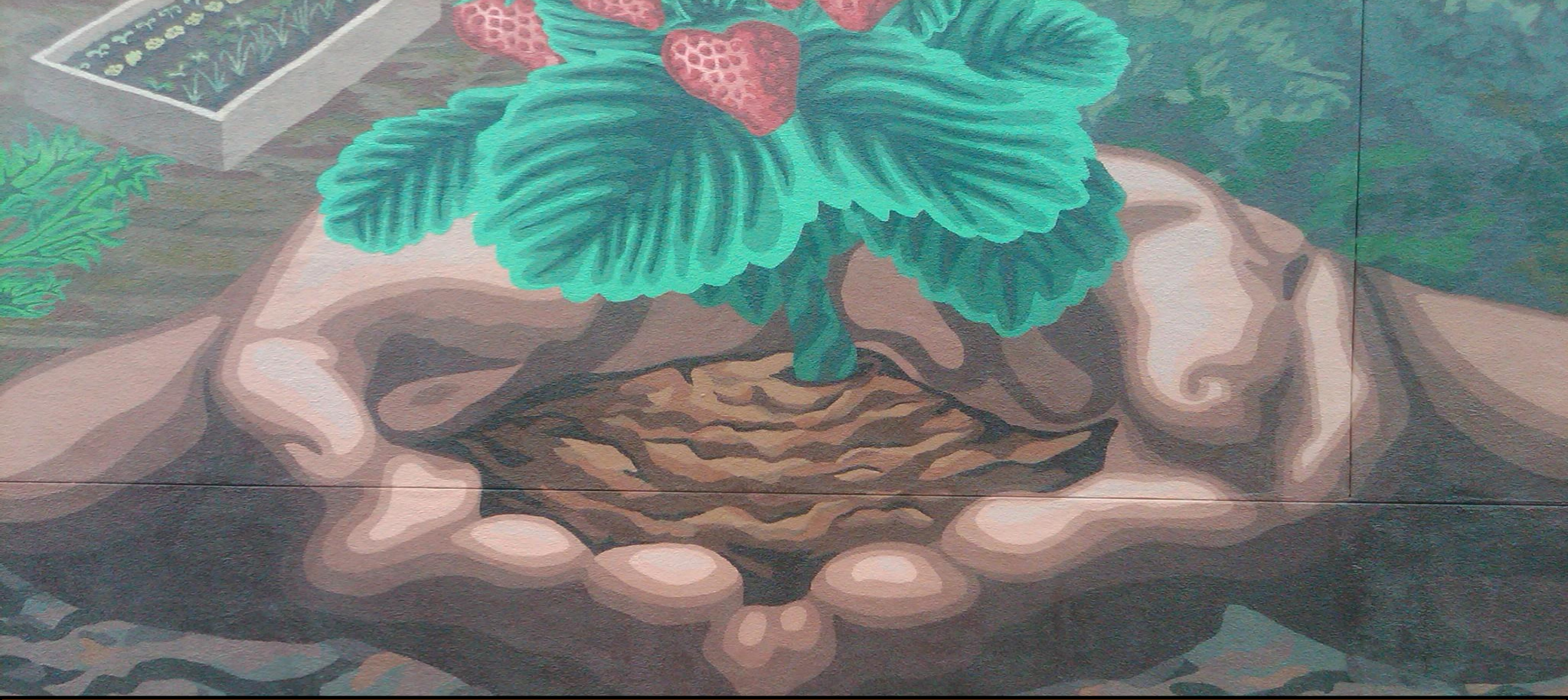


For <u>All</u> Our Babies, *Now and Next*

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…

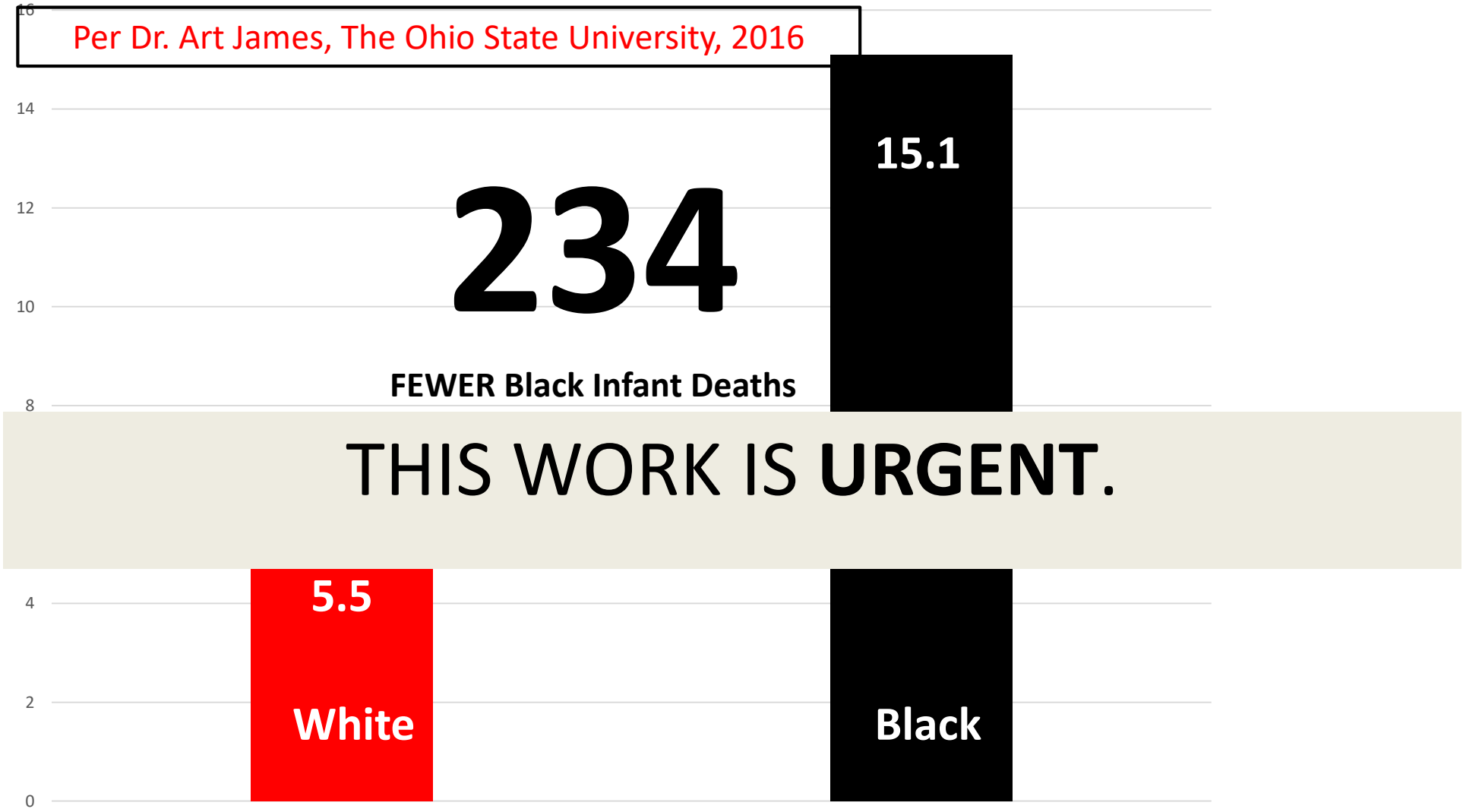
Mrs. Evelyn Zysman

(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…..

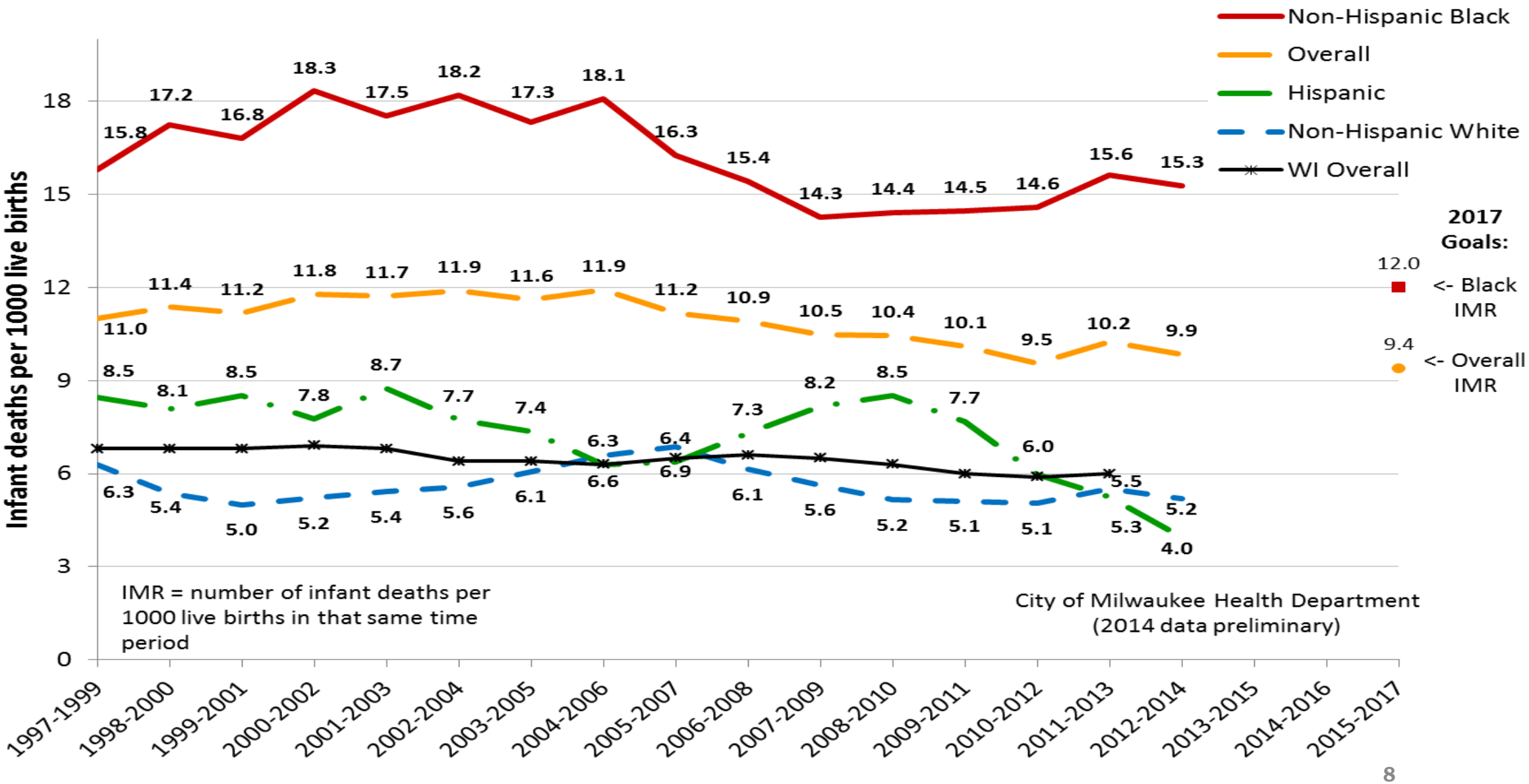


THIS WORK IS **COMPLICATED.**

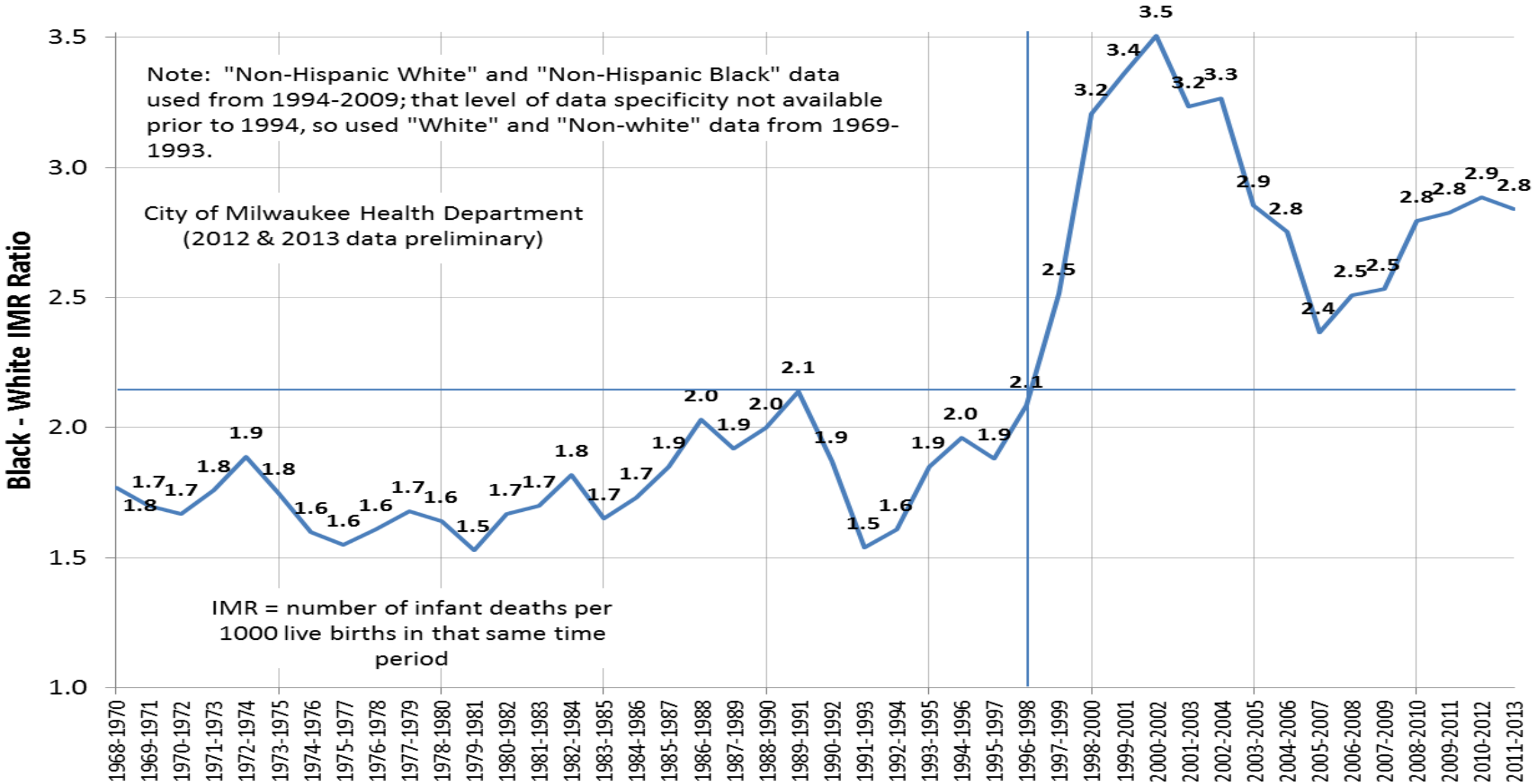
RATE of Infant Deaths - 3 year rolling averages

CITY OF MILWAUKEE INFANT MORTALITY RATE (IMR)

Recent Trends in 3-yr Average IMR by Race & Ethnicity



City of Milwaukee: Black-White IMR Ratio



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.

1.https://www.wickedproblems.com/1_wicked_problems.php

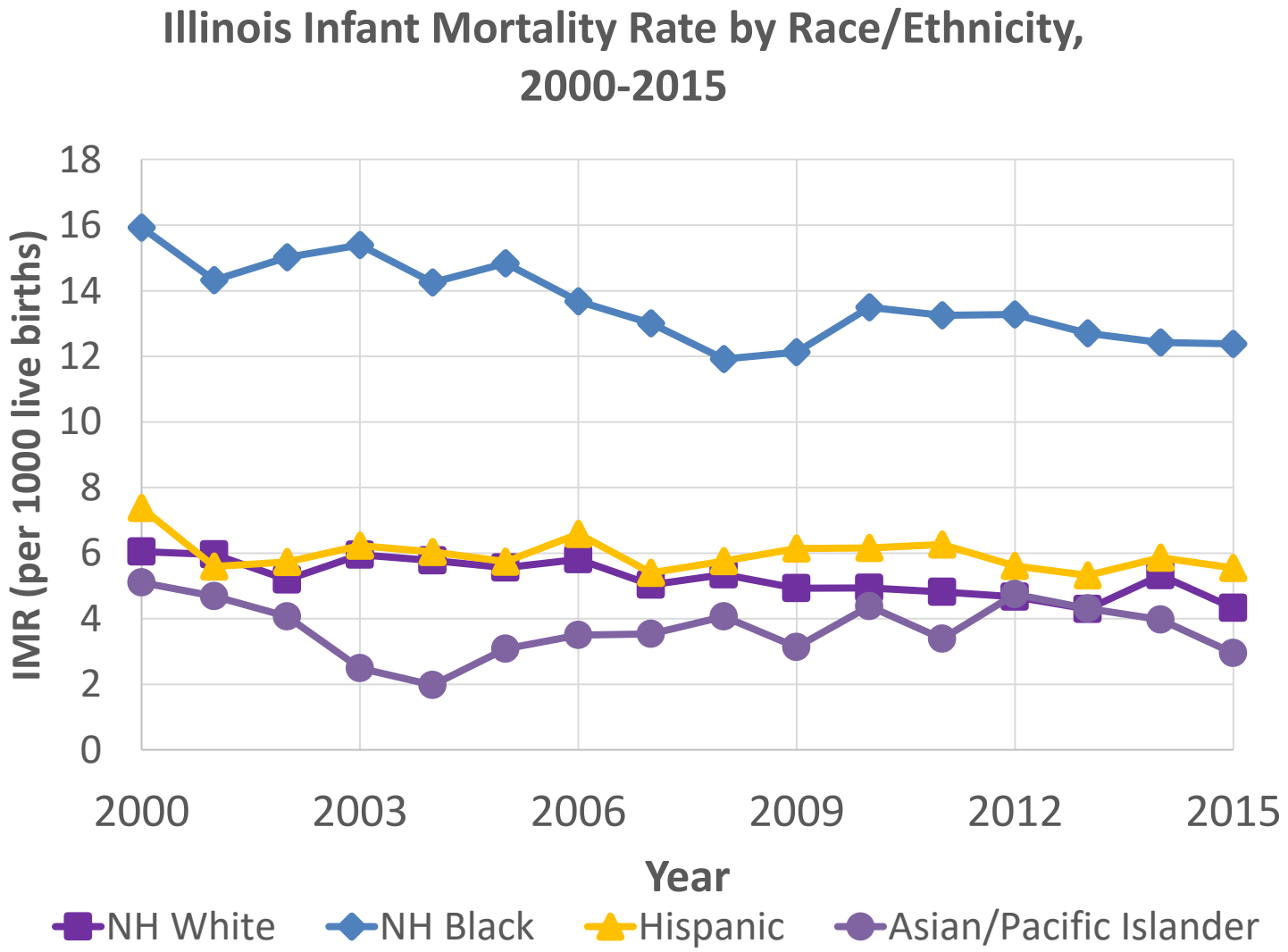
IDPH
ILLINOIS DEPARTMENT OF PUBLIC HEALTH

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

Infant Mortality by Race/Ethnicity



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

IDPH
Illinois Department of Public Health

Perinatal Periods of Risk (PPOR)

Period of Risk	Maternal Health / Prematurity	Maternal Care	Newborn Care	Infant Health
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

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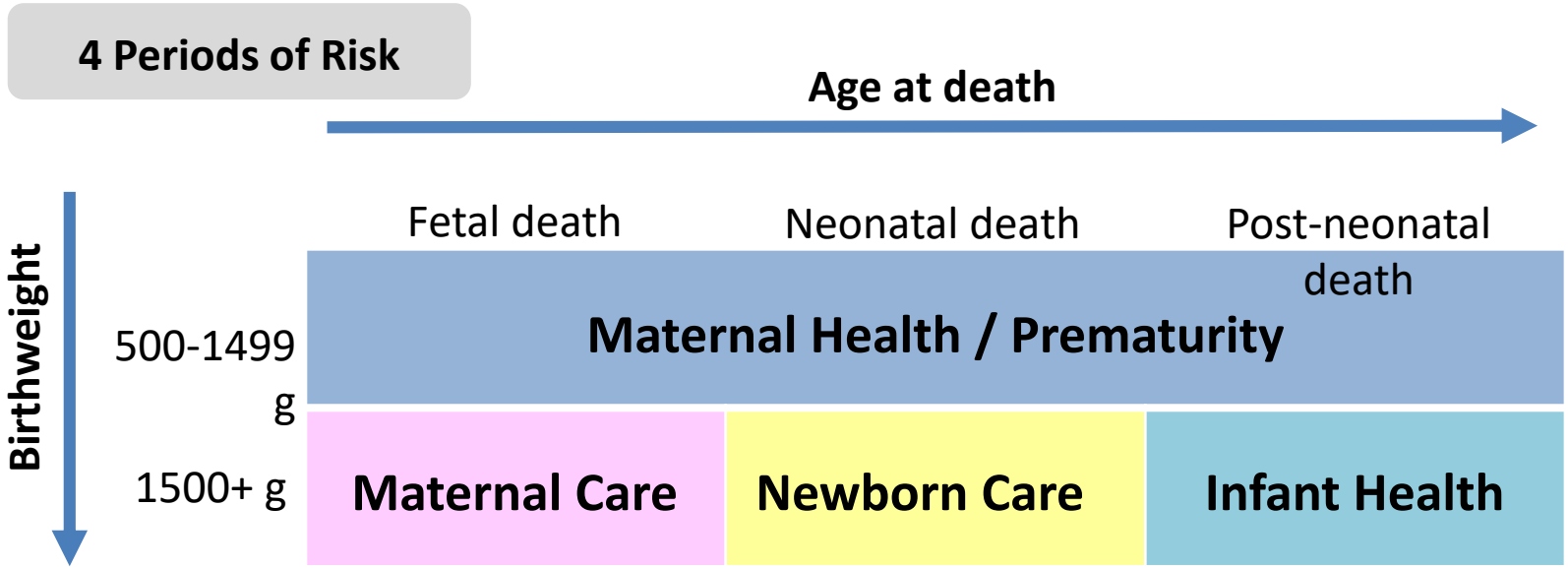
Perinatal Periods of Risk (PPOR)



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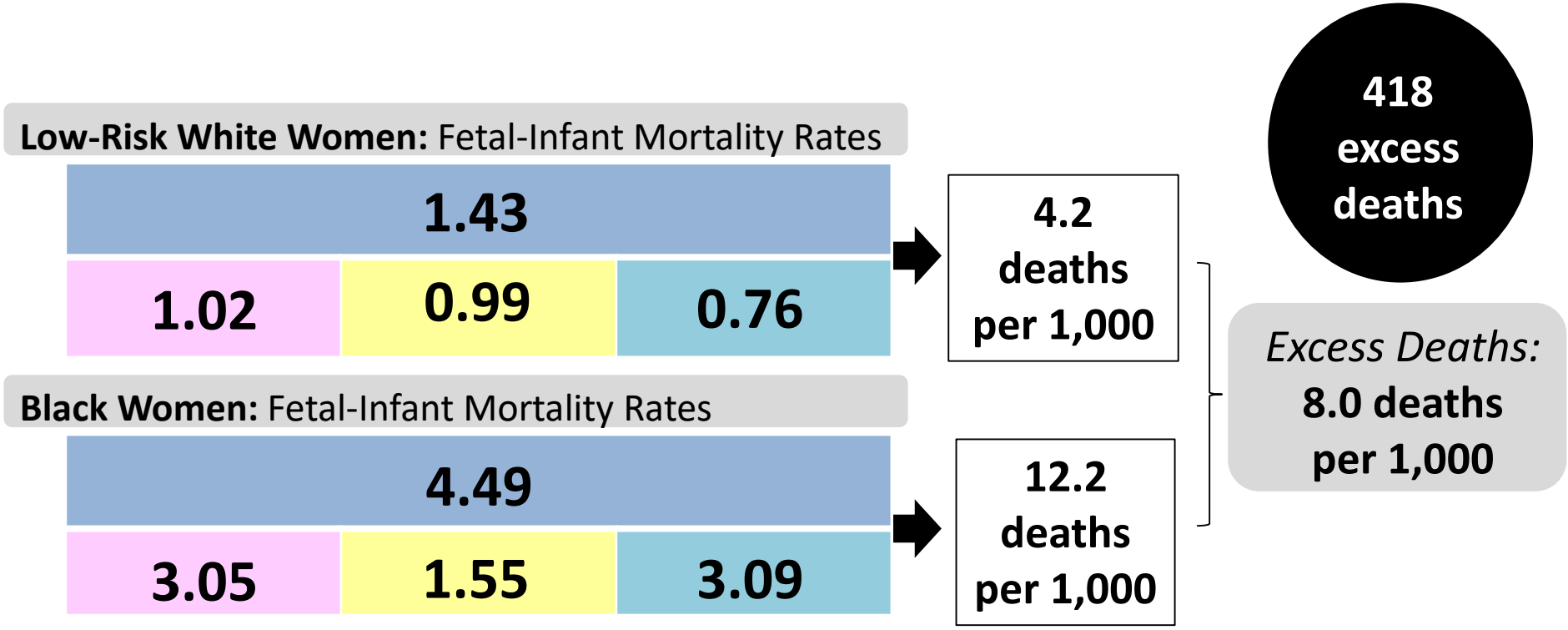
Illinois PPOR Analysis: 2014-2015



Note: All rates expressed per 1,000 live births + fetal deaths

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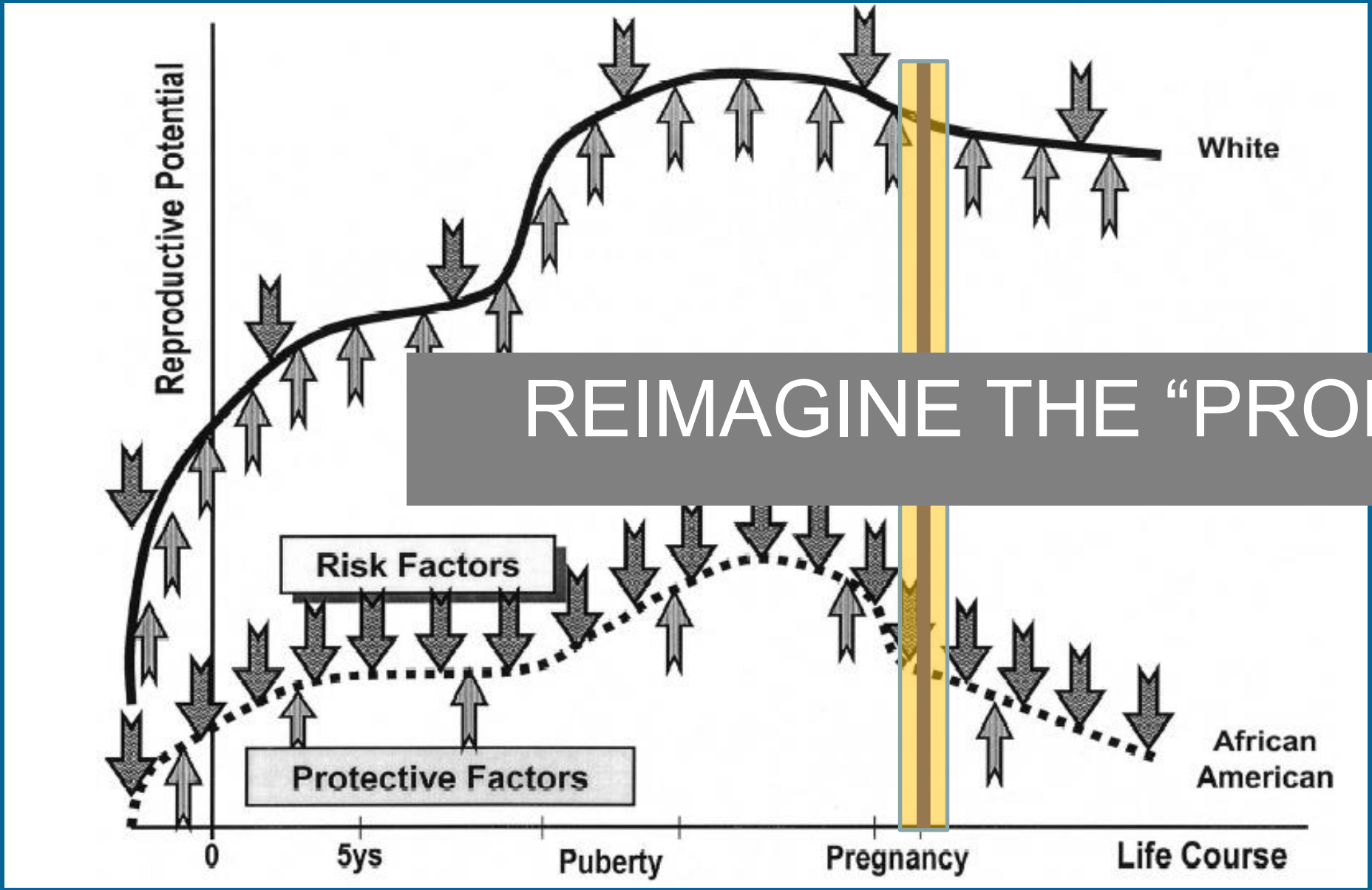
418 excess deaths

Excess Deaths by Period of Risk

Period of Risk	Maternal Health / Prematurity	Maternal Care	Newborn Care	Infant Health
Excess Deaths among Black Infants	160	106	29	123
Targets for Action	• **Preconception Health** • Prenatal behaviors • 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

IDPH
Illinois Department of Public Health

REIMAGINE THE “PROBLEM.”



Source: Lu MC, Halfon N. Racial and ethnic disparities in birth outcomes: a life-course perspective. Matern Child Health J. 2003;7:13-30.

Lifecourse Perspective to Improve Pregnancy Outcomes

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.

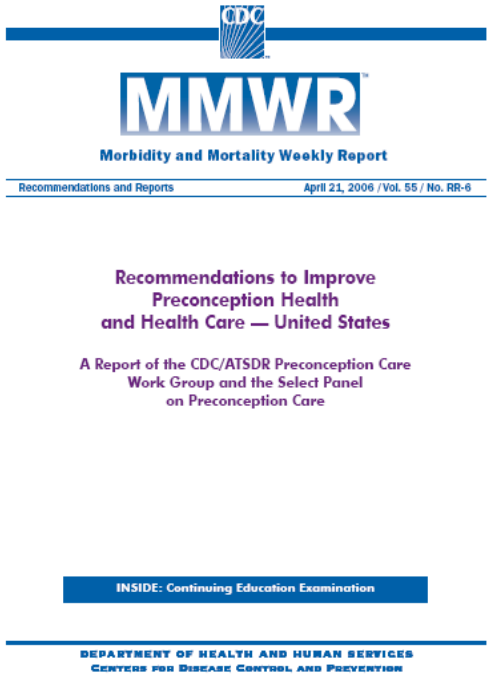
Source: Lu MC, Halfon N. Racial and ethnic disparities in birth outcomes: a life-course perspective. Matern Child Health J. ***2003****;7:13-30.*

Preconception / Interconception Health - Goal

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

march of dimes
A FIGHTING CHANCE FOR EVERY BABY™

Prematurity Campaign Collaborative

- ✓ **8.1% 2020 preterm birth rate goal**
- ✓ **5.5% 2030 preterm birth rate goal**

march of dimes
A FIGHTING CHANCE FOR EVERY BABY™

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.

IOM Committee – Preventive Services for Women

- **Linda Rosenstock, M.D., M.P.H. (*Chair*)**
  UCLA School of Public Health
- **Alfred O. Berg, M.D., M.P.H.**
- University of Washington
- **Claire D. Brindis, Dr.P.H.**
- University of California, San Francisco
- **Angela Diaz, M.D., M.P.H.**
- Mount Sinai Medical Center, NY
- **Francisco Garcia, M.D., M.P.H.**
- University of Arizona
- **Kimberly Gregory, M.D., M.P.H.**
- Cedars-Sinai Medical Center, Los Angeles
- **Paula A. Johnson, M.D., M.P.H.**
- Brigham and Women's Hospital, Boston
- **Anthony Lo Sasso, Ph.D.**
- University of Illinois at Chicago

Jeanette H. Magnus, M.D., Ph.D.
Tulane University

Heidi Nelson, M.D., M.P.H., FACP
Oregon Health and Science University

Roberta B. Ness, M.D., M.P.H.
University of Texas School of Public Health

Magda Peck, Sc.D.
University of Nebraska Medical Center

E. Albert Reece, M.D., Ph.D., M.B.A.
University of Maryland (Baltimore)

Alina Salganicoff, Ph.D.
Kaiser Family Foundation

Sally Vernon, Ph.D.
University of Texas School of Public Health

Carol S. Weisman, Ph.D.
Penn State College of Medicine

Clinical Preventive Services for Women: *Closing the Gaps*

Committee on Preventive Services for Women
Institute of Medicine, National Academy of Sciences
The National Academies Press, 2011

Released July 19, 2011
www.iom.edu

THE NATIONAL ACADEMIES
Advisers to the Nation on Science, Engineering, and Medicine

INSTITUTE OF MEDICINE

Recommendation 8

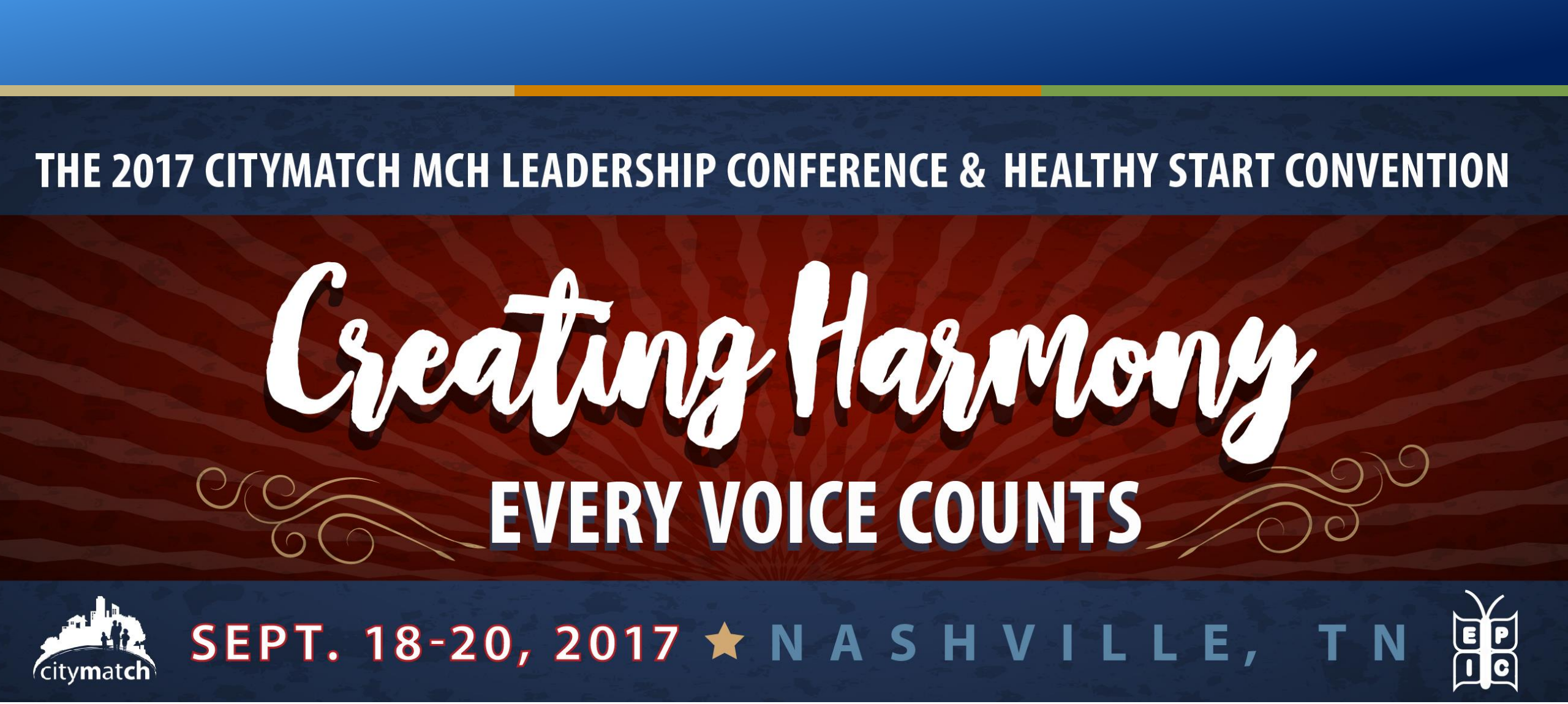
At least one well-woman preventive care visit annually for adult women to obtain the recommended preventive services, including preconception and prenatal care. The committee also recognizes that several visits may be needed to obtain all necessary recommended preventive services, depending on a woman's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



FRESH FROM THE 27th CONFERENCE…

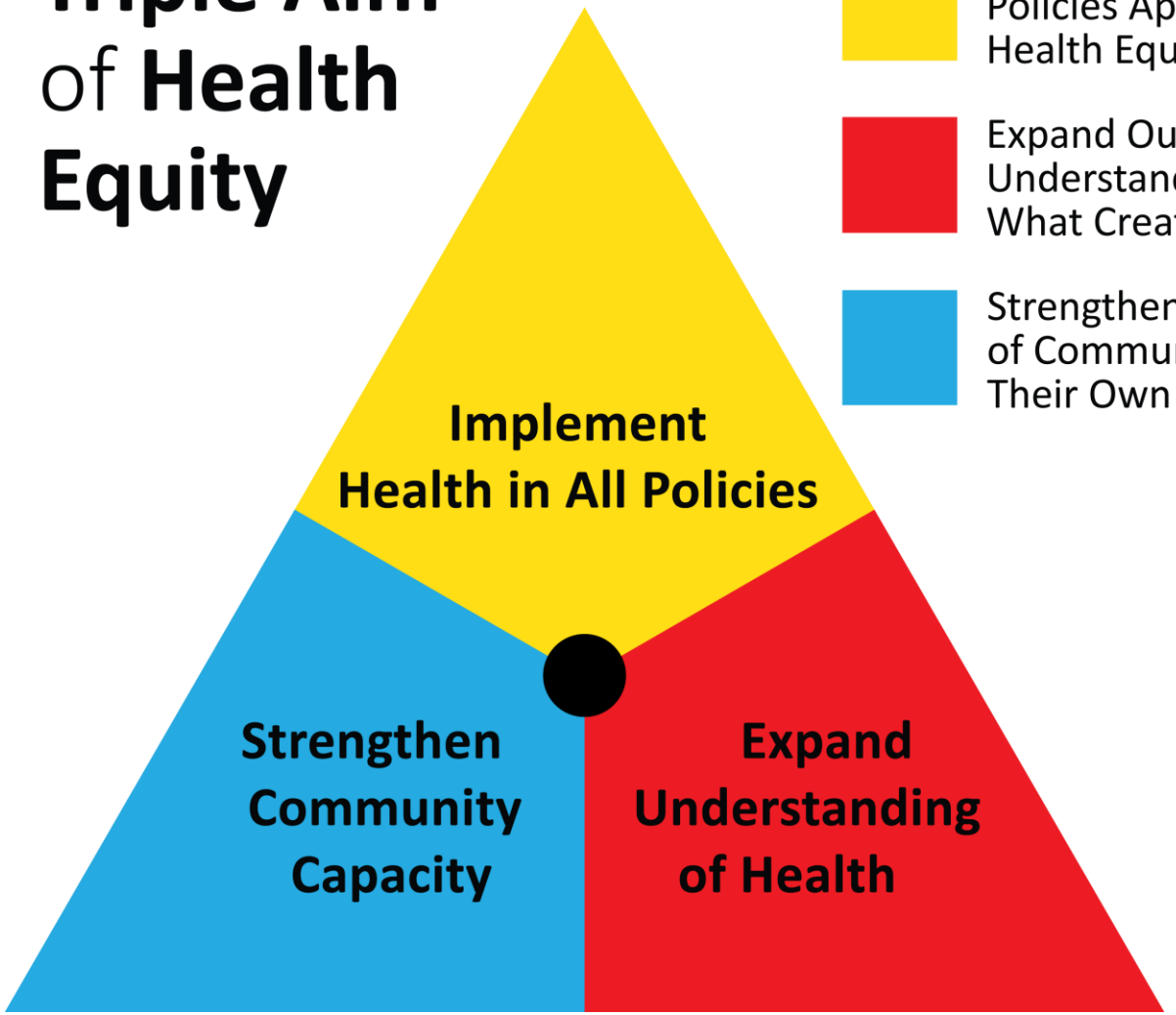
FOCUS: ...*toward a woman-friendly health system*

- ✓ **REPRODUCTIVE HEALTH**
  - well-woman care (UIC)
- ✓ **REPRODUCTIVE RIGHTS**
  - contraceptive deserts
- ✓ **SEXUAL AND REPRODUCTIVE JUSTICE** (NYC)

Bake Women's Health into the System

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.

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

DECLARE EQUITY NON-NEGOTIABLE

astho™

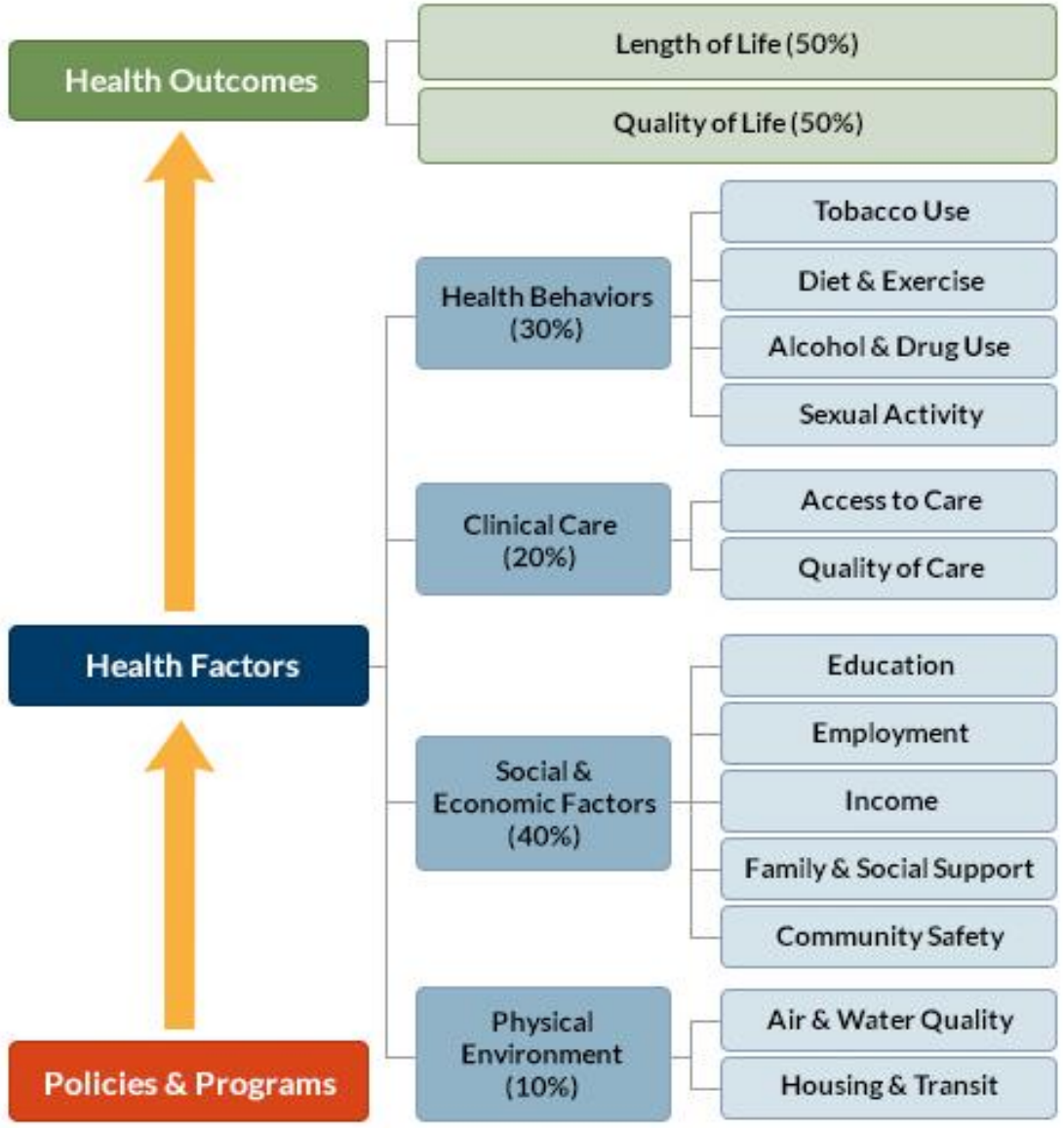
Practices for Advancing Health Equity and Optimal Health for All

- **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

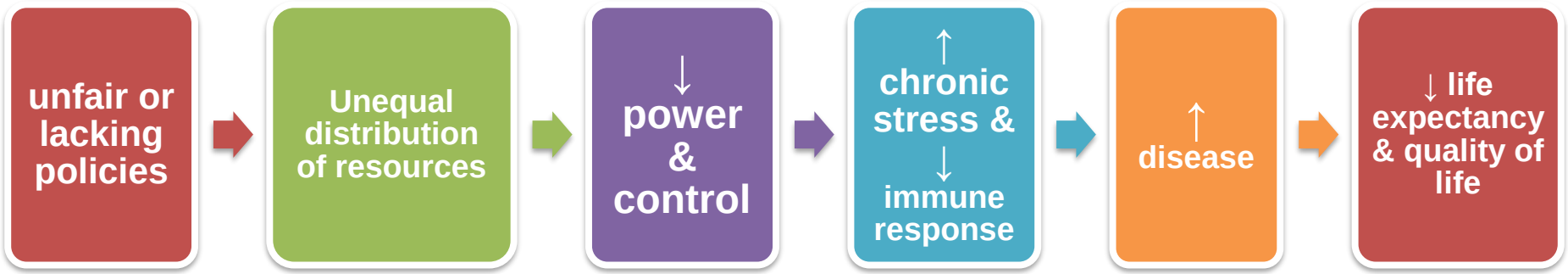
CHANGE THE NARRATIVE: 'HEALTH'

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



How do social determinants affect health?



NASHVILLE'S INFANT VITALITY COLLABORATIVE :

Nashville is the best place for babies to be born and thrive.

- CityMatCH **Collective Impact Learning Collabor**ative 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

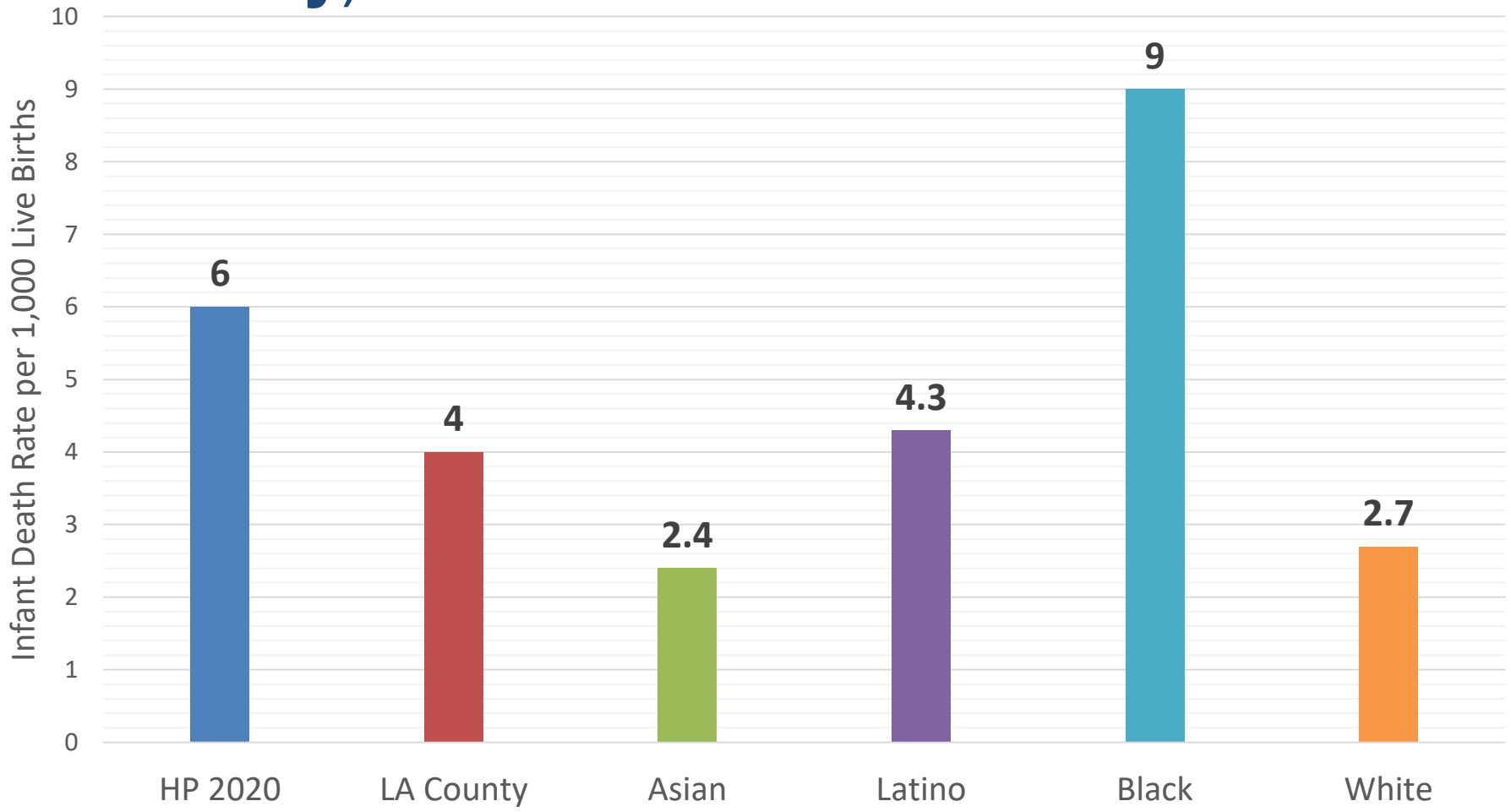
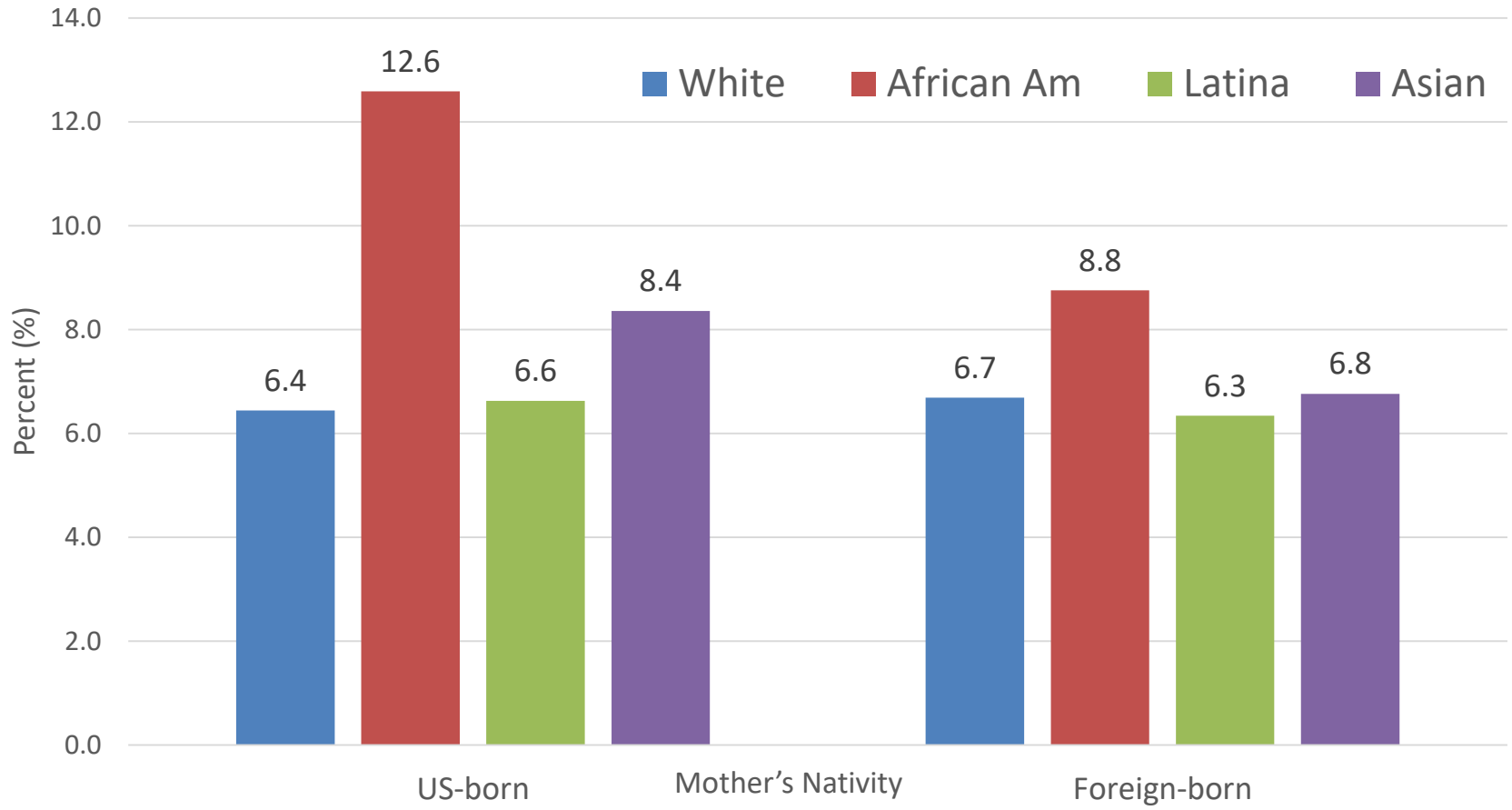


Table does not include data for Native Hawaiian and other Pacific Islander or American Indian/Alaskan Native.

Source: Los Angeles County Department of Public Health, Office of Health Assessment & Epidemiology, Mortality in Los Angeles County 2014

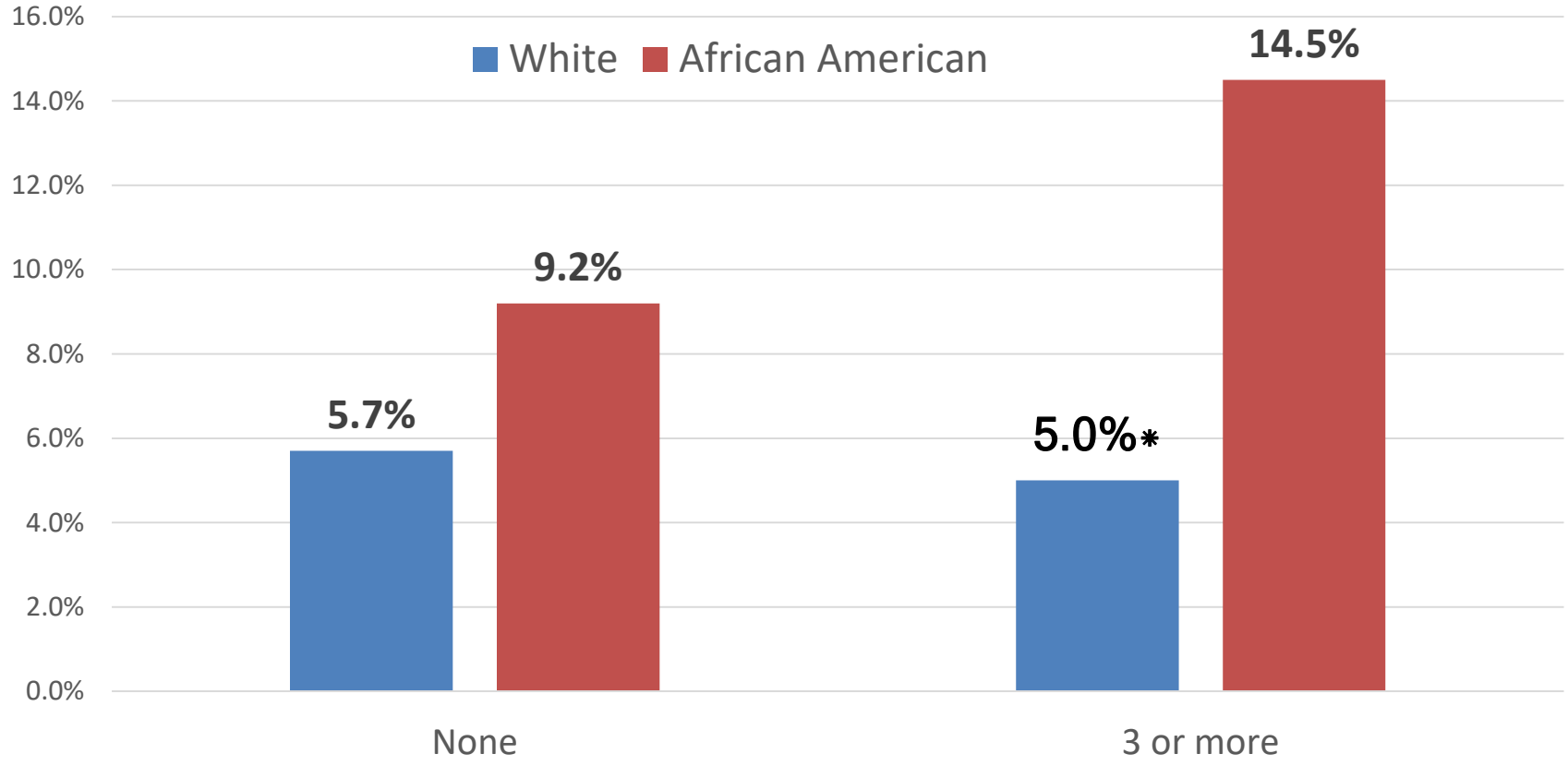
Percent of Low Birth Weight by Mother's Race/Ethnicity & Nativity: LA County, 2010-2015



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

Source: CDPH Birth Cohort Data, 2010-2015. Prepared by Office of Health Assessment and Epidemiology, 6/2017.

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

Adapted from: Medicaid and Social Determinants of Health: Adjusting Payment and Measuring Health Outcomes
http://www.statenetwork.org/wp-content/uploads/2017/07/SHVS_SocialDeterminants_HMA_July2017.pdf

Reframe Using an Equity Lens

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

Why?

How?

What?

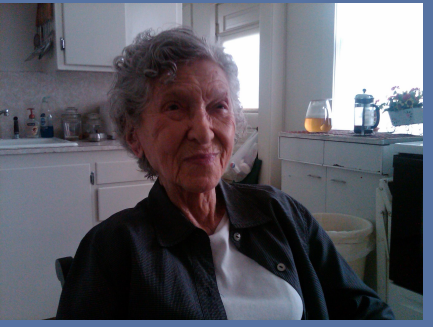
MP@63

ANXIETY =

UNCERTAINTY X

POWERLESSNESS

*CHIP CONNELY: 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!)