For All Our Babies, Now and Next

Dr. Magda Peck | MP3 HEALTH | magdapeck3@gmail.com
Why?
How?
What?
MP@26
Thrilled for the North Carolina Public Health Association:

‘In 2016, the NCPHA Executive Committee discussed ideas to increase member engagement and cross-discipline conversation about current public health problems. The team knew that reducing infant mortality and improving healthy baby outcomes was the answer. NCPHA kicked-off the Healthy Babies Initiative on September 14, 2016 at the New Bern meeting to improve healthy baby outcomes as part of the Strategic Plan for 2016-2020. This new plan, will allow sections to share an overarching theme to work toward member engagement. Since the meeting, each section has determined their focus on this initiative.’
NORTH CAROLINA: A HUB OF EXCELLENCE IN MCH

• NATIONAL PRECONCEPTION HEALTH AND HEALTH CARE INITIATIVE
  – Show Your Love (WWW.SHOWYOURLOVETODAY.COM)
• NATIONAL MCH WORKFORCE DEVELOPMENT CENTER @ UNC-CH
• NORTH CAROLINA DIVISION OF PUBLIC HEALTH
• LOCAL PUBLIC HEALTH DEPARTMENTS
• NORTH CAROLINA HEALTHY START FOUNDATION
• And so much more…
Mrs. Evelyn Zysman (1910-2013)

Oldest living social justice champion in Omaha, Nebraska

**THIS WORK IS HARD AND LONG.**
If OHIO’S Black Infant Death Rate was the same as the White IMR in 2015.....

Per Dr. Art James, The Ohio State University, 2016

234

FEWER Black Infant Deaths

THIS WORK IS URGENT.

5.5
White

15.1
Black
THIS WORK IS COMPLICATED.
RATE of Infant Deaths - 3 year rolling averages
CITY OF MILWAUKEE INFANT MORTALITY RATE (IMR)
Recent Trends in 3-yr Average IMR by Race & Ethnicity

Infant deaths per 1000 live births

IMR = number of infant deaths per 1000 live births in that same time period

City of Milwaukee Health Department (2014 data preliminary)
City of Milwaukee: Black-White IMR Ratio

CITY OF MILWAUKEE BLACK-WHITE INFANT MORTALITY RATE (IMR) RATIOS
LONG-TERM TRENDS IN RATIO OF 3-YEAR ROLLING AVERAGE IMRs

Note: "Non-Hispanic White" and "Non-Hispanic Black" data used from 1994-2009; that level of data specificity not available prior to 1994, so used "White" and "Non-white" data from 1969-1993.

City of Milwaukee Health Department (2012 & 2013 data preliminary)

IMR = number of infant deaths per 1000 live births in that same time period
Infant Mortality/Vitality = ‘WICKED PROBLEM’*

A wicked problem is a social or cultural problem that is difficult or impossible to solve for as many as four reasons:

– incomplete or contradictory knowledge,
– the number of people and opinions involved,
– the large economic burden, and
– the interconnected nature of these problems with other problems.

Maternal and Infant Morbidity and Mortality

Andrea Palmer, MPA, MBA, CHSM
Chief, Division of Maternal, Child and Family Health Services
September 11, 2017

STRONG DATA CAN HELP SORT IT OUT
However, racial/ethnic disparities remain persistent

• Non-Hispanic Black infants are two times more likely to die than Non-Hispanic White infants

• During 2000-2015, the IMR declined faster among Non-Hispanic White infants than Non-Hispanic Black infants
# Perinatal Periods of Risk (PPOR)

<table>
<thead>
<tr>
<th>Period of Risk</th>
<th>Maternal Health / Prematurity</th>
<th>Maternal Care</th>
<th>Newborn Care</th>
<th>Infant Health</th>
</tr>
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</table>
| **Targets for Action** | • Preconception Health  
• Prenatal behaviors and care  
• Perinatal care  
• Social determinants | • Prenatal care  
• High risk referral  
• Obstetric care  
• Social determinants | • Perinatal management  
• Neonatal care  
• Pediatric surgery | • Sleep position  
• Postpartum behaviors  
• Injury prevention |
Perinatal Periods of Risk (PPOR)

4 Periods of Risk

Age at death

Birthweight

500-1499 g

1500+ g

Fetal death

Maternal Health / Prematurity

Neonatal death

Maternal Care

Newborn Care

Post-neonatal death

Infant Health

**Low-Risk White Women:** Fetal-Infant Mortality Rates

- 1.43 deaths per 1,000
- 1.02 deaths per 1,000
- 0.99 deaths per 1,000
- 0.76 deaths per 1,000

**Black Women:** Fetal-Infant Mortality Rates

- 4.49 deaths per 1,000
- 3.05 deaths per 1,000
- 1.55 deaths per 1,000
- 3.09 deaths per 1,000

**Excess Deaths:**
- 418 excess deaths
- 8.0 deaths per 1,000

Note: All rates expressed per 1,000 live births + fetal deaths
### Excess Deaths by Period of Risk

<table>
<thead>
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<th>Period of Risk</th>
<th>Maternal Health / Prematurity</th>
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<th>Infant Health</th>
</tr>
</thead>
<tbody>
<tr>
<td>Excess Deaths among Black Infants</td>
<td><strong>160</strong></td>
<td><strong>106</strong></td>
<td><strong>29</strong></td>
<td><strong>123</strong></td>
</tr>
<tr>
<td>Targets for Action</td>
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<td>• Prenatal care</td>
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</tr>
<tr>
<td></td>
<td>• Social determinants</td>
<td>• Social determinants</td>
<td>• Surgical care</td>
<td>• Prevention</td>
</tr>
</tbody>
</table>

418 excess deaths
Life Course Perspective

REIMAGINE THE “PROBLEM.”
The lifecourse approach proposes that disparities in birth outcomes are the consequences of differential developmental trajectories set forth by early life experiences and cumulative allostatic load over the life course.

To promote the health of women of reproductive age before conception and thereby improve maternal and infant outcomes.
10 Recommendations to Improve Preconception Health and Health Care (2006)

1. Individual responsibility across the lifespan
2. Consumer awareness
3. Preventive visits
4. Interventions for identified risks
5. Interconception care
6. Pre-pregnancy check ups
7. Coverage for low-income women
8. Public health programs & strategies
9. Research
10. Monitoring improvements

National Preconception Health and Health Care Initiative, October 2010
Prematurity Campaign Collaborative

✓ 8.1% 2020 preterm birth rate goal

✓ 5.5% 2030 preterm birth rate goal
Prematurity Campaign Interventions

1. Optimize birth spacing and pregnancy intentionality
2. Eliminate non-medically indicated early elective deliveries (inductions and C-sections)
3. Group prenatal care
4. Smoking cessation
5. Low-dose aspirin to prevent preeclampsia
6. Access to progesterone shots for women with a previous preterm birth
7. Vaginal progesterone and cerclage for short cervix
8. Reduce multiple births conceived through Assisted Reproductive Technology
NORTH CAROLINA’S PERINATAL HEALTH STRATEGIC PLAN
2016 – 2020: Adapted from the “12-Point Plan to Close the Black-White Gap in Birth Outcomes: A Life-Course Approach” developed by Lu, Kotelchuck, Hogan, Jones, Wright, and Halfon.

• IMPROVE HEALTH CARE FOR WOMEN AND MEN

1. Provide interconception care to women with prior adverse pregnancy outcomes
2. Increase access to preconception care
3. Improve the quality of prenatal care
4. Expand healthcare access over the life course
NORTH CAROLINA’S PERINATAL HEALTH STRATEGIC PLAN 2016-2020

• STRENGTHEN FAMILIES AND COMMUNITIES

5. Strengthen father involvement in families
6. Enhance coordination and integration of family support services
7. Support coordination and cooperation to promote reproductive health within communities
8. Invest in community building and urban renewal
NORTH CAROLINA’S PERINATAL HEALTH STRATEGIC PLAN 2016-2020

• ADDRESS SOCIAL AND ECONOMIC INEQUITIES

9. Close the education gap
10. Reduce poverty among families
11. Support working mothers and families
12. Undo racism
ACA Women’s Health Amendment, 2010

Requires that all private health plans cover – with no cost sharing requirements for patients – a newly identified set of women’s preventive services

- evidence-informed preventive care and screenings not otherwise addressed by current recommendations.

Women have longer life expectancies, a greater burden of chronic diseases and disability, reproductive and gender specific conditions …and women often have different treatment responses than men.
**Recommendation 8**

**At least one well-woman preventive care visit annually** for adult women to obtain the recommended preventive services, including preconception and prenatal care. The committee also recognizes that several visits may be needed to obtain all necessary recommended preventive services, depending on a woman’s health status, health needs, and other risk factors.

**Supporting Evidence**

Based on federal and state policies (such as included in Medicaid and Medicare and the State of Massachusetts), clinical professional guidelines (such as those from the AMA and AAFP, and private health plan policies (such as Kaiser Permanente).

USPSTF Grade – Not Addressed

Note: well-child visits include adolescent girls under *Bright Futures*
THE 2017 CITYMATCH MCH LEADERSHIP CONFERENCE & HEALTHY START CONVENTION

Creating Harmony
EVERY VOICE COUNTS

SEPT. 18-20, 2017 ★ NASHVILLE, TN

FRESH FROM THE 27th CONFERENCE...
FOCUS: ...toward a woman-friendly health system

✓ REPRODUCTIVE HEALTH
  o well-woman care (UIC)

✓ REPRODUCTIVE RIGHTS
  o contraceptive deserts

✓ SEXUAL AND REPRODUCTIVE JUSTICE (NYC)
Cuba’s 2016 IMR = 4.3  *How?* Preventive clinical services in every neighborhood; *Hogar de Madres* for high-risk pregnancies. Guaranteed access to quality care.
DECLARE EQUITY NON-NEGOTIABLE

Triple Aim of Health Equity

- Implement a Health in All Policies Approach With Health Equity as the Goal
- Expand Our Understanding of What Creates Health
- Strengthen the Capacity of Communities to Create Their Own Healthy Future
Practices for Advancing Health Equity and Optimal Health for All

➢ Expand the understanding of what creates health
➢ Implement a Health in All Policies approach with health equity as the goal
➢ Strengthen capacity of communities to create their own healthy future
Developed by the Population Health Institute of the University of Wisconsin

50% OF FORCES DRIVING HEALTH OUTCOMES ESTIMATED TO BE FROM CLINICAL CARE AND HEALTH BEHAVIORS

CHANGE THE NARRATIVE: ‘HEALTH’
How do social determinants affect health?

- Unfair or lacking policies
- Unequal distribution of resources
- Power & control
- Chronic stress & immune response
- Disease
- Life expectancy & quality of life
NASHVILLE’S INFANT VITALITY COLLABORATIVE:
Nashville is the best place for babies to be born and thrive.

• CityMatCH Collective Impact Learning Collaborative 2016
• 100 key stakeholders – business, hospitals, education, housing, public health, community for Community-Driven Solutions

• Priority: women with prior preterm birth + housing insecurity
• Collective focus: “affordable, safe and stable physical environments to optimize infant health

• Shared Solution: “Mommy and Me” village: affordable housing specifically for pregnant women and recently delivered families

For More Information: D'Yuanna Allen Robb, Director, Maternal, Child and Adolescent Health, Metro Public Health Department, Nashville TN
Environmental Justice & Reproductive Health: Public Health Priorities in LA County

Cynthia Harding, MPH
Chief Deputy Director
Los Angeles County Department of Public Health
LA County: Birth Statistics

• 2.5 million reproductive age women
• ~130,000 births per year
  – 1 in 30 births in the U.S.
  – 1 in 4 births in California
  – 1 in 3 births to a mother less than 24 years old
• 62 delivery hospitals

State of California, Department of Public Health, Birth Records, 2013
Los Angeles Mommy and Baby Study (LAMB), 2012
Infant Mortality by Race/Ethnicity
LA County, 2014

<table>
<thead>
<tr>
<th>Race/Ethnicity</th>
<th>Infant Death Rate per 1,000 Live Births</th>
</tr>
</thead>
<tbody>
<tr>
<td>HP 2020</td>
<td>6</td>
</tr>
<tr>
<td>LA County</td>
<td>4</td>
</tr>
<tr>
<td>Asian</td>
<td>2.4</td>
</tr>
<tr>
<td>Latino</td>
<td>4.3</td>
</tr>
<tr>
<td>Black</td>
<td>9</td>
</tr>
<tr>
<td>White</td>
<td>2.7</td>
</tr>
</tbody>
</table>

Table does not include data for Native Hawaiian and other Pacific Islander or American Indian/Alaskan Native.
Source: Los Angeles County Department of Public Health, Office of Health Assessment & Epidemiology, Mortality in Los Angeles County 2014
Percent of Low Birth Weight by Mother’s Race/Ethnicity & Nativity: LA County, 2010-2015

- **US-born**
  - White: 6.4
  - African Am: 12.6
  - Latina: 6.6
  - Asian: 6.3

- **Mother’s Nativity**
  - White: 6.7
  - African Am: 8.4
  - Latina: 6.8
  - Asian: 6.8

- **Foreign-born**
  - White: 6.3
  - African Am: 8.8
  - Latina: 6.0
  - Asian: 6.8

*Preterm Live Birth Rate: Live births less than 37 weeks of gestation and ≥ 17 weeks per 1,000 live births.*

Percent Low Birth Weight by Stressful Life Events African American vs. White Mothers
LA County, LAMB 2012 & 2014

*This estimate is statistically unstable due to the small sample size.*
Experiences of Discrimination in Los Angeles

• 37% of LA County mothers report experiencing at least one incident of discrimination over her lifetime.

• The most common reasons for experiencing discrimination varied by mother’s race/ethnicity.
  - White mothers cited gender (16%) and pregnancy status (16%).
  - **African American mothers cited race (40%) and income/gender (20%).**
  - Hispanic mothers cited race (15%) and language (12%).
  - Asian/Pacific Islander mothers cited race (17%) and language/gender (10%).
### Social Determinants of Health: 5 Domains

#### RACISM & DISCRIMINATION

<table>
<thead>
<tr>
<th>Economic Stability</th>
<th>Education</th>
<th>Health &amp; Healthcare</th>
<th>Neighborhood &amp; Built Environment</th>
<th>Social &amp; Community Context</th>
</tr>
</thead>
<tbody>
<tr>
<td>Poverty</td>
<td>High school graduation</td>
<td>Access to healthcare</td>
<td>Access to healthy food/safe parks</td>
<td>Social cohesion</td>
</tr>
<tr>
<td>Employment</td>
<td>Language &amp; literacy</td>
<td>Access to primary care</td>
<td>Density of alcohol, tobacco, cannabis establishments</td>
<td>Civic participation</td>
</tr>
<tr>
<td>Food security</td>
<td>Early childhood education</td>
<td>Health literacy</td>
<td>Crime &amp; violence</td>
<td>Incarceration</td>
</tr>
<tr>
<td>Housing stability</td>
<td>$/per student</td>
<td>Health outcomes</td>
<td>Environmental exposures</td>
<td>Networks</td>
</tr>
</tbody>
</table>

Reframe Using an Equity Lens

<table>
<thead>
<tr>
<th>Conventional Question</th>
<th>Health Equity Question</th>
</tr>
</thead>
<tbody>
<tr>
<td>How can we promote healthy behavior?</td>
<td>How can we target dangerous conditions and reorganize land use and transportation policies to ensure healthy spaces and places?</td>
</tr>
<tr>
<td>How can we reduce disparities in the distribution of disease and illness?</td>
<td>How can we eliminate inequities in the distribution of resources and power that shape health outcomes?</td>
</tr>
<tr>
<td>What social programs and services are needed to address health disparities?</td>
<td>What types of institutional and social changes are necessary to tackle health inequities?</td>
</tr>
<tr>
<td>How can individuals protect themselves against health disparities?</td>
<td>What kinds of community organizing and alliance building are necessary to protect communities?</td>
</tr>
</tbody>
</table>
Why?
How?
What?

MP@63
ANXIETY = UNCERTAINTY x POWERLESSNESS

*CHIP CONNELLY: Emotional Equations
HONEY, WHAT ARE WE GOING TO DO ABOUT IT
...for all our babies?

-KNOW THAT IT IS LONG, HARD, URGENT, COMPLICATED, WICKED.
-STRONG DATA CAN HELP SORT IT OUT.

-REIMAGINE THE PROBLEM, ACROSS GENERATIONS.
-BAKE WOMEN’S HEALTH INTO THE SYSTEM.

-DECLARE ‘EQUITY’ NON-NEGOTIABLE, CHANGE THE NARRATIVE.
-LEAD WITH PERSISTENT UNWARRANTED OPTIMISM.
LEAD WITH PERSISTENT UNWARRANTED OPTIMISM
WITH GRATITUDE AND APPRECIATION

Hani Atrash, Ed Ehlinger, Cynthia Harding, Cheri Pies AND the North Carolina Public Health Association (you!)