Maternal Mortality: Unveiling Racial Disparities and Charting a Path to Change

Karie E. Stewart, MPH, MSN, CNM, FACNM, APRN
University of Illinois Hospital & Health Services, Department of Obstetrics & Gynecology, Chicago, Illinois

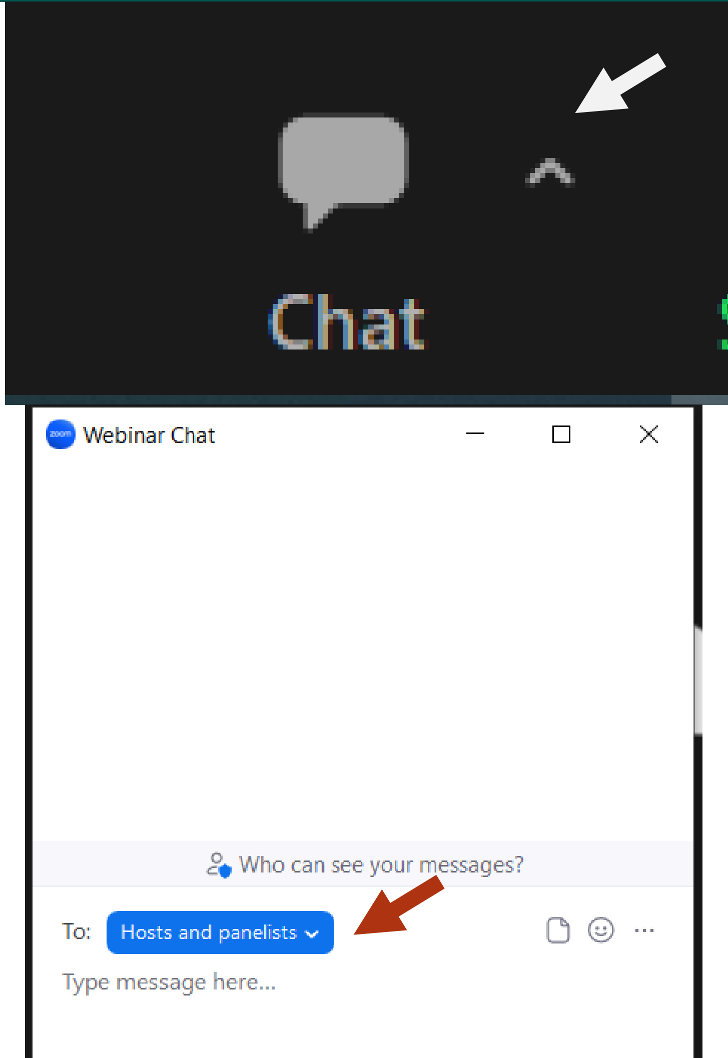
Introduction by: Pamela Stratton, MD, *Office of Research On Women's Health (ORWH),* National Institutes of Health.

Recording and Slides

The recording and slides from today's presentation will be available on *the ODP website in approximately 2 weeks*.

Please visit prevention.nih.gov/PreventionInFocus.

Prevention in Focus Webinar Series



Upcoming Q&A Session

Please send us your questions via the *Chat pod* directed to *Hosts and Panelists*

Please use the Chat pod to request technical assistance

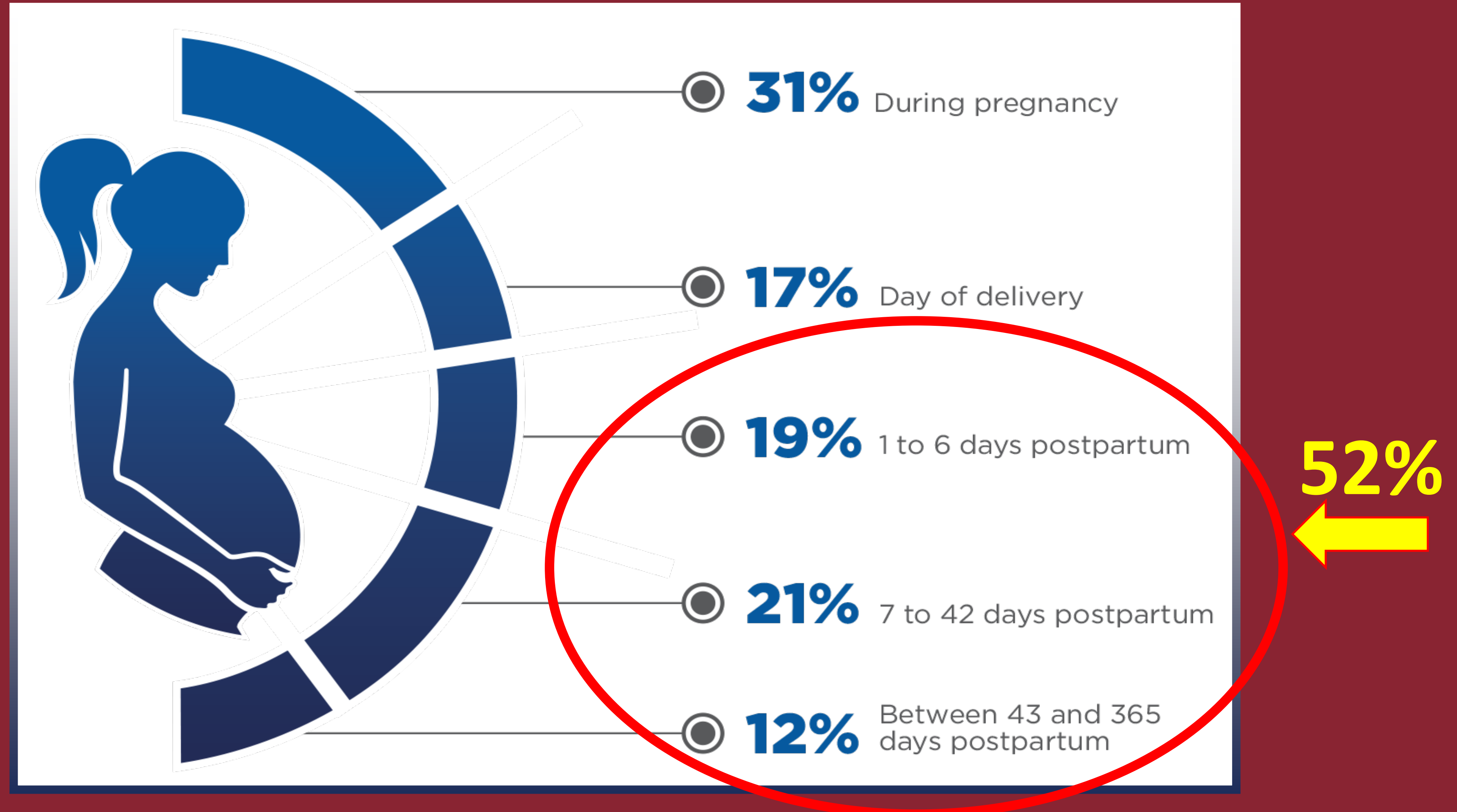
Pathways to Prevention (P2P) Program:

Identifying Risks and Interventions to Optimize Postpartum Health

Office of Research On Women's Health (ORWH)
National Institutes of Health
Pamela Stratton, MD

https://prevention.nih.gov/
Identifying Risks and Interventions to Optimize Postpartum Health | NIH Office of Disease Prevention Website

Proportion of deaths by timing of death



HHS. 2020. Healthy women, healthy pregnancies, healthy futures: Action plan to improve maternal health in America. https://aspe.hhs.gov/system/files/aspe-files/264076/healthy-women-healthy-pregnancies-healthy-future-action-plan_0.pdf
Petersen EE, Davis NL, Goodman D, et al. 2019. *MMWR Morb. Mortal. Wkly. Rep.* 68: 423-429. https://www.cdc.gov/mmwr/volumes/68/wr/mm6818e1.htm

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Office of Research on Women's Health

Questions on Critical Time Points Frame this Workshop and AHRQ Systematic Evidence Review

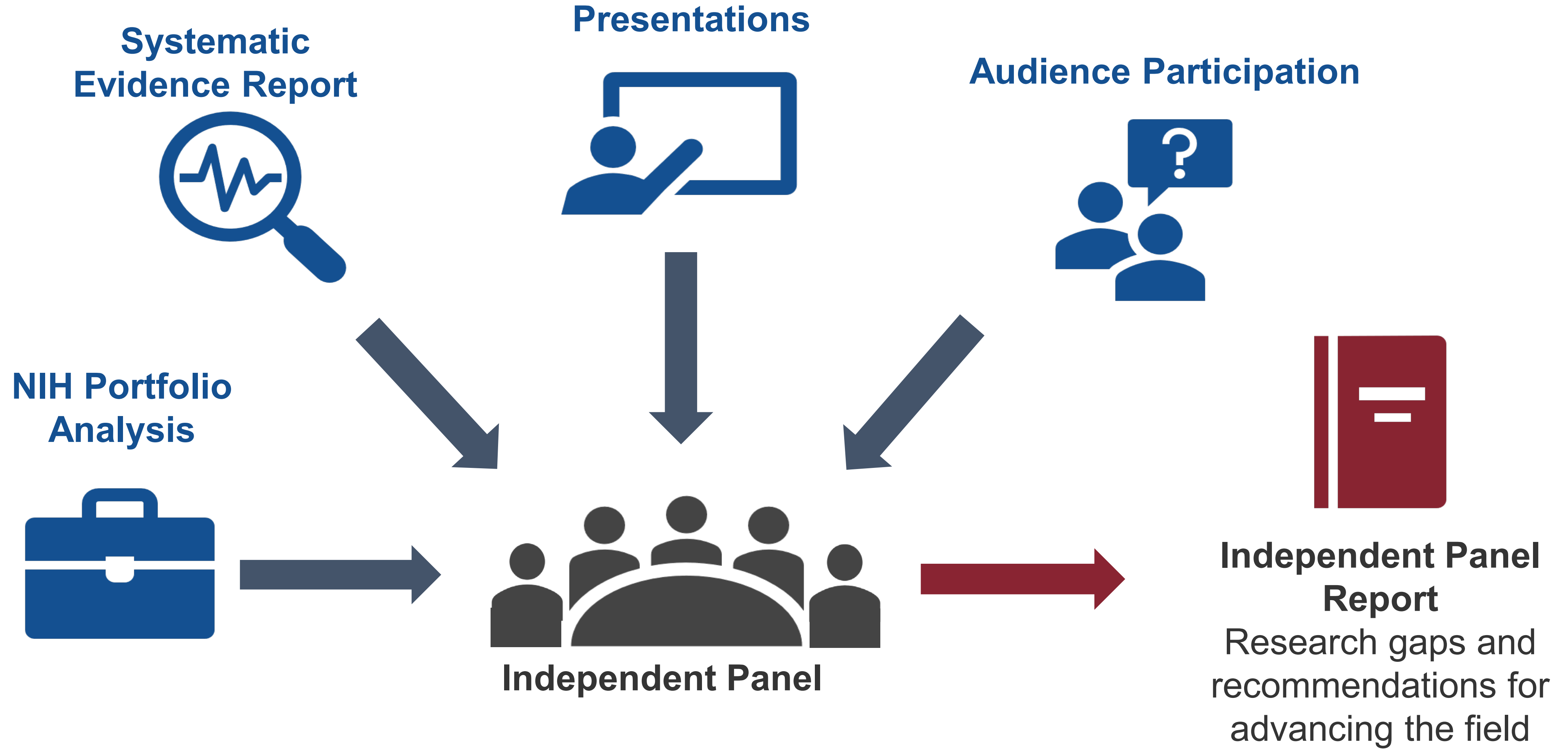
1) At a birthing **person's entry into prenatal care**, what combinations of risk indicators have the greatest effect on (i.e., are the most significant predictors of) poor postpartum health outcomes?

   a. To what extent do these patterns of predictors of poor postpartum health outcomes vary by the race/ethnicity of the birthing person?

2) **Immediately before or immediately after delivery and before release from birthing-related care**, what combinations of risk indicators to the birthing person have the greatest effect on (i.e., are the most significant predictors of) poor postpartum health outcomes?

   a. To what extent do these patterns of predictors of poor postpartum health outcomes vary by the race/ethnicity of the birthing person?

Things came together at the P2P workshop,



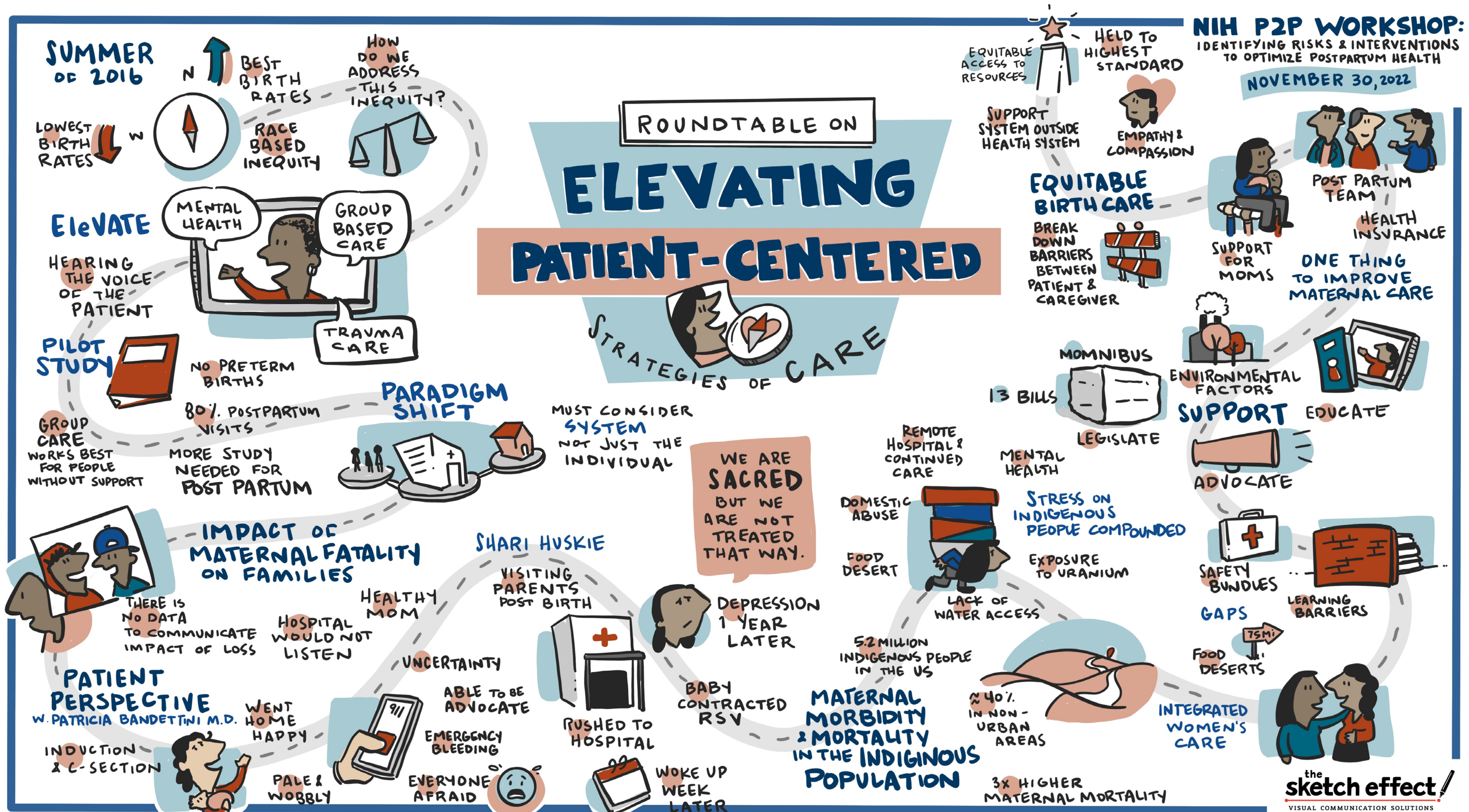
Select speakers

Maternal Health and the Nation's Failure to Commit Itself to Reproductive Justice
Khiara M. Bridges, J.D., Ph.D.
University of California, Berkeley, School of Law

Midwifery in a Federally Qualified Health Center Birth Center Model Utilizing a Reproductive Justice Framework
Ebony Marcelle, M.S., CNM, FACNM
Community of Hope

Advancing Postpartum Health and Equity
Alan Tita, M.D., Ph.D
University of Alabama at Birmingham

Roundtable Day 2



Some Main Takeaways:

- The “stress test” of pregnancy continues postpartum,
- We need to bridge the chasm,
- Take a life course perspective,
- And importantly, listen to the patient and their families…..

Workshop recordings and other resources are available at prevention.nih.gov/P2P-PostpartumHealth

Independent Panel Report to be published alongside the Systematic Evidence Review, late 2023 or early 2024

NIH Joins Forces to Tackle Critical Public Health Crisis:
IMPROVE Initiative

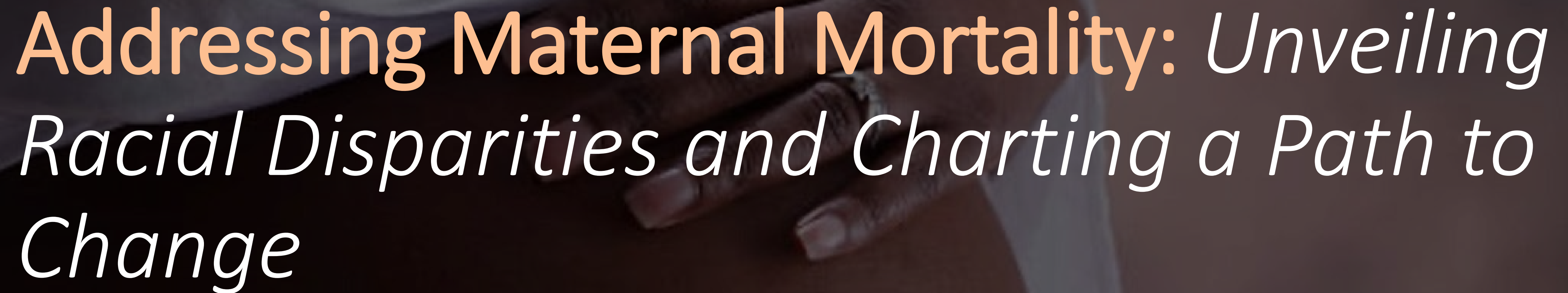
Federal Partners meeting

NIH Coordinating Committee for Maternal Morbidity and Mortality (CCM3)

led by
Eunice Kennedy Shriver National Institute of Child Health and Human Development,
NIH Office of Research on Women's Health, and
National Institute of Nursing Research

Fall, 2023

https://www.nichd.nih.gov/research/supported/IMPROVE
https://www.nichd.nih.gov/research/supported/IMPROVE/coordinating-committee



Addressing Maternal Mortality: *Unveiling Racial Disparities and Charting a Path to Change*

Karie E. Stewart, MPH, CNM, FACNM

University of Illinois Hospital & Health Services

Department of Obstetrics & Gynecology

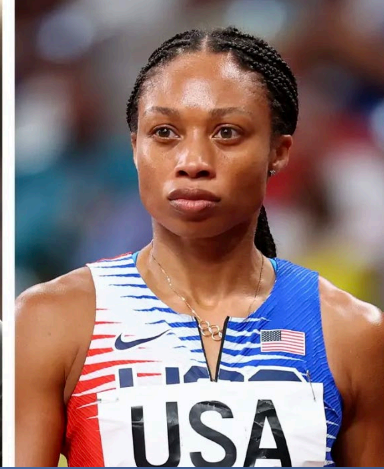
Chicago, Illinois

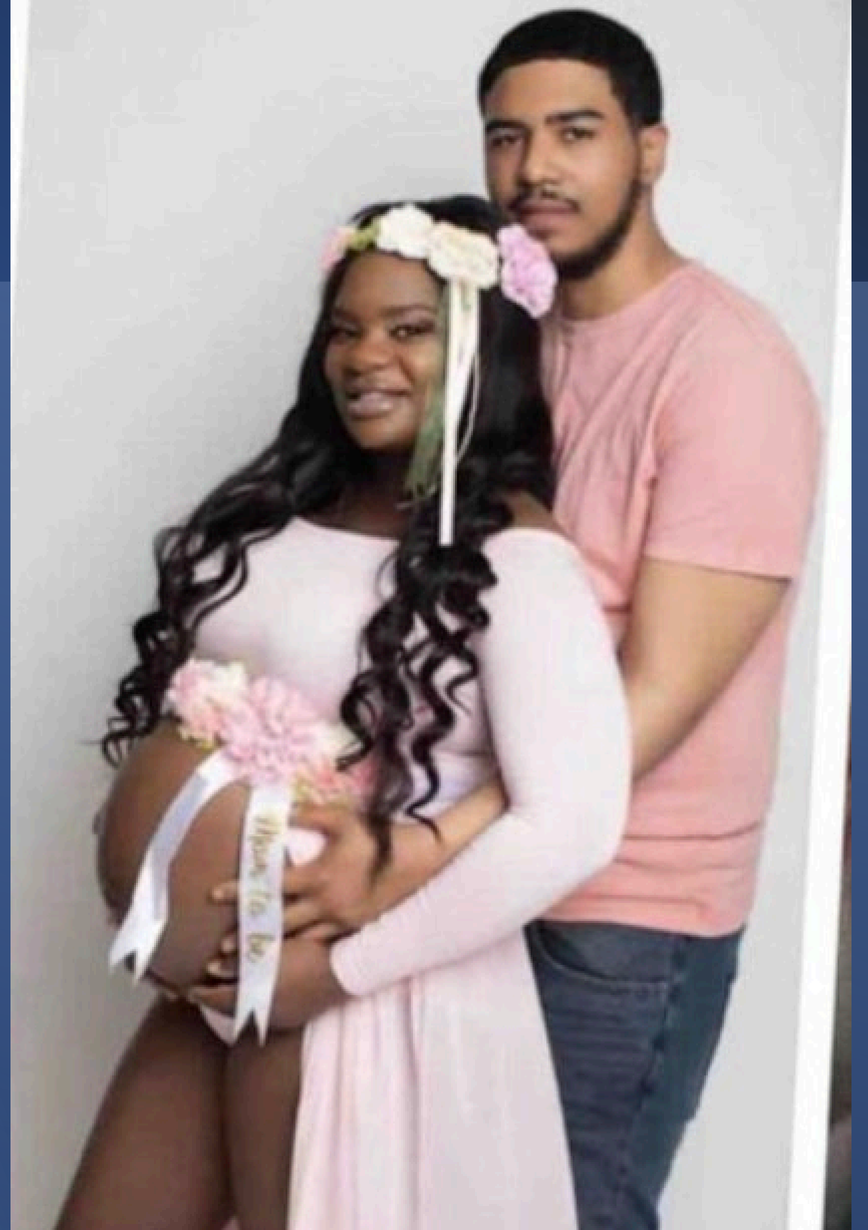
Positionality

- I recognize that not all people who have been pregnant or given birth identify as being a “woman.”
- I will use the term “women” instead of “people” or “persons” as an intentional device to highlight the vulnerability of people who society typically identifies as being female.
- The use of "women" is not intended to exclude or silence those who do not identify as female, but to draw attention to the ways pregnant or postpartum people are discriminated against because of their female gender assignment at birth.

Karie E Stewart, MPH, CNM, FACNM

- **PhD student** – UIC Department of Human Development & Nursing Science
- **Former Director of Midwifery Services** – University of Chicago Department of Biological Sciences
- **Founder & CEO** - Melanated Midwives, NFP
- **President** – American College of Nurse Midwives Illinois Affiliate Chapter
- **Certified Nurse Midwife** University of Illinois College of Nursing
- **Registered Nurse –** Mt. Sinai Hospital Labor & Delivery trained
- **Single Black Mother –** 1 son in last year of college


USA



Health Disparities

Preventable differences in the burden of disease, injury, violence, or opportunities to achieve optimal health that are experienced by socially disadvantaged populations

Health Disparities

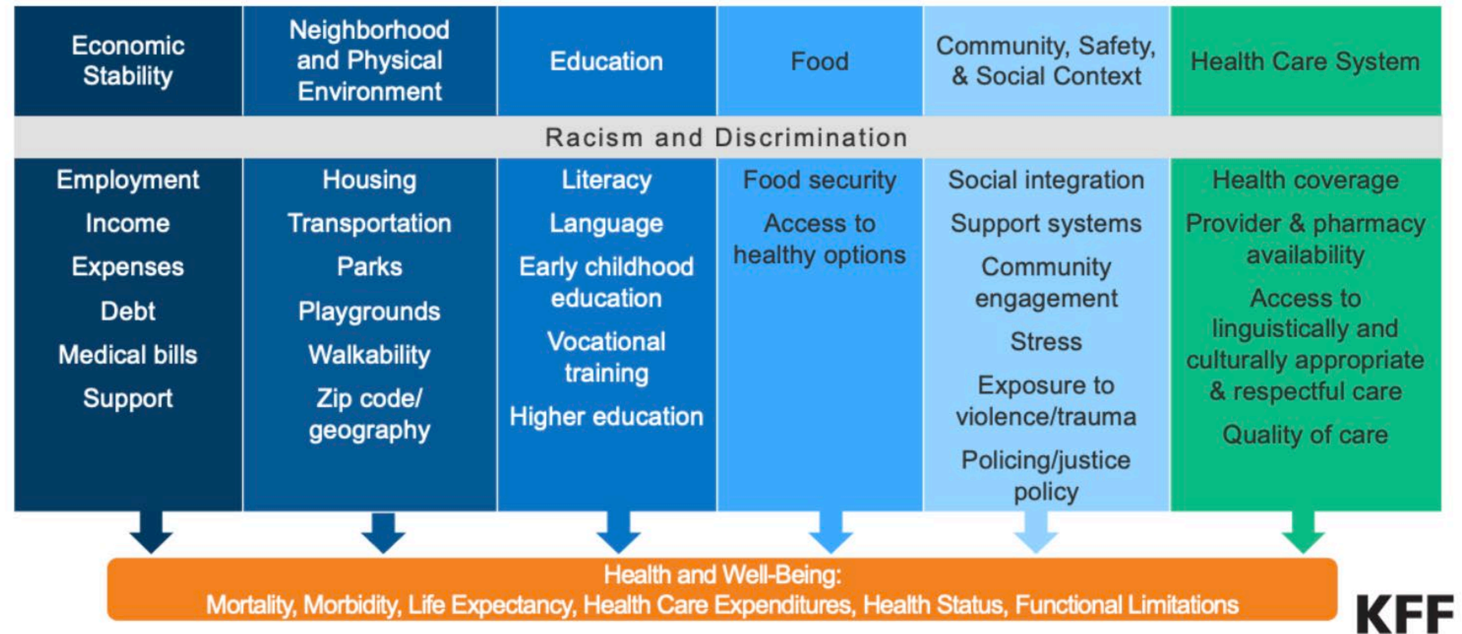


Figure 1: Health Disparities are Driven by Social and Economic Inequities

https://www.kff.org/racial-equity-and-health-policy/issue-brief/disparities-in-health-and-health-care-5-key-question-and-answers/

Health Disparities vs Health Equity

From Health Disparities to Health Equity

Health Disparities:

"…**preventable** differences in the burden of disease, injury, violence, or opportunities to achieve optimal health that are experienced by socially disadvantaged populations"[1]

Health Equity:

"When **every person has the opportunity to 'attain his or her full health potential'** and no one is 'disadvantaged from achieving this potential because of social position or other socially determined circumstances"[2]

© 2020 Johns Hopkins Center for Health Equity. May be reproduced with attribution.

1. Community Health and Program Services (CHAPS): Health Disparities Among Racial/Ethnic Populations. U.S. Department of Health and Human Services; 2008.
2. Whitehead M, Dahlgren G. Levelling Up (Part 1): A Discussion Paper on Concepts and Principles for Tackling Social Inequities in Health. World Health Organization. Available at http://www.euro.who.int/document/ e89383.pdf.

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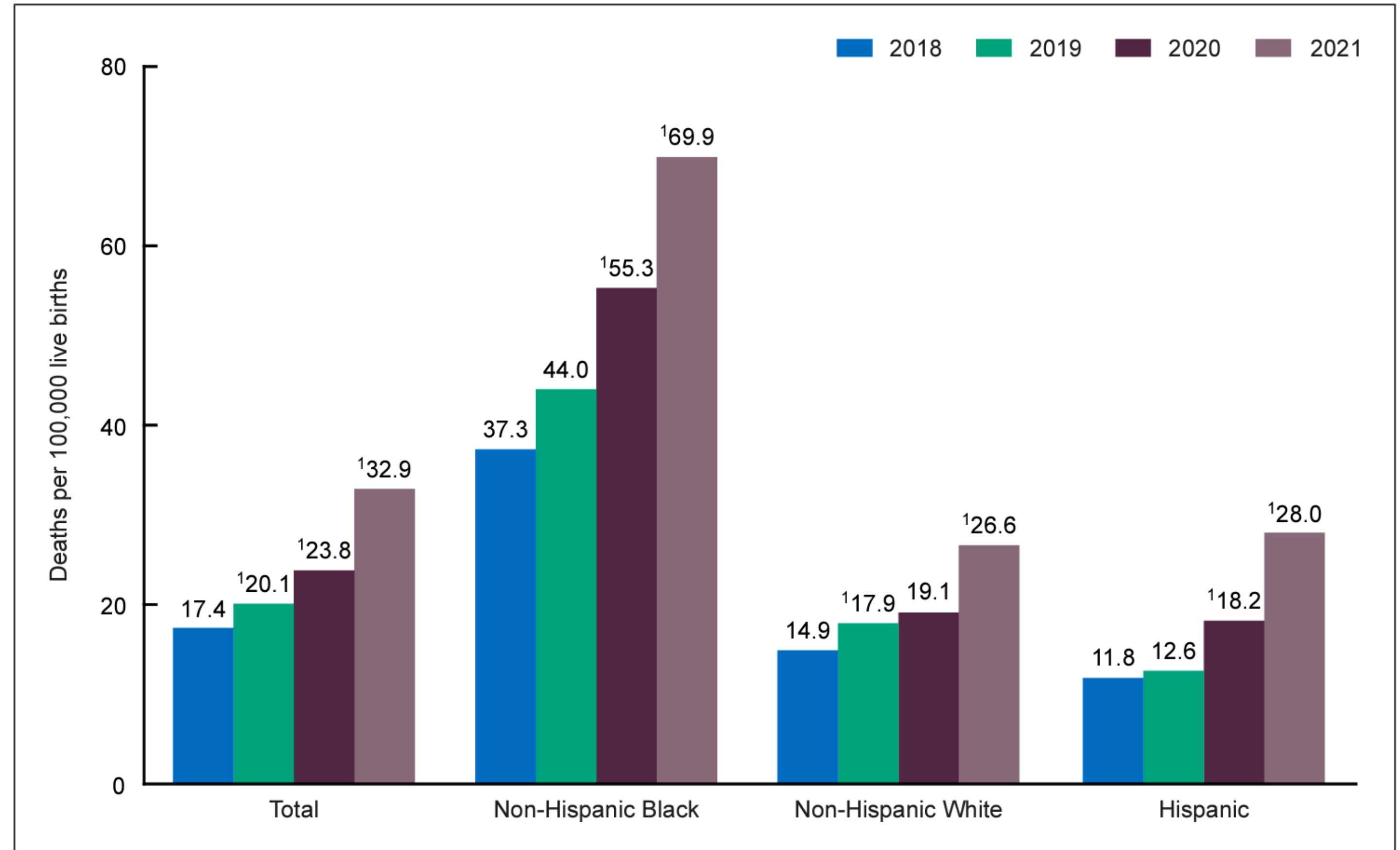
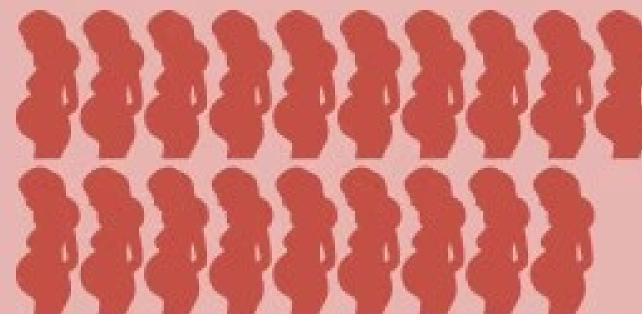
Maternal Health Disparities



Black Women Face Three Times the Maternal Mortality Risk as White Women

Black mothers: ~~55~~ 70

White mothers: ~~19~~ 26



Hispanic mothers: ~~18~~ 28

*Deaths per 100,000 live births

Source: https://www.cdc.gov/nchs/data/hestat/maternal-mortality/2020/maternal-mortality-rates-2020.htm

In Chicago Black women are six times as likely to die as White women.

Impact of US Maternity System on Black Maternal Health

Maternity care is failing Black women

Black mothers experience disrespectful and discriminatory healthcare

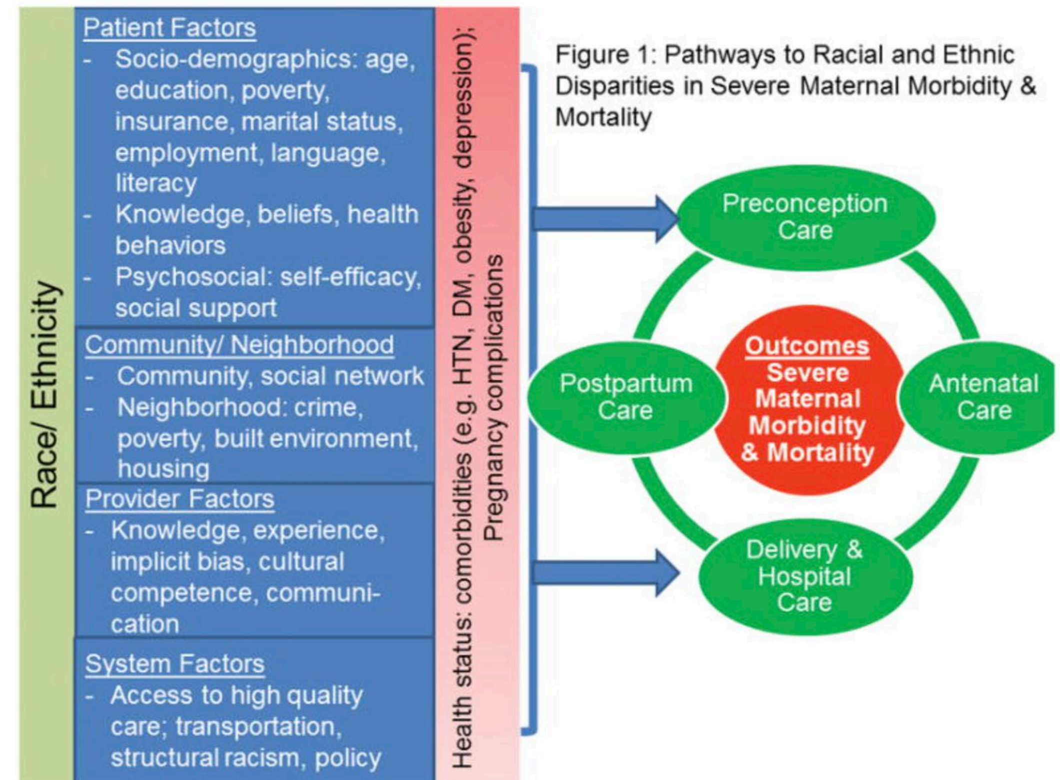
1/3 of all maternal deaths are within 1 year postpartum

Postpartum women are often neglected once they leave the health care system after birth.

83% of maternal deaths in IL are preventable

Each woman who dies of maternal cause, 50-100 more experience life threatening complications, and Black women are disproportionately impacted.

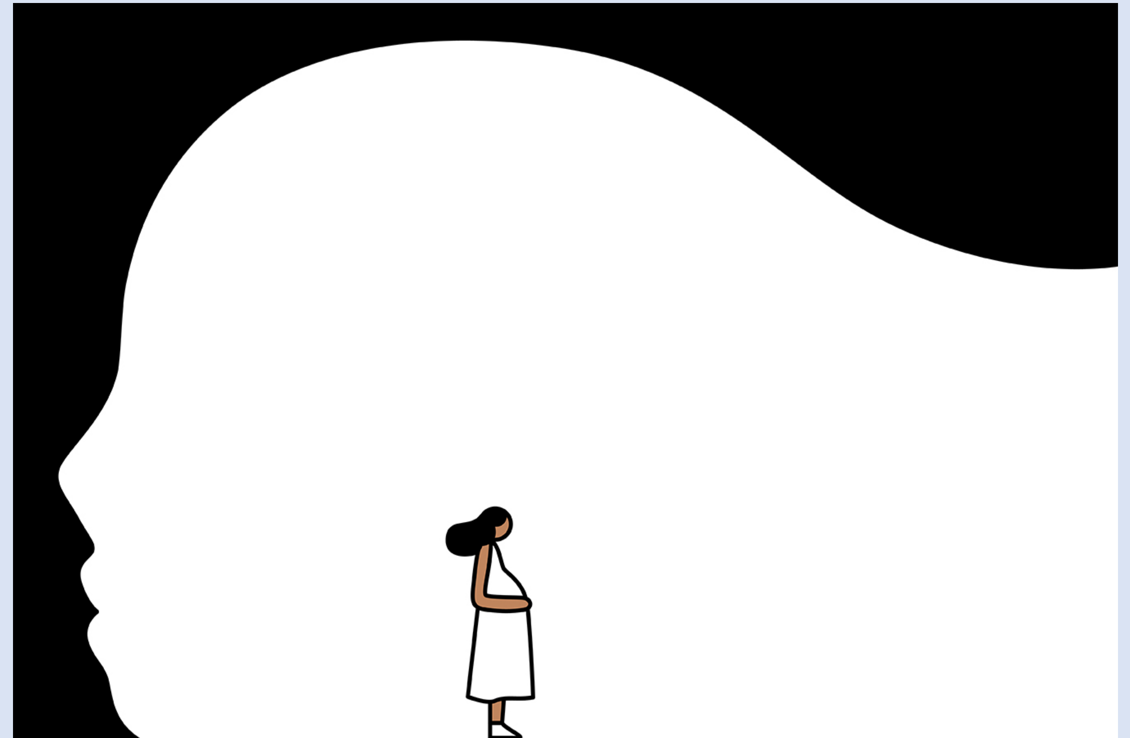
Maternal Health Disparities



Howell EA. Reducing Disparities in Severe Maternal Morbidity and Mortality. Clin Obstet Gynecol. 2018 Jun;61(2):387-399. doi: 10.1097/GRF.0000000000000349. PMID: 29346121; PMCID: PMC5915910.

Maternity Care Paradigm Shift

- **No single intervention has substantially reduced maternal health disparities**
- The complexity of maternal morbidity and mortality needs a multi-faceted approach
- A model of maternity care centered on what Black women need does NOT exist
- Broad structural changes to attenuate the impacts of structural racism are needed



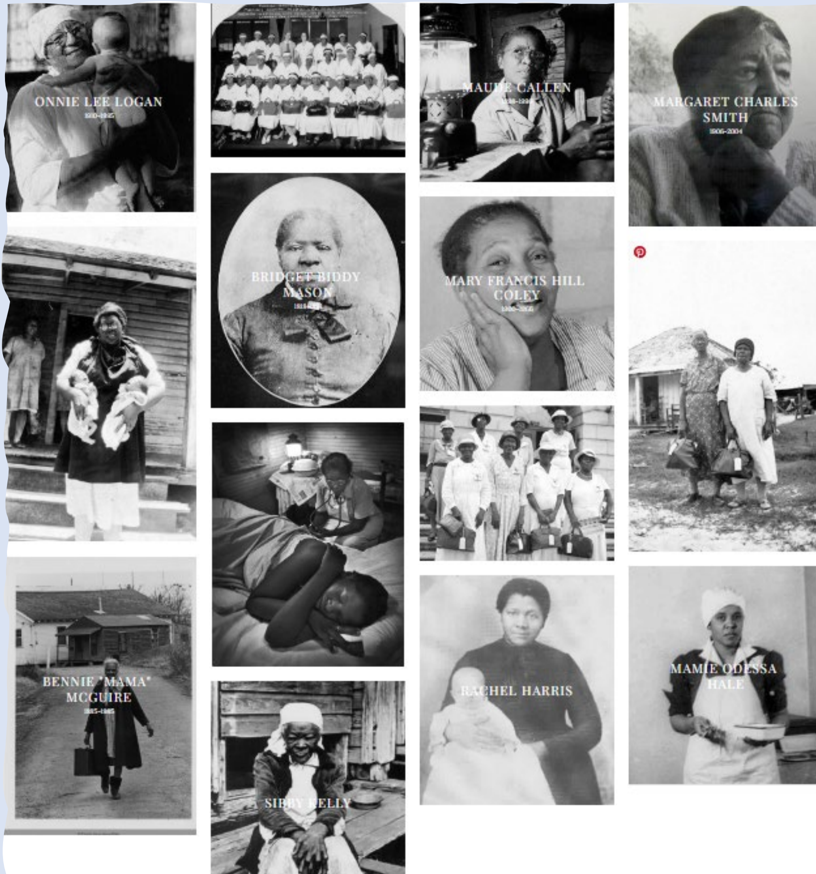
Address Discrimination & Social Determinants of Health

- Discrimination in healthcare reinforce feelings of distrust and leads to disengagement among Black mothers

BLACK MIDWIVES GROUP CARE NURSE NAVIGATORS POSTPARTUM DOULAS

MELANATED GROUP MIDWIFERY CARE

Concordant Care: Black Midwifery in the US



- Granny Midwives in the South
- Sheppard Towner Act of 1921 – licensing and regulation → shifting control of birth-care to the state
- Transition of birth-care to regulated clinical practice, excluding Black midwives
- Early 1900’s: 50% of all births in US attended by midwives
- Today: 90% of births in the US are under physician care
- Midwives: CPM, CNM, CM, lay midwife
- Approximately 7% of CNMs are Black

Why do outcomes improve when providers and patients share the same race?

Enhanced trust

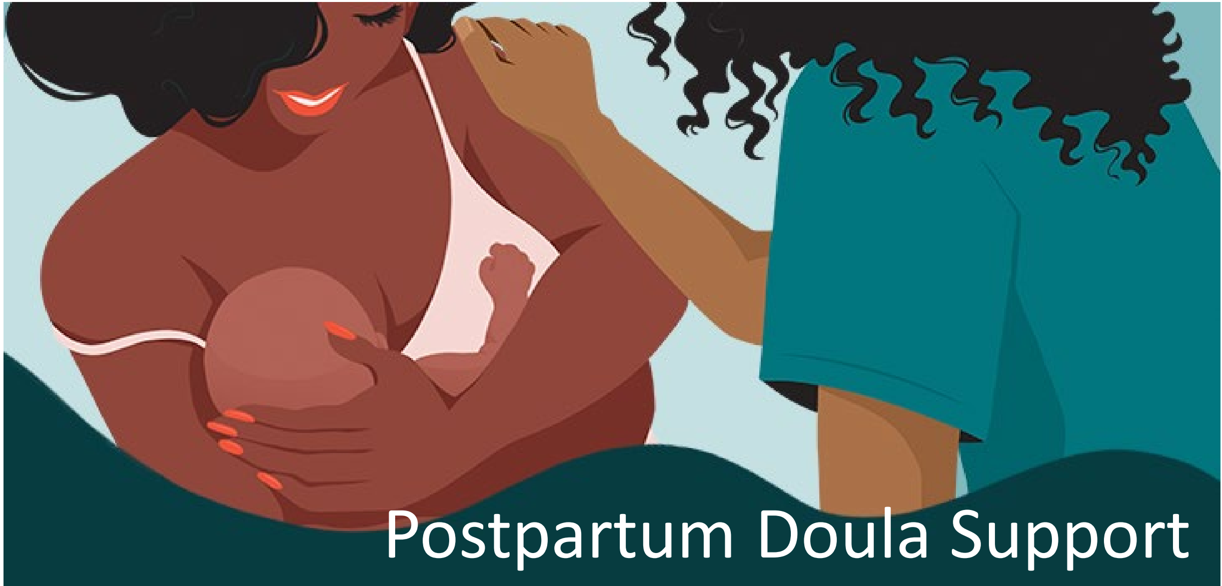
Increased engagement

Better communication

Nurse Navigation

Group Prenatal Care

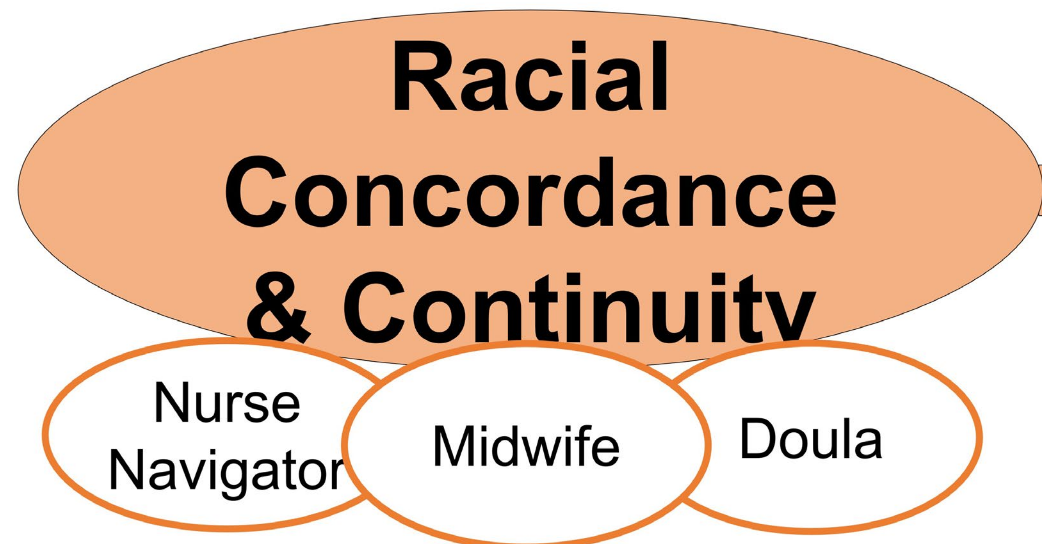
Racial Concordance


Postpartum Doula Support

MGMC Bundle: Four Evidence-Based Strategies

1. **Racial concordance** between providers and Black patients:
    a. Increases healthcare engagement
    b. Earns patient trust
    c. Increases patient satisfaction
    d. Halved the racial disparity in neonatal mortality

Source: Greenwood, B. N., Hardeman, R. R., Huang, L., & Sojourner, A. (2020). Physician-patient racial concordance and disparities in birthing mortality for newborns.



MGMC Bundle: Four Evidence-Based Strategies

1. **Racial concordance**
2. **Group healthcare:**
   a. Is structured to disrupt power hierarchies
   b. Uses interactive learning
   c. Builds social support and community
   d. Associated with better attendance, mental well-being, satisfaction, lower rates of preterm birth, and higher rates of breastfeeding
      - Stronger results for black women

Group Prenatal Care

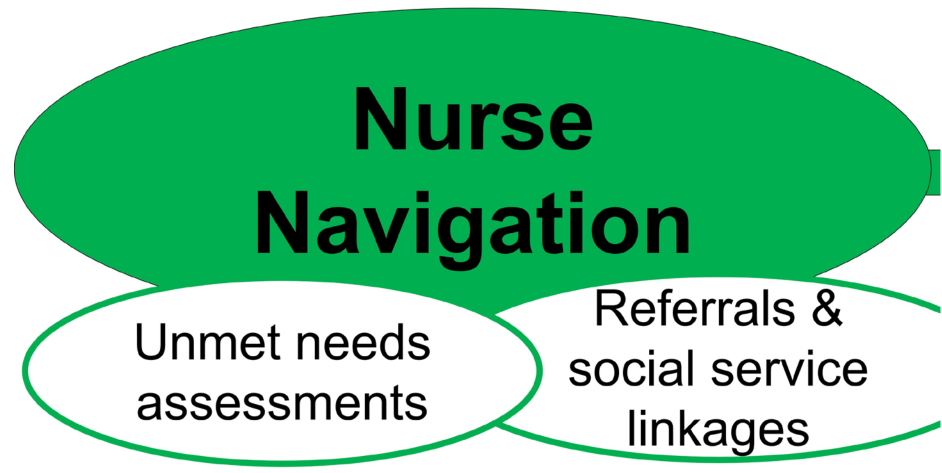
Disrupt power hierarchies

Interactive Learning

Community building & peer support

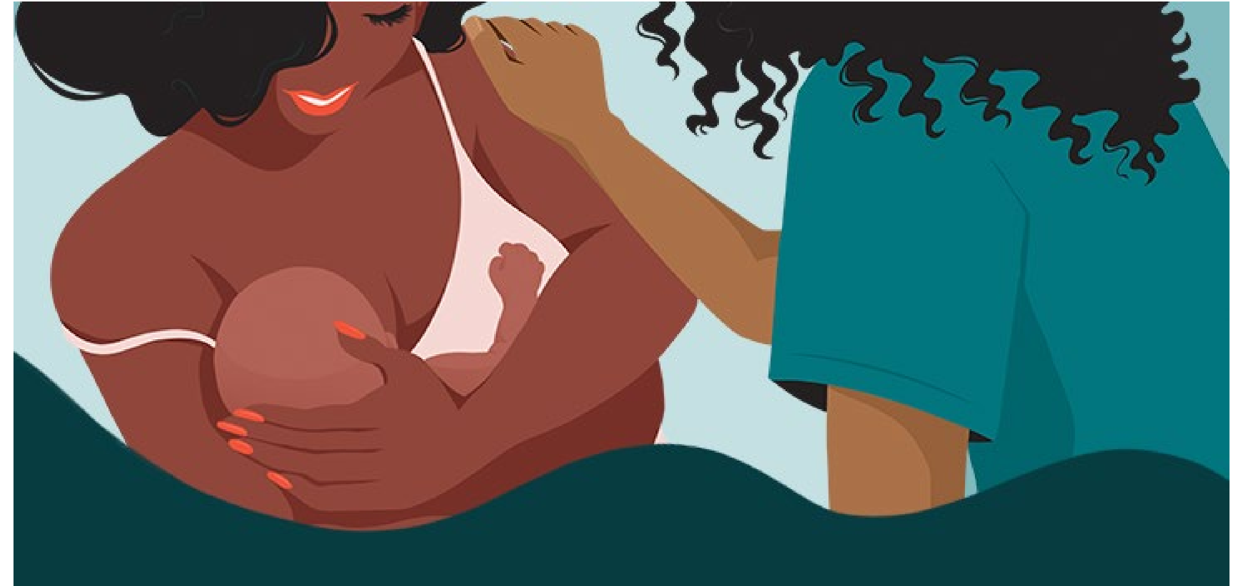
MGMC Bundle: Four Evidence-Based Strategies

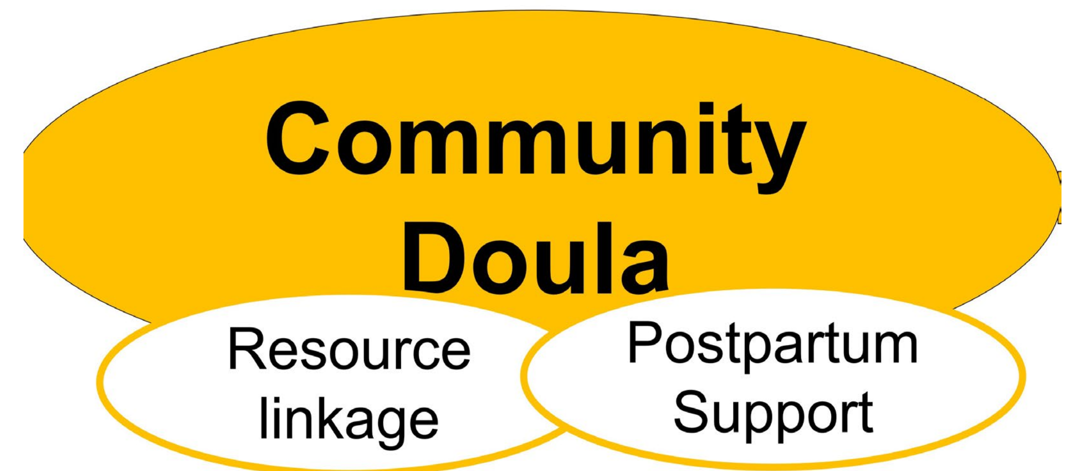
1. **Racial concordance**
2. **Group healthcare**
3. **Nurse Navigation**
   a. Extensive, active referrals, linkages, and follow-up improves perinatal outcomes
   b. Proactive (vs reactive) management of obstetric complications
   c. Shared decision-making



MGMC Bundle: Four Evidence-Based Strategies

1. **Racial concordance**
2. **Group healthcare**
3. **Nurse Navigation**
4. **In-home, postpartum doula support**
   a. Decreases postpartum depression
   b. Increases breastfeeding
   c. Improves bonding between mother and infant
   d. Improve maternal sense of control of complications





Community Partner: Chicago Birthworks Collective

UIC

Community Advisory Board

Stakeholder Advisory Board

Study Population

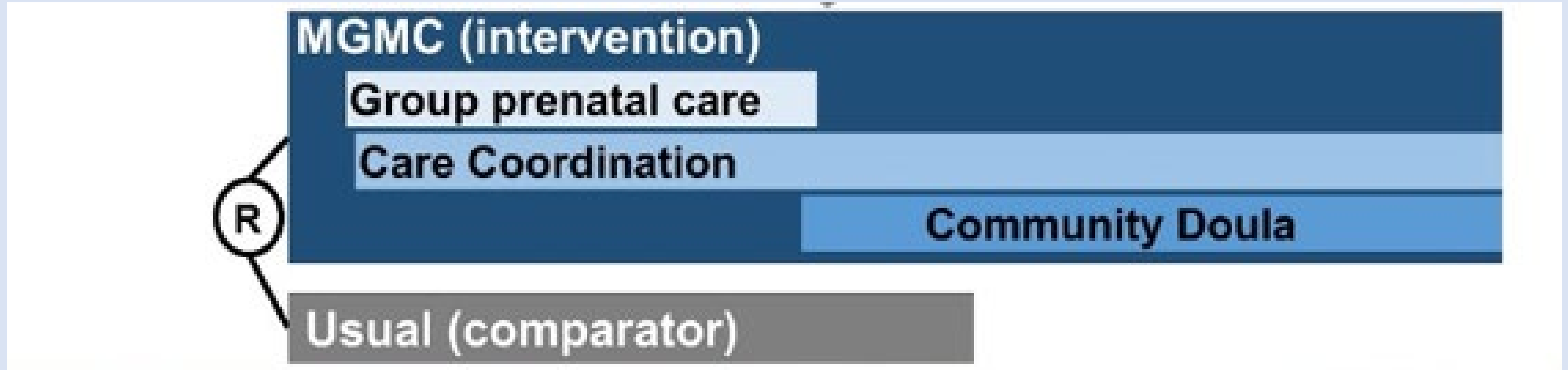
MGMC staff will pre-screen potential participants from the Center for Women's Health clinic schedule

- Patients must be:
  - Self-identify as Black or African American
  - 16yo or older
  - Singleton Pregnancy
  - $\leq$24 weeks pregnant
  - English speaking
- Patients who require sole management by MFM or high-risk OB are ineligible if not cleared for co-management.

If the patient consents, they will be randomized:

- Half (N=216) will remain in usual care
- Half (N=216) will participate in intervention group

RCT Design



- Primary Outcome: Patient Engagement and Trust
- Secondary Outcome: Implementation Evaluation (Observations, Study Notes, Individual and Focus Group Interviews)

(R) = randomization, n=432

We hypothesize MGMC intervention participants will have 20% higher engagement in their prenatal and postnatal care compared to those in usual care.

Outcome Measure		
Engagement	Prenatal, categorical (0-3), Postnatal (0-2)	EMR
Adequacy, prenatal	Appropriate number (yes/no), appropriate timing (yes/no)	EMR
Adherence, prenatal	Five tests completed (yes/no)	EMR
Adequacy postnatal	Appropriate number (yes/no), appropriate timing (yes/no)	EMR

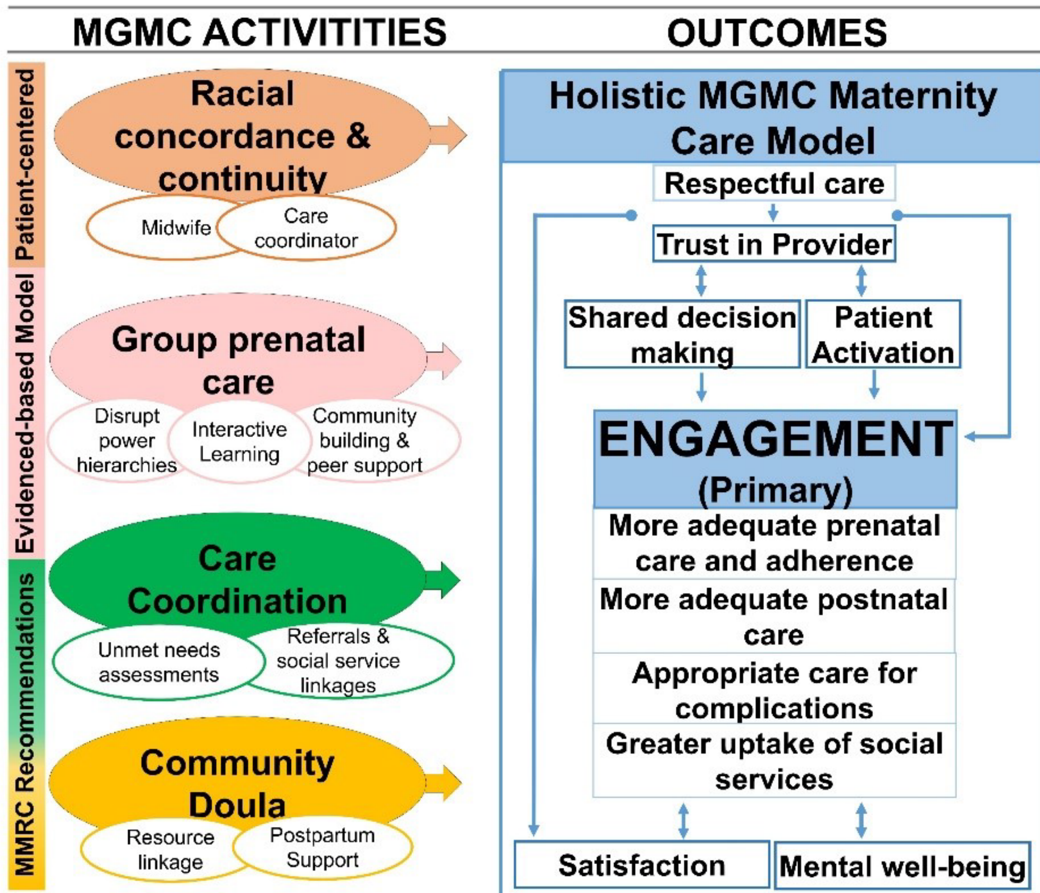
We hypothesize that women in MGMC will report better outcomes for six patient-reported outcomes:

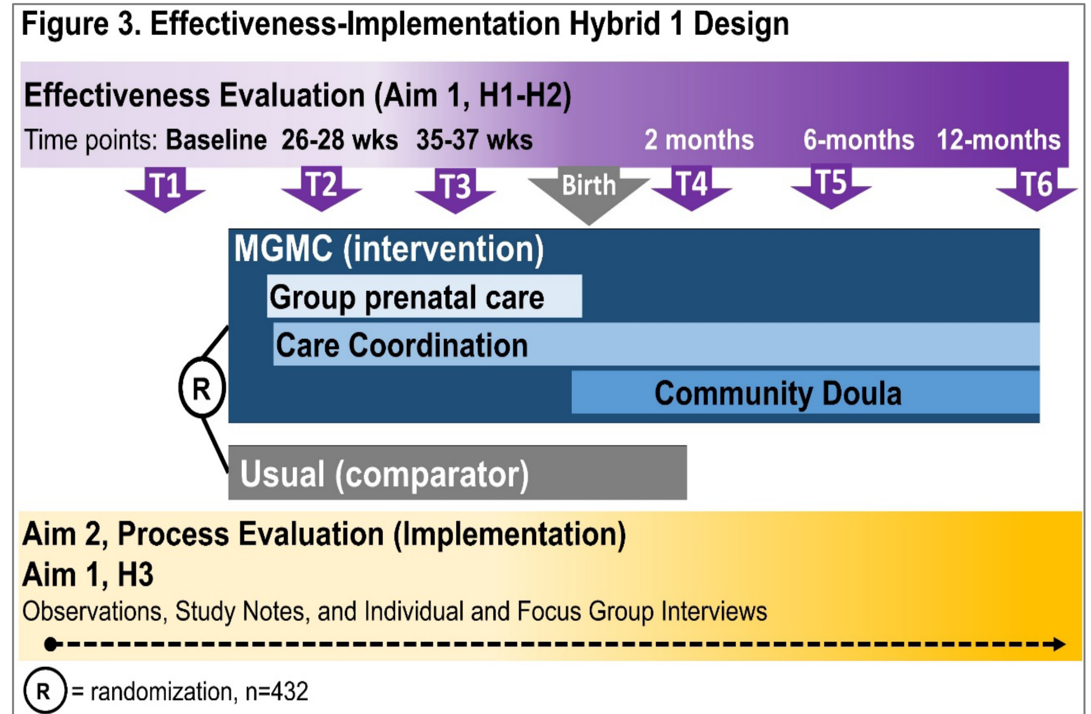
Outcome Measure		
Patient Activation	Patient Activation Measure (PAM), 13-item scale, Likert	PRO
Autonomy	Mothers Autonomy in Decision-Making Scale.	PRO
Provider Trust	Trust in Physician Scale, 11 items, range Likert; α =0.85-0.90.	PRO
Satisfaction	Prenatal, 22 items; 5-point Likert; α =0.95.	PRO
Mental well-being	GAD-7; PHQ-9	PRO
Respectful care	Mothers on Respect index (MORi) 14 items, Likert, α =0.94	PRO

MGMC aims to increase linkages and address social determinants leading to increased risk morbidities and mortality; MGMC women will have more appropriate care.

Outcome Measure		
Medical complexities	Referral and treatment pathway experiences	Qualitative EMR Review
Social complexities	Referral and pathway experiences	Qualitative EMR Review

Primary Outcome: Patient Engagement and Trust





Call to Action

- Race is NOT a biological reality
- Racism is THE problem
- Foci: policy, systems, and structural changes
  - Illinois: the first state to extend continuous eligibility for full Medicaid benefits through 12 months postpartum!
  - Illinois: passed legislation to cover in-home postpartum visitation under Medicaid
- Implementation strategy while doing the associated policy work
- Build pipelines for melanated midwives, physicians, nurses, support staff, doulas, community health workers
- Build community partnerships with community organizations
- Support Momnibus and other legislative

Call to Action

- **PhD student** – Centering the voices of Black birthing people and Black Midwives
- **Director of UIH-Mile Square Women's Health Institute of Excellence** – Make Reproductive and Maternal Healthcare accessible to more Black communities in Chicago
- **Founder & CEO** – Diversify the midwifery workforce
- **President** – ACNM-IL Chapter – Lead the charge for access to midwifery care in Illinois
- **Certified Nurse Midwife** – Continue to advocate and clinically care for Black and brown women and birthing people
- **Single Black Mother** – Share my story

Thank You!

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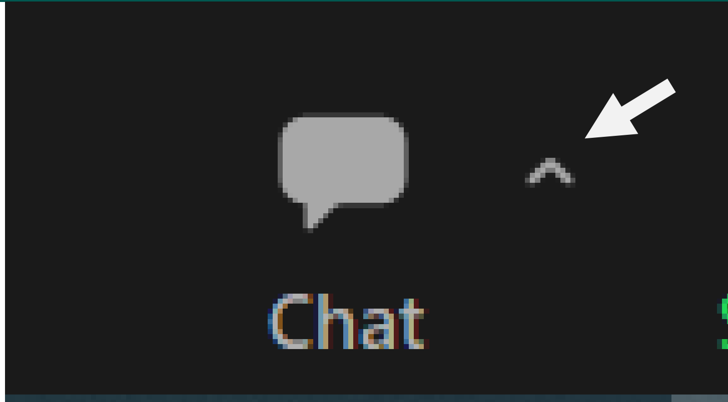

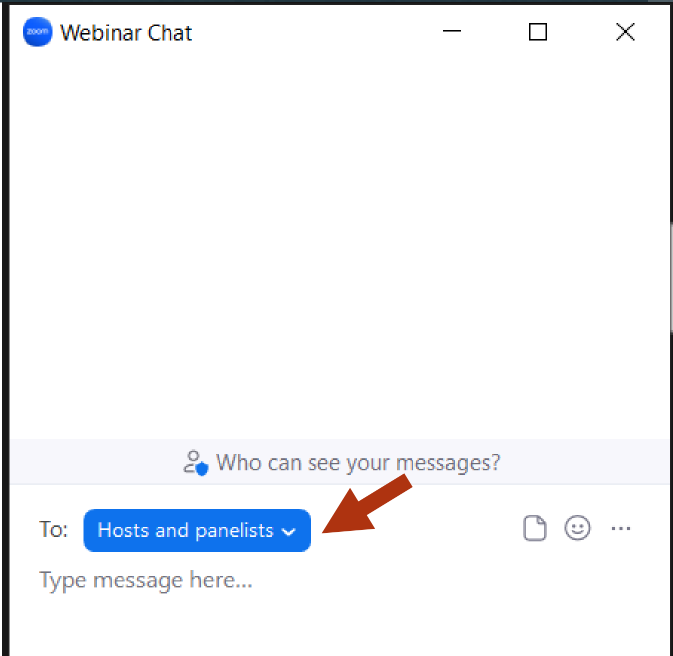

Q&A Session

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Thank You!

See you for our next webinar on October 26th!

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