Raising the Bar

FOR MOMS & BABIES

Raising the Bar for Maternal Health Equity and Excellence

Actionable Strategies for Healthcare Systems

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national partnership for women & families

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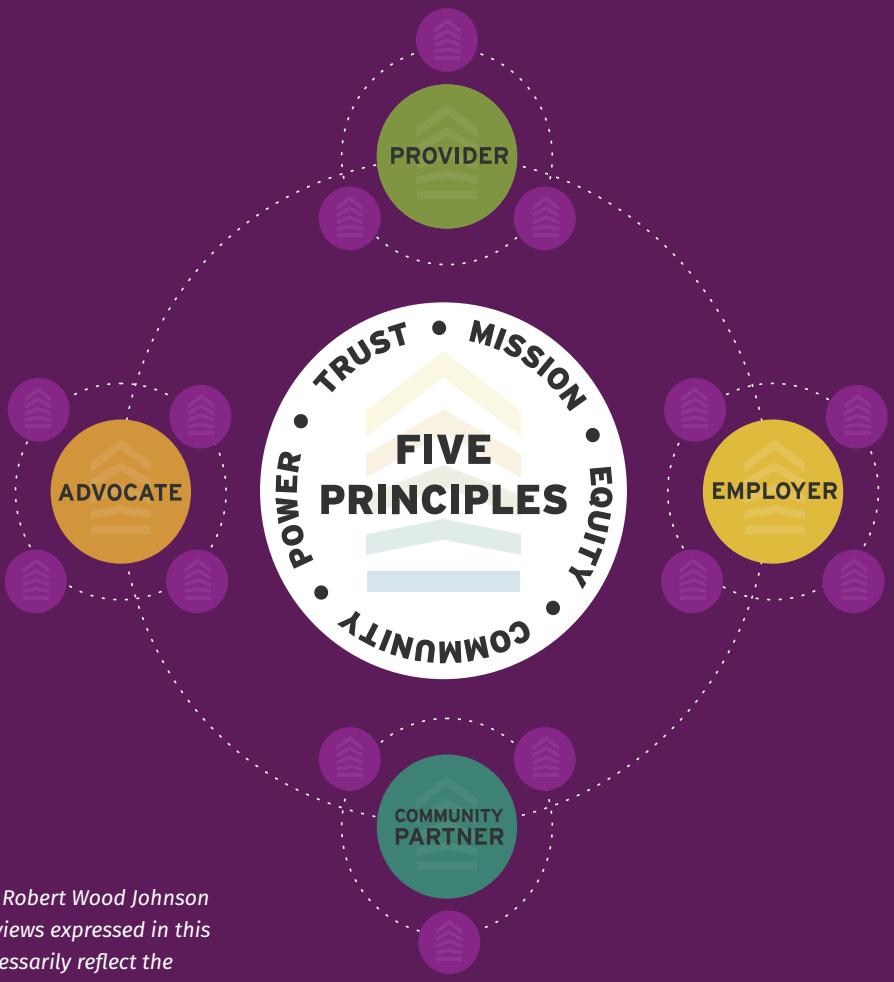

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Introduction

Healthcare provider institutions across the country face multiple challenges. They are charting a course toward rebuilding capacity, improving outcomes, reducing health and healthcare inequities, and protecting their financial sustainability even as the COVID-19 pandemic shows no signs of ending. Moreover, the urgency of solving the maternal* health crisis continues to escalate, not only because the pandemic exacerbated the crisis and widened disparities, but also because of the enormous harm it inflicts on women and their families and because it is emblematic of the intractable racial and ethnic health disparities that plague our nation. The convergence of these imperatives makes a compelling case for transforming healthcare to serve whole-person health grounded in patients' individual, family, and community context to solve the maternal health crisis. And it underscores the need for concrete, actionable strategies that healthcare leaders can implement to make needed progress.

Raising the Bar for Equity and Excellence in Maternal Health offers a practical guide for healthcare provider institutions – including hospitals and hospital systems, integrated health systems, independent women's health and multi-specialty provider groups, and federally qualified health centers – on advancing equity and excellence in maternal health. It is based on the *Raising the Bar: Healthcare's Transforming Role*[1] framework, developed through a deliberate, multi-stakeholder process sponsored by the Robert Wood Johnson Foundation. This framework crystallizes the many roles that healthcare, as a sector, plays in advancing the nation's health. In addition to providing healthcare services, this sector serves as an employer, a community partner, and a policy advocate – underscoring its enormous impact on health writ large.

Healthcare provider institutions have a powerful opportunity to advance equity and excellence in maternal and newborn health. To take advantage of this opportunity, institutions should work on developing and implementing action plans based on their current circumstances, tackling systemic barriers to health, improving structures and processes, and leaning into their many roles within the healthcare ecosystem.

Working to solve a generations-long crisis fueled by multiple factors is daunting, but making a difference is within your power. You already have assets at your disposal that you can deploy toward advancing maternal health equity. These include, for example, key infrastructure, committed staff, and a treasure trove of data, including information on patient safety and quality

* We recognize and respect that pregnant, birthing, postpartum, and parenting people have a range of gender identities and do not always identify as "women" or "mothers." In recognition of the diversity of identities, this report uses both gendered terms, as well as gender-neutral terms such as "people," "pregnant person," and "birthing people." In referencing studies, we use the typically gendered language of the authors.

improvement. To be sure, many external factors complicate efforts to transform maternity care in the service of achieving equity – such as the current payment system. There are even more external challenges to improving maternal health, such as the social drivers of health and deeply embedded structural inequities. This guide will help you identify what you can do *now* to make a difference with the care you provide, your organizational policies, and the way you collaborate with community partners, even as you advocate for more comprehensive solutions.

How to use this guide

This guide provides a roadmap for healthcare provider institutions that seek to reduce inequities and to improve maternal healthcare, experiences, and outcomes. Recognizing the importance of executive leadership, the primary recommendations are aimed at those serving in these roles: the decision-makers – such as C-suite executives and boards of directors. We also include more detailed recommendations for senior implementers – the department heads in areas such as maternal and women's healthcare, quality improvement, community and patient engagement, diversity, equity, and inclusion (DEI) work, human resources, and government affairs. Explore the Implementation Toolbox for complementary resources including checklists, inspirational stories of institutions that are raising the bar for maternal health equity, and a resource directory.

The guidance is divided into **four core roles** that healthcare provider institutions play: **(1) care provider, (2) employer, (3) community partner,** and **(4) advocate**. Each section includes a brief description of the importance of the role in advancing maternal health, suggestions for decision-makers on how to catalog and assess their work, and a menu of action items decision-makers can direct implementers to execute, based on the results of the assessment and identified priorities. We hope that this will help institutions "gut check" their ongoing maternal health and equity initiatives and identify strategies to refine, expand, and accelerate the work.

We understand that each institution is different in terms of the geography and populations they serve, their resources, priorities, and concrete challenges, and that they are all at different points in their journeys to be forces for improving maternal and infant health. We encourage you to start with whichever role or roles you deem most urgent, important, or strategic, and take the specific actions that you believe your organization is best positioned to implement. Our hope is that over time you will lean into all four roles to maximize progress.

We also hope that this guide and equity framework will inspire similar work in your institution in other clinical areas that also demand attention.

Raising the Bar: Healthcare's Transforming Role

Raising the Bar: Healthcare's Transforming Role is a framework and call to action for the healthcare sector to embrace all the resources and opportunities available to advance equity and excellence. The framework is built on five foundational principles[2] for a transformed healthcare system. To put these principles into practice, healthcare organizations need to act across four key roles, and 14 specific actions[3] to pursue the primary goal of improving health and well-being while treating all people with dignity and respect. These principles are designed for stakeholders who **provide care**, those who **pay for care**, and those who **help facilitate the delivery and payment** of physical, mental, behavioral, and social care and services.

Why focus on healthcare?

Healthcare exists in a broader ecosystem that includes those directly engaged in the delivery or payment of care, public health and social services organizations, and many other community stakeholders that influence economic and social well-being. The healthcare sector is neither solely responsible for, nor capable of, achieving health and well-being by itself; this must be a multi-sector effort.

RAISING THE BAR: FOUNDATIONAL PRINCIPLES

Healthcare, though, has a central role to play in transformation:

- Healthcare constitutes a fifth of the U.S. economy.
- Healthcare organizations have stature, power, and influence locally and at state and national levels that they can harness for positive change.
- Healthcare providers offer vital care to individuals and, by raising the bar, can help people and their communities become healthier.
- Payers and providers increasingly have incentives to support stronger prevention and engagement at the community level, particularly as healthcare systems transition to risk-sharing models.
- Many healthcare organizations are mission-driven, with the ability to incorporate equity and social justice imperatives within their mission.
- All healthcare actors have an opportunity and obligation to improve health equity and address institutional and structural harms.
- This work is already underway in forward-thinking and innovative organizations, but more action is needed.

A framework for health equity

The Robert Wood Johnson Foundation launched the development of Raising the Bar's principles in 2020 through a coalition led by the National Alliance to impact the Social Determinants of Health (NASDOH). NASDOH convened extensive discussions with provider, hospital, payer, and community representatives to develop foundational principles, essential roles, and concrete actions for the sector to help achieve optimal health for all. Two advisory councils oversaw the development of Raising the Bar's principles, roles, and actions. The Stewardship Council comprised senior leaders and stakeholders in healthcare, behavioral health, public health, and social services, along with advocates and people with lived experience of inequities. The Council to Improve Healthcare for Individuals, Families, and Communities (IFC), facilitated by the National Partnership for Women & Families, included community advocates, patient and family representatives, and people with lived experience of inequities. The present guidance applies the framework to the specific context of maternal and infant health.

Focusing on solutions to the maternal health crisis is both urgent and strategic for achieving health equity and improving our nation's overall health

Today, the United States is the most dangerous place in the industrialized world to have a baby, especially for those who are not white.[4] Our maternal health crisis is the clearest example of why healthcare needs to transform to address long-standing, worsening, and appalling inequities by supporting whole-person health – particularly considering that nearly 85 percent of maternal deaths are preventable.[5] In addition, the more we learn about the connection between maternal and infant health and people's long-term health, the more we understand that improving maternal and infant health is a powerful strategy for improving health over people's life span, preventing chronic disease, and reducing health inequities.[6] Moreover, healthcare provider institutions' focus on maternal and infant health is very strategic given the central place childbearing has in the healthcare system. Giving birth and being born are by far the most common reasons for being in the hospital, and cesarean birth is the nation's most common operating room procedure.[7] The care of mothers and newborns combined comprise the largest expenditures across all payers.[8]

The maternal and infant health crisis is persistent, worsening, and deeply inequitable

While available data indicate that the United States spends more on maternity care than any other country,[9] we lag far behind other high-income nations on results. Across 11 high-income nations, the United States had the worst rates of maternal mortality, neonatal mortality, and infant mortality, and its low birthweight rate was next to last.[10] What's more, while maternal mortality has been improving around the world since 1990, in the States, it has been getting worse.[11] This crisis has fallen most heavily on Black and Indigenous women. Compared to white women, Black women were three times as likely – and Indigenous women twice as likely – to experience a pregnancy-related death.[12] The COVID-19 pandemic exacerbated this crisis, increasing maternal mortality rates across all groups and widening racial disparities, with 2021 being the first time the rate for Hispanic women surpassed that of white women.[13] Compared to white women, Black women were about three times as likely – and Hispanic women were about twice as likely – to experience maternal deaths attributable to COVID-19.[14] In addition to racial and ethnic inequities, rural women also fare worse – with their rate of maternal mortality and severe morbidity being 9 percent higher than that of their urban counterparts.[15]

While maternal mortality has been garnering significant public and decision-maker attention, severe maternal morbidity (SMM), sometimes known as a "near miss" of dying, is often overlooked, despite it being far more likely and having serious consequences for mothers and babies.[16] In

the United States, SMM is estimated to be from 50 to 100 times more common than maternal mortality[17] and has been increasing steadily for decades.[18] Women of color fare much worse than white women. For every 10,000 hospitalizations for childbirth in 2019, 122 Black women, 81 Hispanic women, 65 white women, and 88 "other" women (including Indigenous, Asian and Pacific Islander, and mixed-race women) experienced SMM.[19] In addition, rural women fare worse than urban women. For many birthing people, infants, and families, SMM can be a traumatic experience, with devastating and far-reaching effects, including short- and long-term disability.[20]

People with disabilities and those who identify as LGBTQIA+ also contend with structural barriers and discrimination linked to worse birth outcomes, which may be linked to difficulty accessing services and providers with the skills and knowledge to provide tailored appropriate and respectful reproductive healthcare.[21] One national survey found that lesbian women were more likely to have stillbirth – and bisexual women more likely to have miscarriage – than heterosexual women in relationships with men;[22] and people with self-reported disabilities of any type were more likely to have preterm birth and low birthweight than those who did not identify any disability.[23]

Maternal morbidity does not have to be clinically severe to be harmful and concerning. Perinatal harm takes many other forms and affects large proportions of childbearing families. Perinatal depression and anxiety disorders are the most common complications of childbearing, affecting an estimated one in five pregnant or postpartum women.[24] Mental health conditions, including suicide and substance use disorder, are the leading causes of pregnancy-related death.[25] While treatments have a high rate of success, most childbearing women and people with these conditions do not receive treatment.[26] Pregnant and postpartum women of color are at elevated risk for mood disorders, yet are disproportionately undertreated for these conditions.[27] Left untreated, these conditions may lead to impaired fetal development, preterm birth, low birthweight, barriers to attachment, and developmental and psychological impairment in children.[28] Along with mental health diagnoses, many childbearing women and people experience pregnancy loss, trauma, mistreatment, and other forms of distress.[29] Yet birthing people and their families are largely left to navigate these challenges on their own. Among 11 high-income nations, the United States is the only country without guaranteed access to postpartum home visits.[30] Among *all* nations, only the United States and six Pacific island countries fail to provide guaranteed paid leave after childbirth.[31]

Addressing maternal and infant health is a strategic pathway to better overall health

Improving maternal health is a powerful way to achieve a healthier, more resilient nation, given the scale of impact and what we know about the effect of childbearing on women's health, and how pregnancy, childbirth, the postpartum period, and infancy can similarly affect the lifelong

well-being of the child. The science is clear that experiences before, during, and after birth can impact mom and baby over the long term and contribute to racial and other inequities in our society.[32] Some 83 percent of women in the United States give birth to at least one child.[33] The relationship between preeclampsia and future hypertension, or gestational diabetes and future type 2 diabetes, and the long-term benefits of breastfeeding are just three maternal examples.[34] Experiences at this this time can likewise work in favor of the child's long-term health or increase risk for conditions such as obesity, asthma, and allergies.[35] Whether it is allostatic load, the microbiome, or epigenetics – to name a few evolving fields of research[36] – robust accumulating evidence underscores the outsized importance of doing whatever we can to provide optimal maternity care for women and getting the next generation off to a healthy start.

How we did it: Our principles, partners, and process

With the support of the Robert Wood Johnson Foundation, the National Partnership for Women & Families launched the development of guidance for implementing the Raising the Bar principles in maternal health in fall 2020 with partners, advisers, and communications experts.

Our principles

The development of concrete guidance on how to raise the bar for maternal health was grounded in **principles of engagement**, implementing our best practices to focus on those closest to the maternal health crisis. This foundation allowed us to collaboratively and iteratively engage with stakeholders affected by the crisis to create solutions.

Four key principles guided our process:

- **Co-creation and collaboration:** This guidance results from a co-created process grounded in the perspectives of people with lived experience of inequities that resulted in poor maternal health outcomes, as well as the realities and opportunities identified by leaders in the community and healthcare delivery.
- **Centering on individuals navigating the worst maternal health barriers:** To succeed, it was vital to focus on those most often excluded from the high-level framing and decision-making. Including diverse opinions and a range of experiences is not just the right thing to do, it is the smart thing; it effectively solves a challenge by setting up systems that ultimately work better for us all.

- **Using available evidence and understanding its limitations:** We reviewed available evidence with a clear understanding that marginalized communities are sometimes excluded from research efforts. These evidence gaps can limit efforts to identify the causes of poor maternal health and to develop effective solutions. We relied on stakeholders sharing their lived experience, promising practices, and ongoing strategies to help fill some of those gaps. We also strove to remedy the erasure of the historical and ongoing mistreatment of communities of color at the hands of the medical establishment.
- **Developing a shared understanding of our collective purpose and ultimate goals:** Our collaborative orientation and sustained engagement process was unusual, particularly in that it was completely virtual because of the pandemic. More importantly, the work started with an effort to define optimal maternal health that focused on communities marginalized by inequitable economic, political, and cultural power.

Our partners

In service of collaboration, we worked with partners as well as an Expert Advisory Group (EAG). Partners were compensated through direct contracts, and EAG members were compensated directly for their time.

Organizational partners

We worked with three organizations throughout this project. The National Birth Equity Collaborative (NBEC) is a national organization addressing maternal health inequities for Black women and birthing people. The Alliance of Community Health Plans (ACHP) represents the nation's top-performing nonprofit health insurance organizations, serving tens of millions of Americans in 37 states and DC. ACHP is the voice of a unique payer-provider partnership model advancing proven solutions that deliver better value for patients, employers, and taxpayers. Their participation focused on the intersection of reimbursement structures and population health in provider-aligned health systems. The Health Care Transformation Task Force (HCTTF) is a consortium of nonprofit and private patient advocacy organizations, providers, payers, and healthcare purchasers. Together, the partners represent a broad spectrum of the perspectives and stakeholders affected by, or in a position to address, the maternal health crisis. They contributed to evidence generation and best practices; developing, designing, testing, and producing the guidance; creating additional resources tailored to their constituencies; and dissemination and promotion.

Maternal Expert Advisory Group (EAG)

To prioritize the expertise, vision, values, and voices of the people and communities most affected by the maternal health crisis, we invited a diverse set of people to serve in our EAG. They included midwives, community-based organizations, physicians, birth justice leaders,

social workers, and researchers who worked in varied areas, such as rural health, public health, disability, maternal mental health, social services, clinical professional societies, quality improvement, and safety-net hospitals. See Acknowledgments, page 96.

Over the course of two-and-a-half years, EAG members provided high-level recommendations for the guidance's primary audiences to improve maternity care and provided strategic direction and insight regarding promising practices, available evidence, and accountability metrics. This was done through virtual meetings, multiple smaller working-group sessions, and written feedback and revisions. The process started with defining "optimal maternal health" as the goal of our efforts. This definition provides clear parameters and conditions needed to support the physical and mental health and social well-being before, during, and after childbirth for both birthing persons and infants. See optimal maternal health statement, page 3.

Our process

Our process included a number of ongoing and sometimes overlapping activities with our partners.

Environmental scan

We worked with an independent researcher to help develop an overview of health equity, social drivers, and maternal health. We drew on peer-reviewed research, gray literature, and healthcare media articles covering healthcare's role in addressing patients' social, emotional, and physical health and in achieving health equity. We also reviewed implementation science and knowledge translation literature to identify key factors in organizing maternal health equity recommendations. We especially focused on identifying evidence gaps and where the patient and community voices were missing.

Focus groups and interviews

We recognized the need to get more data and information, especially on the challenges and successes of achieving equitable, high-quality maternal health and the kinds of tools and messages decision-makers need to improve maternity care at their institutions.

- **Communications research and message testing.** The Robert Wood Johnson Foundation commissioned a series of message testing and research among healthcare leaders and consumers, conducted by McCabe Message Partners between spring 2020 and fall 2022. Among healthcare leaders, there was widespread understanding of the need to advance health equity – especially in the wake of the COVID-19 pandemic. However, a shared definition of what constitutes "health equity" is lacking – and therefore efforts to advance health equity remain siloed across different departments, task forces, and initiatives. Where healthcare institutions have embarked on equity work, there is often a maternal health component. However, many leaders who are working on these issues expressed uncertainty

about the extent of maternal health inequities within their organizations. Lastly, healthcare organizations are overwhelmed: Financial resources, bandwidth, and burnout are serious concerns.

Research targeting healthcare consumers across the country prioritized people of color, individuals with disabilities and chronic illnesses, and LGBTQIA+ individuals to understand how healthcare could better serve their goals and needs. Consumer respondents were primarily concerned about quality, accessibility, and cost of care. They also understood the connections between health and social needs. Multiple participants identified maternal and women's healthcare as an area where improvement is particularly needed – most especially for Black women.

- **Partners surveyed their membership.** The ACHP and the HCTTF surveyed their plan and provider members to understand current efforts to improve maternal health, challenges to high-quality person-centered maternity care, and specific health-equity efforts within organizations. The findings indicate an ongoing evolution to value-based payment: Most plans and providers are using value-based maternity care payment, most commonly pay for performance, pay for reporting, and episode payment (bundles). Similarly, nearly all plans and providers HCTTF surveyed report that they are currently screening pregnant people for social needs, and most are working with community-based organizations to address identified needs. Common strategies to advance health equity within institutions include implicit-bias training, efforts to diversify staff, and the creation of diversity, equity, and inclusion (DEI) leadership positions.

  There was remarkable consistency in the identified challenges to advancing maternal health equity. One of the most pervasive was data availability and quality – particularly with race and ethnicity data and using it to inform care-delivery approaches. Partners also identified a pressing need for new payment models and other financing programs that address health equity or maternal health. Additional challenges include a lack of trust and access to care among patient populations.

- **Individual conversations with healthcare leaders.** We supplemented the information with a series of interviews with health provider institution CEOs, hospital leaders, and federally qualified health center (FQHC) representatives to test messaging and strategies for improving maternal health.

Iterative drafting and feedback process

We compiled all this information and feedback into concrete recommendations and an overarching report. EAG members provided insight about how to apply the roles and actions in a maternal health context based on their expertise and unique vantage points. We developed guidance recommendations and tailored them based on feedback from partners, advisers, and others with content and communications expertise. We also collected a variety of resources to complement the report.

Raising the bar during unprecedented crises

The COVID-19 pandemic brought increased urgency to the Raising the Bar project. The work was launched in 2020, just weeks before COVID-19 began to spread in the United States, and months before the public outcry and global protest movements in response to the murders of George Floyd, Breonna Taylor, Ahmaud Arbery, and many other Black women, men, and trans people. These events highlighted the connection between health equity and racial justice. The inequitable distribution of COVID cases, deaths, and vaccines revealed the stark impact of social circumstances on health. An inadequate response to escalating mental and behavioral health challenges further underscored the need for more effective and equitable provision of whole-person care.

The COVID-19 pandemic also exacerbated the maternal health crisis and pernicious inequities in maternal and infant health. Relative to non-pregnant women with COVID infections, pregnant women experienced more severe infections, required more intensive treatment, and were more likely to die.[37] Maternal mortality rose exponentially during the pandemic, the Black-white gap widened, and the formerly lower maternal mortality rate of Hispanic women rose to the same rate as that of white women.[38] The pandemic also dramatically altered maternity care experiences, for example, with restrictions on supportive companions at birth, increased rates of cesarean birth, and frequent separation of mothers and newborns.[39]

Additionally, the pandemic heightened longstanding shortages of obstetrician-gynecologists and other clinicians[40] and concerns about their burnout and professional dissatisfaction.[41] We recognize and empathize with the compounding toll the pandemic has had on the resilience of front-line workers in healthcare provider institutions. By improving care processes and work conditions, engaging and supporting a broader maternal health workforce, and supporting more effective maternity care, healthcare leaders can reduce the burden on front-line staff and contribute to their increased professional satisfaction.

Raising the Bar for Maternal Health in the context of the assault on women's health

Abortion is both an essential part of healthcare and a basic human right. Nearly one in four women in the United States will have an abortion by age 45.[42] Access to abortion care facilitates people's autonomy and dignity, and enables people to better care for themselves and their families. Abortion is essential to optimal maternal health. Women forced to carry a pregnancy and give birth after being denied an abortion experience more life-threatening complications during and after pregnancy, such as preeclampsia and postpartum hemorrhage.[43]

Access to abortion has never been guaranteed, especially for Black, Indigenous, and other people of color (BIPOC), LGBTQIA+ people, those with low incomes, and youth. While *Roe v. Wade* protected the *right* to an abortion as a matter of constitutional law, in practice, it didn't ensure *access* for all – which varied according to geography, insurance coverage, income level, and age. In June 2022, the U.S. Supreme Court upended this 50-year precedent in *Dobbs v. Jackson Women's Health*, giving states full authority to determine abortion law. Some states continue to support, and are affirming, the right to abortion. However, many other states are imposing restrictions, including complete or early-pregnancy abortion bans, which criminalize providers and others who facilitate access to care, as well as increasing the surveillance and possible criminalization of pregnant people. These divergent pathways reflect a great maternal health divide.[44]

An estimated 100,000 additional forced births will occur annually in the United States as a result of *Dobbs*.[45] Unintended pregnancies and births have been shown to harm the birthing person's physical, emotional, social, and financial well-being. Compulsory pregnancy and childbirth are especially dangerous for BIPOC women, who are significantly more likely to die from pregnancy-related causes or suffer SMM, and disproportionately live in states with bans and other restrictions. Immigrant, low-income, rural, and non-English-speaking people, among others, will also be harmed disproportionately. In fact, research indicates that the proposed national ban on abortion would sharply increase the maternal mortality rate by 24 percent, with an even higher increase for Black people.[46]

In this evolving landscape, widespread fear, uncertainty, and new restrictions are spilling over into the experience of pregnancy and pregnancy care for all people, including both those who are forced to carry out their pregnancies against their will and those who want to be pregnant and give birth. Many childbearing people experience new acute needs for safety, support, and well-being. In many jurisdictions, legal threats are fueling hesitancy and delays in seeking and obtaining safe, timely care for miscarriages (which occurs in 10 to 30 percent of pregnancies) and life-threatening ectopic pregnancies and stillbirths, which may require some of the same medications and procedures as abortion care.[47] Legal fears – rather than medical considerations and patient preferences – are driving decisions about managing pregnancy loss, jeopardizing women's health and lives. This further erodes trust between patients and healthcare providers, especially in communities where trust is already tenuous, given historical and ongoing mistreatment by the medical establishment. There are also far-reaching effects for the healthcare workforce, for example because medical residents in those states cannot get trained in the full complement of skills necessary for managing women's health.

Defining, creating and sustaining optimal maternal health

A consensus statement from the project's Expert Advisory Group

Optimal maternal health encompasses the health and well-being of a birthing person and infant. It involves physical, mental, and social well-being and applies before, during, and after the physiologic process of childbearing. Furthermore, it encompasses reproductive justice, personal agency, and bodily autonomy of all birthing people, and freedom from bias, racism and other forms of discrimination.

- **Physical health** is not merely the absence of disease, but overall wellness and ability to thrive, including contributing to one's family, community, and society as desired.
- **Mental health** encompasses emotional and psychological well-being and resilience, and may include freedom from violence, trauma, and conditions such as chronic stress, anxiety, depression, and alcohol and other substance-use disorders.
- **Social well-being** means individuals and families are born, grow up, live, learn, work, play, and age in communities with socioeconomic structures and conditions that support their physical and mental health and promote their agency, autonomy, resilience, and ability to thrive.

Resilience is an indispensable component of optimal maternal health as it enables people to safely survive and thrive, and enhances their ability to cope in the face of chronic and episodic physical, emotional, and social stressors and trauma.

Optimal maternal health contributes to safe, nurturing, warm, responsive infant-caregiver relationships that are crucial for the child's lifelong well-being. The birth parent is the child's first environment and often the most essential infant caregiver. The pregnancy, birth, postpartum, newborn, and infant periods are all crucial foundations for lifelong well-being and involve a number of conditions that can contribute optimal health.

Conditions for optimal maternal health

Optimal maternal health requires **reproductive justice**, which posits that every person has the right:

1. To decide when or if to become pregnant, or continue a pregnancy;
2. To determine the conditions under which they will birth and create a family; and
3. To parent with dignity any children they have, with the necessary social supports, in safe environments and healthy communities, and without fear of violence from individuals or the government.

Optimal maternal health is rooted in good health status prior to pregnancy, anchored in healthy communities and healthy families, and enabled by health-supporting structures, policies, programs, and practices.

For optimal maternal health, future childbearing people and parents must be born, grow up, live, age and work in health-generating conditions.

Optimal maternal health involves honoring and respecting the cultural practices, beliefs, and traditions of individuals, families, and communities and meets the social needs that include: economic security; safe workplaces, neighborhoods and homes; nourishing food; accessible and reliable transportation; strong social networks; and quality education, including health literacy.

Optimal maternal health requires the elimination of adverse childhood experiences (ACEs), which often lead to lifelong trauma of childbearing people and parents. Pathways to prevent ACEs can include improving the conditions and environments that reach back to before a person is born, including the impact of intergenerational trauma and historical policy decisions that either suppressed or denied opportunities to live a healthy life.

Optimal maternal health requires dismantling the toxic effects of the various levels of racism (including structural, systemic, institutional, and interpersonal), physical and emotional abuse, and other oppressive structural inequities and forms of bias

Communities of color and others adversely affected by intersecting structures of disadvantage must be included and prioritized when designing, implementing, and evaluating the research, education, practices, and policies needed to achieve equity in maternal health.

Centering the lived experiences and expertise of those most affected must drive these efforts.

Achieving optimal maternal health requires truly accessible, high-quality, affordable, culturally congruent, and comprehensive healthcare, in addition to solving the broader structural inequities that undermine health.

Achieving optimal maternal health requires truly accessible, high-quality, affordable, culturally congruent, and comprehensive healthcare, in addition to solving the broader structural inequities that undermine health.

Healthcare must be person-centered, affirming, respectful, supportive, and confidence-building and must provide the information and the options people need to make informed decisions about their health and healthcare, based on the best available and applicable evidence that recognizes deep historical biases and gaps in evidence generation and analysis.

Healthcare that supports optimal maternal health must encompass longitudinal primary care before and after giving birth, including comprehensive reproductive and sexual healthcare, first-line primary preventive maternity care, more specialized maternity care for those with higher risks and complications, and mental health and substance use disorder services and support. It must also take on a more expansive and concrete role in ensuring that the social needs of birthing people and infants are met and fully integrated within healthcare.

To truly raise the bar in healthcare and achieve optimal maternal health, the healthcare system must center and prioritize maternal and infant care given its long-term impact across the life course.

We thank Sister Song and the many Black women leaders who have worked to create, refine, and promote the Reproductive Justice framework, which was foundational to the development of this definition of optimal maternal health.

Endnotes

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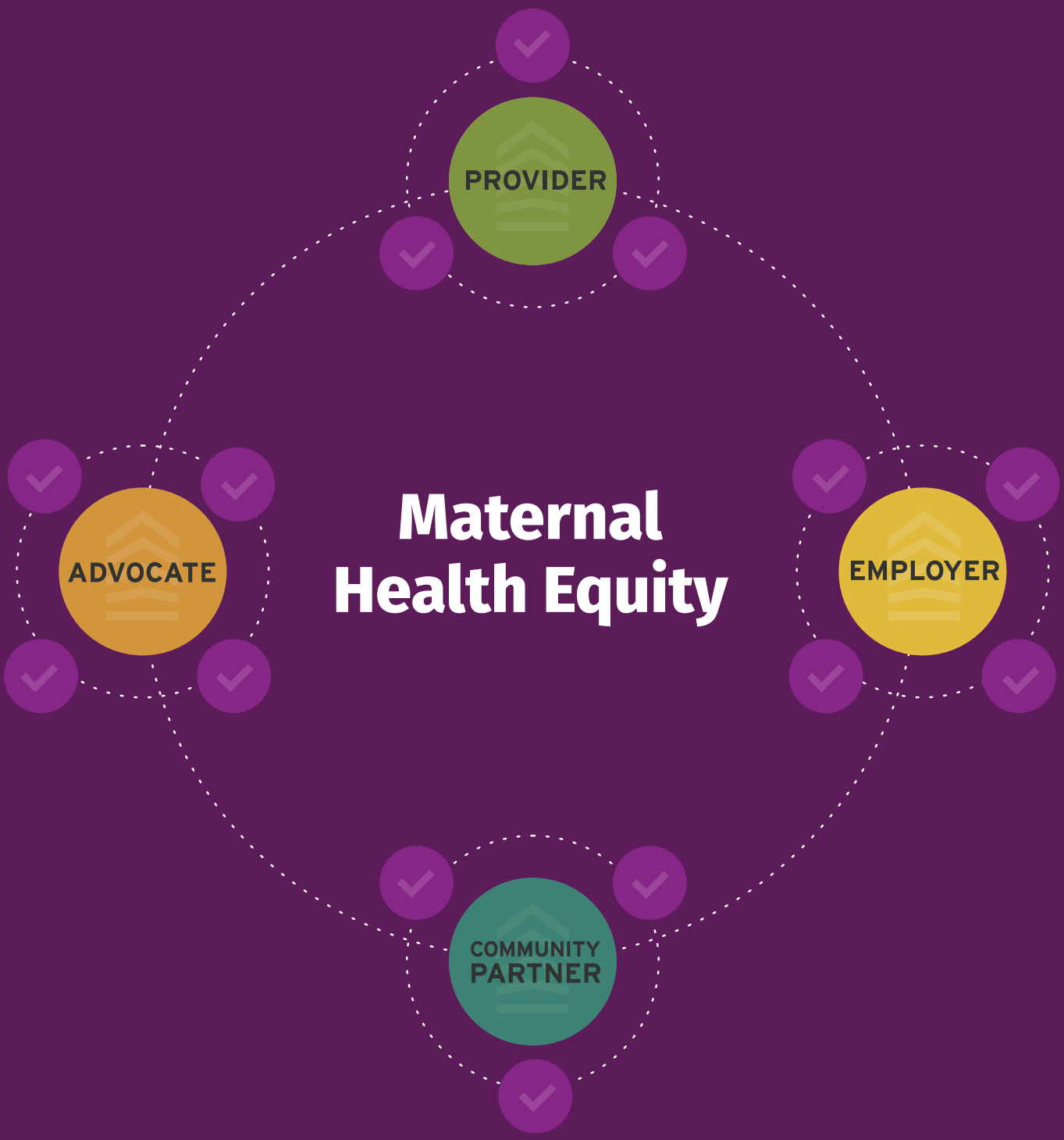
PROVIDER
ADVOCATE
Maternal
Health Equity
EMPLOYER
COMMUNITY
PARTNER

The Maternal and Newborn Care Provider Role

Provide whole-person care to achieve maternal health equity

Dedicated and hardworking maternal and newborn care providers have faced several years of unprecedented demands during a grueling pandemic. They are also being called upon to improve care, equity, experiences, and outcomes of childbearing families. The recommendations below support an effective response to these expectations, with a focus on strengthening the structures that support provision of excellent maternal-newborn care. Improving structures and processes can raise the bar for childbearing families, enhance professional satisfaction, and mitigate burnout and turnover.

To deliver optimal care for birthing people* and their families and mitigate the maternal health crisis, provider institutions should recognize that a family's life context has at least as much influence on maternal and infant health outcomes as the clinical care they receive. Provider institutions should understand and address people's health needs in the context of their overall physical, mental, emotional, spiritual, social, behavioral, and environmental well-being. Providing "whole-person care" is critical for birthing families, and even more so for families who must also contend with racism, ableism, and other forms of structural inequities that undermine their health. Healthcare provider institutions should develop and implement policies, programs, and practices tailored to that reality. Lastly, structures of accountability should reinforce this pathway for achieving optimal maternal and newborn health.

While addressing the drivers of maternal-newborn health is not the exclusive responsibility of healthcare provider institutions, they have a central role to play within their mission. Concretely, this requires rethinking *how* care is provided and *by whom*.

Providing comprehensive, high-quality, culturally centered whole-person care takes time and skill and ideally should be tailored to people's varying needs and contexts. This will likely require a range of activities, from strengthening clinical systems to enhancing the social drivers of health in their community (see Advocate Role, page 78). To effectively provide whole-person care, care teams should include personnel such as midwives, mental health providers, reproductive healthcare providers, social workers, care navigators, lactation counselors, and doulas (see Employer Role, page 38). Developing and resourcing partnerships with local community-based organizations will be instrumental in doing this well (see Community Partner Role, page 60).

Whole-person care must focus on the dignity, personal agency, and bodily autonomy of birthing people. It should be free from racism and other forms of bias and discrimination, and respect the autonomy of birthing people and their culture. This may include enabling alternative complementary practices.

* We recognize and respect that pregnant, birthing, postpartum, and parenting people have a range of gender identities and do not always identify as "women" or "mothers." In recognition of the diversity of identities, this report uses both gendered terms, as well as gender-neutral terms such as "people," "pregnant person," and "birthing people." In referencing studies, we use the typically gendered language of the authors.

Spotlight on Innovation

A Multifaceted Strategy to Improve Black Maternal Health

Who: Penn Medicine Department of Obstetrics and Gynecology

Where: Greater Philadelphia, PA

What: Within a systemwide program to advance health equity, the Penn Medicine Department of Obstetrics and Gynecology is implementing multifaceted strategies to advance maternal health equity. Within one year, they reduced severe pregnancy complications in Black women by nearly one-third.

WHY: In 2020, as outrage over the police killing of George Floyd sparked worldwide attention on institutional racism, the University of Pennsylvania's health system committed to take anti-racist action and establish a new institutional culture. The need for change was urgent in Philadelphia, where almost one in four residents lives in poverty, and roughly two-thirds are people of color. Moreover, community violence, limited access to fresh food, and other factors associated with worse health outcomes – including childbearing complications – are abundant.

Relative to the national Black maternal health crisis, disparities are more pronounced in Philadelphia, where Black women are four times more likely to die in pregnancy, childbirth, and the first year postpartum than white women. To alter these sobering statistics, Penn Medicine tackled racial disparities in maternal morbidity, declaring maternal health equity a priority for the 2021 fiscal year.

GOAL: The Ob-Gyn Department and Women's Health Service Line developed and implemented Penn Medicine's goal of reducing maternal morbidity and mortality among Black women across the system's five maternity units.

Six Levers to Advance Black Maternal Health Equity

1. Bold leadership
2. Workforce diversity
3. Embedding equity in quality improvement and research
4. Addressing biases
5. Leveraging technology
6. Engaging the community

HOW: The department and service line identified major factors contributing to maternal morbidity and created a composite quality metric. Adding this goal created personal stakes for over 600 senior leaders whose level of compensation — from 10 to 40 percent of it — would depend on their ability to meet team goals. By tying executive salaries to reduction of severe complications related to childbirth, the hospital system signaled its commitment to maternal health equity.

Addressing hemorrhage, a serious complication of childbirth, was a priority. The Penn Medicine team leveraged system-wide partnerships to pool resources and foster structural change. They created a learning collaborative across the system's five maternity units. Monthly meetings covered evidence-based practices, including how to assess hemorrhage risk, measure blood loss, and respond quickly. The ob-gyn staff frequently carry out simulations to respond according to structured protocols when hemorrhage occurs. The team also made progress toward more equitable use of cesarean birth, with staff intentionally applying evidence-based practices and using standardized labor induction guidelines.

RESULTS: After a year of implementing the program, severe pregnancy-related complications in Black women declined by 29 percent.

MORE ON THE MODEL: The team goal was a part of a comprehensive strategy with six major levers the ob-gyn department developed to advance maternal health equity. The first requires bold leadership from the CEO, management, and the ob-gyn department chair to tackle maternal morbidity and mortality among Black women. The approach also includes recruiting and retaining a diverse workforce, embedding equity across quality improvement efforts and a robust research portfolio, implicit bias trainings and mechanisms for reporting bias; innovative technology platforms to improve outcomes and reduce disparities, and engaging the community in quality, safety, and research efforts. Achieving maternity health equity will require sustained commitment to this multipronged strategy.

The Takeaway

With high stakes for executive leaders and comprehensive collaborative approaches to address the causes of maternal mortality, the Penn ob-gyn department's strategy and health equity improvements are a model for other health systems nationwide.

Healthcare can and must be better at supporting birthing women and people

In the United States, rates of maternal mortality, severe maternal morbidity, and other more common complications are increasing, and maternal and newborn outcomes are inequitable and lag behind other high-income nations.[1] This underperformance suggests that there are opportunities for the maternity care system to more reliably provide women and other birthing people with the high-quality care, services, and support that they need to thrive and have healthy children. The great majority of dollars paid for maternity services are allocated to the brief window of hospital care around the time of birth,[2] and to a model that provides technology-intensive care to nearly all moms and babies, regardless of need or preference. This leaves just a fraction of resources to support people in pregnancy and postpartum, when needs and opportunities to improve outcomes are great. Concerns about the quality of maternity care include broad practice variation, with considerable overuse of unneeded care and underuse of preventive and other beneficial practices,[3] and challenges in identifying and meeting social and mental health needs, which affect maternal and infant health outcomes.[4]

Crucially, the burden of these concerns is inequitably distributed and disproportionately impacts communities that have been adversely affected by racism and other forms of discrimination. These include communities of color, LGBTQIA+ individuals, people with disabilities or low incomes, and rural communities. Childbearing families living at the intersection of these identities experience compounding layers of harm that widen gaps in care, experiences, and outcomes.[5]

One of the most pervasive and intractable concerns is the disrespectful treatment of birthing people, especially those who have been structurally marginalized, which contributes to preventable adverse outcomes. Studies show that many women who gave birth in hospitals, where almost all U.S. births take place, were mistreated during childbirth.[6] Among the kinds of mistreatment experienced, one study found that being yelled at or scolded was the most common, followed by being ignored or having a request for help refused.[7] Another study found that a quarter of women who were induced or had a cesarean birth felt pressured to consent to those interventions, and nearly 60 percent who had episiotomies were not asked to give consent.[8]

Many Black women and other women of color describe how they are disrespected and ignored by the system and individual providers, and studies have confirmed a pattern of mistreatment.[9] The racial disparities on some mistreatment indicators were particularly pronounced, with Black, Hispanic, Asian, and Indigenous women all being twice as likely as white women to report being ignored or having their request for help refused. Young women, immigrant women,

and women having their first child were also more likely to report mistreatment.[10] Birthing people also report experiencing ableist,[11] transphobic,[12] and anti-fat[13] bias, which can compound the mistreatment of people of color.

These experiences of disrespect and mistreatment have direct negative impacts on the health of birthing people and their babies. For example, a study of maternal mortality in California found that provider factors – such as delayed response to clinical warning signs – were the most common contributor to maternal deaths.[14] This is particularly disturbing given the racial disparities in providers ignoring or refusing requests for help from women of color.

Actions that raise the bar for providing high-quality, equitable, whole-person maternity care

1. Provide maternal-newborn care tailored to diverse socioeconomic and cultural life contexts and needs.

Given the disproportionate burden of poor maternal-newborn health among those from communities that have been marginalized by racism and other structural inequities, healthcare provider institutions should actively work to redesign care for birthing people to make it truly high-quality, culturally centered, and accessible for everyone in our rapidly diversifying nation. Institutions should ensure that all people and families can access the pregnancy, birthing, postpartum, and comprehensive reproductive healthcare and support they need, with a special focus on mitigating – if not eliminating – barriers, including financial, physical, geographic, and those rooted in sexism, racism, homophobia, and ableism.

2. Establish and sustain a trusting environment where all childbearing families are treated with dignity and respect and feel welcomed.

The stories of birthing people – especially Black women and other women of color – being dismissed and ignored underscore the urgency of sustaining environments built on trust, and for healthcare provider institutions to consistently act in a trustworthy manner. The history of sterilization and other reproductive and sexual health appropriation, manipulation, and exclusion can still impact treatment today. Healthcare provider institutions must acknowledge

the link between historical mistreatment, discrimination, and racism and the contemporary experience of discrimination and bias. They should actively work to elicit and listen to the experiences of birthing people and their families as a first step toward establishing a culture of dignity. Healthcare provider institutions should follow through on commitments to being anti-racist and continue to take active steps to eradicate all forms of racism and bias from their work. This could include a comprehensive assessment of how the remnants of patterns based on white supremacy, misogyny, and other types of discrimination affect care. Striving for virtuous cycles of caring and respect can help build and sustain trust.

3. Provide holistic, effective, high-quality care responsive to the needs and preferences of childbearing women and people, as well as plans co-created with individuals, families, and caregivers.

Whole-person care requires recognizing the expertise each person has in their own body, life, needs, and desired childbearing experience. A holistic model of care engages the birthing person in understanding their needs and preferences and making their maternity care plans, understanding that one size will not fit all. Plans should be co-created; they should cover care from pregnancy through the first year postpartum and center on effective communication. They should not only cover physical health goals, but also account for social, mental health, and emotional support needs. Given the importance of social conditions for maternal-infant health and the opportunities for maternity care to help address unmet social needs across this long episode of care, initial and periodic screening for social needs is essential for creating and implementing an optimal care plan. The care plans should be accessible to the birthing person and to all members of the care team through electronic health records and patient portals. Ideally, plans should integrate the full range of personnel – home- and community-based health workers, social workers, licensed behavioral health professionals, and others – and organizations needed to deliver effective and comprehensive care, including social services and public health agencies. Plans should be dynamic, in recognition of the birthing person's evolving circumstances and preferences. Lastly, the plans should be supported and encouraged by the care team in ways that demonstrate their commitment to not only the plan, but the birthing person's agency.

There are opportunities for maternity care to help address unmet social needs across this long episode of care.

Raising the bar for whole-person maternity care in your organization: Priority recommendations

Operationalizing the above vision will require breaking it down into sequential strategies and concrete tactics. Your organization can start by recognizing and using existing structures (and data) for patient safety and quality improvement efforts.

Effective leadership will be the most important factor in any effort to achieve this needed evolution. The executive leadership (e.g., chief executive, operating, financial, medical, and nursing officers (CEO, COO, CFO, CMO, CNO), chair of the board of directors) should commit to this work, set expectations and accountability, and provide the budgets and other resources needed. The relevant senior leadership for the selected improvement from among vice presidents and directors must prioritize implementation. Clinical and front-line staff should set meaningful goals and help identify needed support and resources. This will in many instances bring together staff from outside the department that provides maternal care to achieve institutional alignment and optimal results.

Executive leadership

Raising the bar for better maternal healthcare, experiences, and outcomes starts with you. Your enthusiasm and commitment will drive your managers and staff toward measurable success. Clear directives, accompanied by necessary resources (budgets, infrastructure, and personnel), are indispensable.

Assessing your organization's current conditions and activities should be your first step. An effective plan should be tailored to your organization's starting point and ongoing initiatives. Therefore, a comprehensive assessment is a necessary first step for data-driven improvement. To be sure, you can take immediate actions while such an assessment is underway. Nevertheless, assessment will provide a "gut check" on what you are currently doing and where identified gaps call for further action. Assessments should be informed by available data and should involve those who are familiar with the needed information. The assessment team could include a combination of people from your quality improvement department, clinical innovation team, community health team, and patient experience team. It should also include input from those using or seeking those services.

Building on and updating progress to date, the assessment should include the following:

- Latest maternal and infant health access, outcomes, quality, and experience data, stratified by self-identified race, ethnicity, limited English proficiency, disability, sexual orientation and gender identity, and type of coverage, with historical trends if available (CMO and/or Quality Improvement (QI) team).
- Inventory and assessment of clinical maternity and reproductive healthcare services (pre-conception, pregnancy, childbirth, and postpartum practices) through the lens of whole-person care (CMO and/or QI team).
- Inventory and assessment of the intercultural competence of leaders and organization (CMO and/or QI team).[15]
- Inventory and assessment of the capacity to support the mental health and social needs of diverse childbearing women and people (CMO and/or QI team).
- Assessment of the current capability to effectively and respectfully serve specific groups of people who wish to become pregnant, are currently pregnant, or recently gave birth (QI team, CMO, COO). These groups include:
  - People from communities experiencing historical and ongoing racism.[16]
  - Immigrants, including those without legal status.[17]
  - People with limited English proficiency.[18]
  - People with disabilities.[19]
  - People with varied sexual orientations and transgender and gender-nonconforming people.[20]

- Survey of current and potential birthing people about their expectations for and recommended improvements of maternity-related services, co-designed with service users (QI, patient experience, community health team).
- Hospital assessment of facility readiness to support breastfeeding using CDC's mPINC 10 Steps Assessment Tool.[21]

Once the assessment is complete, it is essential to discuss the findings with the executive team and senior leadership to identify priority areas for action and investment and create an implementation plan. The executive leadership and the board of directors should set the vision and commitment to whole-person, equity-centered care that spans the full episode of maternity care.

Senior leadership team

Once the executive leadership sets a direction, develop and implement the budgets and plans to carry out this commitment. Senior leadership may include directors of functions such as quality improvement, maternity services, community health, patient experience, outpatient services, DEI, and even human resources. Below are recommended next steps.

- **Allocate the necessary budget(s) to improve institutional readiness for exemplary service to diverse populations.**
  - **Why:** Changing the status quo – both to improve patient care and the work environment and burdens on staff – requires resources. People with disabilities or limited English proficiency, and people who are transgender or gender-nonconforming, among others, might require specific staff, staff training, equipment, facility modifications, signage, forms, website changes, or other modifications to access high-quality, equitable, person-centered care. Depending on the kinds of changes needed, different department or office heads may need to work together and think creatively about how to repurpose savings. Making these kinds of investments will help to relieve existing pressures.
  - **How (examples):**
    - ☐ For purchasing new equipment, the CFO, COO, facilities management lead, and DEI staff must work together.
    - ☐ Improving the readability of the website may require involvement from IT.
    - ☐ Training staff on how to work respectfully with people of different sexual orientations and gender identities might need to involve HR.

- **Establish performance metrics across executive management and other staff.**[22]
  - **Why:** Excellent outcomes for equitable whole-person maternal care will require the involvement and accountability of people across the institution. Therefore, your organization should adopt position-specific performance metrics.
  - **How (examples):**
    - ☐ Tying executive compensation to improvements in outcomes and reductions in inequities.
    - ☐ Implementing associated performance metrics at various levels – complying with the requirement will be measured for all staff in their performance reviews.
    - ☐ Provide DEI training with respect to preconception, prenatal, birthing, and postpartum care for all relevant staff.
- **Implement best practices for equitable maternal care delivery, with a focus on mitigating the impact of racism, addressing social needs, and dismantling systemic racism and other structural inequities.**[23]
  - **Why:** Racism and unmet social needs are clearly linked to poorer birthing outcomes, and a number of care models and interventions have been shown to mitigate these factors.
  - **How (examples):**
    - ☐ Tailor initiatives to minimize specific departures from high-quality care implicated in disparate outcomes, such as hemorrhage, hypertension, cardiac conditions, substance use disorder, inequitable breastfeeding, and safely avoidable cesarean birth, including repeat cesarean birth.[24]
    - ☐ Review severe maternal morbidity (SMM) cases[25] and apply lessons.
    - ☐ Ensure that policies enable birthing families to choose who and how many can accompany them during appointments and birthing.
    - ☐ Enhance institutional ability to provide racial/ethnic and language-concordant care by diversifying staff (see Employer Role, page 38).[26]
    - ☐ Provide anti-racist and inclusive training to all personnel who interact with childbearing people and set aside time to process learnings.

Excellent and equitable maternal care outcomes will require the involvement and accountability of people across the institution.

Specific opportunities to improve maternity care quality, equity, and outcomes

Given the urgency of the maternal health crisis, healthcare provider institutions should begin implementing recommendations while the assessment is still in progress and before developing a comprehensive improvement plan. Senior leaders should consider the following options that should have near-universal benefit for birthing families, irrespective of the specific pain points that the assessment will uncover. (See Implementation Toolbox for detailed recommendations.)

- **Make care more accessible.**
  - Offer evening and weekend appointments.
  - Offer telehealth visits, in-home visits, mobile clinics, and other options for expanding access to care.
  - Co-locate laboratory, imaging, mental and behavioral health, and other services to facilitate one-stop prenatal and postpartum visits.
  - Ensure the accessibility of exam rooms and other service areas.
  - Make translators available and ensure signage and websites are available in priority languages.

- **Increase access to maternity services in rural areas.** Health systems and hospitals without – or at risk of losing – rural maternity services should explore options to make essential high-quality maternity services available, including:
  - Considering the clinical and business case for operating maternity units in critical access hospitals.
  - Relying on birth centers to make essential, high-quality maternity services available.
  - Expanding local capabilities through provider access to telehealth, electronic databases, clinical pathways, protocol cards, and life flight.
  - Providing telehealth to childbearing families for routine visits, lactation and mental health support, and other services.
  - Expanding professional skill sets (e.g., general surgeon proficiency in cesarean birth, and nurse-midwife proficiency as surgical first assist, and in ultrasonography, assisted vaginal birth, and mental health).

- **Ensure birthing people can access a diverse, well-equipped, and effective care team.**
  - Include a range of clinical care providers and support personnel, such as midwives, maternal-fetal medicine specialists, mental health providers, comprehensive reproductive healthcare providers, lactation support providers, care navigators, community-based doulas, and other community-based providers.
  - Establish contracts with community-based organizations that can provide culturally congruent support and care.
  - Create a no-wrong-door approach for connecting with needed social and community services.
  - Enable birthing people to contribute to, help coordinate, and implement their care plans.
- **Implement evidence-based practices associated with vaginal birth and reduction of safely avoidable cesarean births.**
  - Track and report:
    - ☐ The nationally endorsed cesarean birth performance measure.
    - ☐ The nationally endorsed balancing measure to ensure safe levels of cesarean birth (Unexpected Complications in Term Newborns).
    - ☐ The Vaginal Birth after Cesarean (VBAC) Delivery Rate, Uncomplicated measure.
  - Implement proven practices for increasing the likelihood of vaginal birth, including midwives,[27] and continuous support during labor, especially from a doula.[28]

- **Screen for physical and mental health and social needs at key points in pregnancy and the postpartum period.**
  - Use robust, culturally responsive screening tools.
  - Co-create and consistently update care plans with the birthing person.
  - Facilitate access to the plan by all members of the care team.
- **Prioritize meeting mental and behavioral health needs during pregnancy and the postpartum period.**
  - Measure and report the Prenatal Depression Screening and Follow-Up and Postpartum Depression Screening and Follow-Up performance measures.
  - Offer telehealth options for mental health services.
  - Publicize the National Maternal Mental Health Hotline.
  - Provide referrals to respected support and community organizations.

- **Support the reliable provision of respectful maternal-newborn care.**
  - Measure respectful care, disaggregated by race and ethnicity, for internal improvement and accountability.
  - Use existing toolkits and frameworks to promote respectful maternity care.
  - Support staff's ability to provide respectful, appropriate care and customer service for diverse families.
- **Expand options for prenatal care and track engagement.**
  - Advance innovative models with added value relative to standard prenatal care, such as:
    - ☐ Midwifery-led prenatal care.
    - ☐ Group prenatal care options.
    - ☐ Telehealth and home monitoring programs.
  - During pregnancy, track patient activation by reporting the nationally endorsed Gains in Patient Activation Measure (PAM) Scores.
- **Provide non-coercive, culturally centered support for lactation.**
  - Report the nationally endorsed Exclusive Breast Milk Feeding performance measure.
  - Provide access to peer counselors and lactation specialists to support human milk feeding
  - Establish breastfeeding-friendly spaces and adhere to the 10 Steps to Successful Breastfeeding.
- **Provide postpartum services for at least 12 months.**
  - Optimize the current two postpartum visits recommended by the American College of Obstetricians and Gynecologists.
  - Report the nationally endorsed Contraceptive Care-Postpartum performance measure.
  - Provide access to educational programs, including Post-Birth Warning Signs and Hear Her.
- **Participate in your state's perinatal quality collaborative (PQC) and in sequential high-impact quality improvement initiatives.**
  - Identify inequities by race, ethnicity, and other demographic variables within the quality improvement programs.

- **Ensure that staff responsible for interacting with childbearing families have the skills and knowledge to reliably inform and connect them to necessary social supports.** Examples include:
  - Special Supplemental Nutrition Program for Women, Infants, and Children (WIC).
  - Information about available state and local paid family and medical leave programs.
  - Legal protections relating to job security and workplace accommodations.
  - Written statements to managers about any needed temporary accommodations.
- **Implement a consistent, streamlined process for accessing financial assistance or charitable care, within and outside the provider institution, that is not punitive or predicated on the existence of medical debt.** Healthcare provider institutions can assist patients by:
  - Not pursuing legal action to collect unpaid medical debts from patients eligible for financial assistance.
  - Preventing, detecting, and reporting billing fraud and abuse.
  - Providing onsite financial navigators, increasing repayment flexibility, and proactively identifying patients at risk of medical debt.
  - Providing understandable information to patients on costs and access to financial assistance.
- **Establish and sustain an active and well-supported, maternity-specific patient and family advisory council (PFAC) that is representative of the community served.**
  - Incorporate members' expertise on policy changes, new programming, and other concrete maternal health activities.
- **Ensure access to high-quality comprehensive reproductive healthcare as a necessary complement to maternal healthcare.**
  - Provide medically accurate, evidence-based information on options for abortion care and non-stigmatizing support for people considering pregnancy termination.
  - Understand obligations and protections under both the HIPAA (Health Insurance Portability and Accountability Act) privacy rule and the Emergency Medical Treatment and Labor Act regarding patients who are pregnant or experiencing pregnancy loss.

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The Employer Role

Employ and support a diverse maternal health workforce

Being an employer is a central function of the healthcare enterprise. One of the greatest challenges healthcare provider institutions face today is recruiting and retaining the workforce they need to operate effectively and provide high-quality, culturally congruent, person-centered care for all of their patients. Longstanding workforce challenges include deep concern about the impending retirement of an entire generation of clinicians and an insufficient pipeline to replace them, as well as professional burnout and dissatisfaction. There is also growing understanding that the lack of cultural congruence is a missed opportunity for better health outcomes.

The COVID-19 pandemic demonstrated with new urgency how not having the needed number, distribution, and diversity of healthcare staff undermines an institution's ability to serve their patients and broader communities and support their staff. The pandemic continues to exacerbate existing workforce challenges, leading to increased burnout and staffing shortages. Moreover, the disparate impact of the pandemic on communities of color highlighted the trust deficit between providers and the people they serve, which contributes to the persistent inequities these communities face – including in maternal health.

For more than a decade, the American College of Obstetricians and Gynecologists has identified concerns about the underrepresentation of Black and Hispanic ob-gyns and multiple converging factors that contribute to a projected workforce shortfall.[1] The pandemic exacerbated challenges for this specialty and for midwives, maternity nurses, and doulas as well.[2]

Healthcare provider institutions should leverage their role as employers to reduce inequities and improve the health outcomes. The shifting demographics of communities across the country have profound implications for the needs of patients and their families, and for the pool of available staff. The maternity care workforce and the entire healthcare industry must adapt to provide optimal care to everyone during this transition. Healthcare provider institutions should invest in leadership teams committed to health equity, a diverse and robust workforce – of both direct employees and contracted staff – and equitable policies that support the well-being of the entire workforce.

Spotlight on Innovation

Air Traffic Controller for Maternal Health Equity

Who: Henry Ford Health

Where: Southeastern Michigan, including Detroit

What: Henry Ford Health created a Director of Maternal Health Equity to lead a systemwide strategy to advance equity and respectful high-quality maternal and newborn care.

WHY: Health equity is part of the DNA of Henry Ford Health (HFH), a major health system serving metropolitan Detroit. HFH has participated in the Women-Inspired Neighborhood Network: Detroit, a consortium of the major health systems serving Detroit to reduce the metro area's infant mortality rate for more than 15 years.

Despite this important work, southeastern Michigan still has a Black maternal and infant mortality rate three times that of white women. When HFH leaders assessed maternal health outcomes across their system, the data revealed racial disparities, for example, in postpartum hemorrhage rates – a leading cause of largely preventable maternal mortality.

HFH realized success would require a comprehensive, sustained focus on Black maternal health, and a way to lead and coordinate systemwide efforts across five hospitals using the institution's existing architecture for quality improvement.

GOALS:

- To reduce maternal and infant mortality in specific regions in Southeastern Michigan, including Detroit, and
- To reduce the rates of severe maternal postpartum hemorrhage and maternal hypertension in African American and Latina women by 40 percent by 2025.

HOW: In 2021, the HFH executive leadership and board of directors identified maternal and infant mortality as the top priority in their health equity work. This included allocating the funding and assigning the authority for a new, systemwide position, Director of Maternal Health Equity. This position coordinates the people, processes, and tools necessary to reduce maternal and infant mortality and achieve equitable outcomes, particularly for Black and Latina women — like an air traffic controller for maternal health equity. This position is currently held by an accomplished board-certified maternal-fetal medicine physician.

The Diversity, Equity, Inclusion, and Justice Strategic Plan, developed by the executive leadership and approved by the board of directors in early 2021, included tactics to deliver highly reliable, equitable, and respectful maternal and infant care. The plan identified measurable goals for reducing rates of maternal and infant mortality, postpartum hemorrhage, maternal hypertension, and risk of sudden unexplained infant death in Black and Latinx women and babies. HFH also convened the Maternal Infant Health Equity Strategic Taskforce, a team of maternity care providers, pediatricians, neonatologists, inpatient and ambulatory nurses, hospital administrative staff, doulas, lawyers, a data analyst, and birthing people.

The Director of Maternal Health Equity meets monthly with HFH's Women and Children's Council, which includes leaders from all five hospitals, to implement this strategic plan systemwide. Planned initiatives include mobile integrated postpartum home health visits and social needs screening at all prenatal and pediatric visits. The director also actively supports initiatives related to the root causes of racial and ethnic maternal and infant health inequities through social justice and systems change, and by equipping the surrounding communities with resources.

RESULTS: To ensure the level of attention and resources needed to advance maternal health equity, HFH established a new position to develop and lead a five-year strategic plan.

The Takeaway

Establishing and resourcing a senior-level position exclusively dedicated to advancing equity across maternity services is an innovative strategy for the complex task of providing high-quality, respectful, and equitable maternity care necessary to increase survival of Black women and infants within Southeastern Michigan.

Birthing families urgently need diverse providers to improve their health.

Maternity and newborn care exemplifies the need for healthcare provider institutions to use their role as employers to advance health equity. Culturally congruent maternity care is foundational for improving quality, building trust, and eliminating racial and ethnic inequities in maternal and infant health outcomes.[3] Today, nearly half the babies are born to mothers who are Black, Indigenous, Latinas, Asian American, or Pacific Islander[4] – all communities with worse maternal health outcomes than non-Hispanic white birthing people.[5] Yet generally speaking, the clinical staff attending these families does not share their background (see table below), which can engender misunderstandings, disrespect, and mistrust, and can contribute to poorer outcomes.[6]

Moreover, maternity care teams should include non-clinical staff, such as doulas, care navigators, community health workers, and other perinatal health workers, who can provide respectful, trusted, culturally congruent care to birthing people* from communities of color. However, these team members should supplement – rather than substitute – a clinical workforce that can provide culturally congruent care.

Table. Birthing Population, Obstetrician-Gynecologists, and Nurse-Midwives by Race and Ethnicity, 2019

Race and Ethnicity	Birthing Population	Obstetrician-Gynecologists	Nurse-Midwives
White	51.1%	70.0%	77.3%
Hispanic or Latino	23.6%	8.4%	6.6%
Black or African American	14.6%	11.0%	6.7%
Asian	6.4%	8.3%	7.5%
Unknown	0.9%	1.8%	1.6%
American Indian and Alaska Native	0.7%	0.5%	0.3%

Sources: Zippia. "Ob-Gyn Demographics and Statistics in the U.S.," accessed January 14, 2023, https://www.zippia.com/ob-gyn-jobs/demographics/; U.S. Centers for Disease Control and Prevention, "About Natality, 2016–2021 Expanded," accessed January 14, 2023, https://wonder.cdc.gov/controller/datarequest/D149

* We recognize and respect that pregnant, birthing, postpartum, and parenting people have a range of gender identities, and do not always identify as "women" or "mothers." In recognition of the diversity of identities, this report uses both gendered terms, as well as gender-neutral terms such as "people," "pregnant people," and "birthing persons." In referencing studies, we use the typically gendered language of the authors.

Actions that raise the bar for maternal health in your role as an employer

1. Invest in and support leaders who advance and embed equity, quality, and value across the organization to improve maternal health.

Leaders committed to advancing health equity should set the vision, direction, and priorities for the workforce. Building this bench of leaders involves both improving the skills of existing leaders to understand and advance equity, and recruiting the next generation of leaders.

Increasing diversity at the leadership level (e.g., the C-suite, the board, and department heads) can strengthen an organization's policies and practices, which in turn will likely improve maternal and infant health outcomes. However, the healthcare industry is missing the mark when it comes to leadership that represents the communities they serve. Roughly nine out of 10 hospital CEOs are white.[7] Only 15 percent of healthcare CEOs are women, despite comprising a large majority of healthcare workers, including the maternal health workforce.[8]

Across industries, racial and gender diversity in leadership and staff is positively associated with employee retention, engagement, satisfaction, and trust; with organizational innovation and performance; reputation and integrity; and financial performance – both in times of stability and turbulence.[9] Diversity in leadership can enable leaders across the organization to better understand and serve diverse clients, staff, and their communities when designing programs and policies, while helping to prioritize diversity at all levels. At the board level, female directors are more likely to include social issues (e.g., human rights and income equality) in corporate strategy,[10] and demographically diverse boards are more likely to adopt workplace policies (e.g., work-life supports) that can lead to employee satisfaction.[11] In order to realize these benefits, it is important to create opportunities for leaders to share diverse thoughts and concerns without fear of retribution.

2. Employ and cultivate a workforce that is representative of the surrounding community and is trained, equipped, and supported to advance maternal and infant health equity.

Employing a diverse workforce – with regard to race and ethnicity, sexual orientation and gender identity, disability status, and primary language – can improve the health of birthing people and families. The value of racial and cultural concordance has been identified in

maternity nursing,[12] midwifery care,[13] birth center care,[14] and doula[15] and lactation[16] support. Black women have expressed a preference for racial concordance with their providers during pregnancy and childbirth.[17] Racial concordance between Black newborns and their physicians is associated with *halved* infant mortality rates, as compared with white newborns.[18] Nursing workforce diversity is associated with reduced severe maternal outcomes during childbirth.[19] Similarly, increasing the number of health workers who identify as having a disability and who require accommodations to practice can improve healthcare experiences and outcomes for patients with disabilities.[20] Birthing people with disabilities face unique challenges accessing care, and often deal with healthcare practitioners who lack knowledge or comfort in managing their pregnancies, which puts them at heightened risk for pregnancy-related health complications.[21]

A culturally congruent care team is an important first step in ensuring patients have a healthy pregnancy and a safe childbirth experience. Having one's background and circumstances understood, valued, and respected improves clinical care and experience by helping people feel connected to the healthcare system. A diverse and representative workforce can offer care that meets the unique social, cultural, and linguistic needs of birthing people and their families. When staff see themselves represented in the healthcare workforce, they are more likely to trust their provider, which is fundamental to improving the patient-provider relationship.[22]

Hiring a more representative and inclusive workforce also helps attract a wider pool of job seekers and improves retention by fostering a sense of community.[23] A diverse workforce can also alleviate the stress and reduced morale that comes from feeling disconnected or unable to engage authentically in the workplace.[24]

3. Create and sustain workplaces and jobs where employees can be healthy, thrive, and help guide effective and equitable maternal care.

Supporting staff's health and well-being is critical to reducing burnout and churn. Some health workers experience the same challenges as their patients, including food and housing instability and systemic racism.[25] Gender and racial disparities in pay persist.[26] Employees who are healthy and economically secure are better positioned to deliver high-quality, compassionate care. They also are more likely to remain in their roles, mitigating the operational challenges institutions face due to staff shortages and burnout. Also, considering that the vast majority of clinical providers of maternity care are women, it is essential that employee health and wellness policies support the maternal and infant health of pregnant and parenting employees.

4. Leverage procurement to ensure the diversity and well-being of contract workers who provide care and otherwise support the health of birthing people and are birthing people themselves.

Many essential workers are employed by outside contractors. While a growing number of the contracted workforce are nurses, they also include support workers (e.g., medical and nursing assistants, pharmacy and personal care aides, and phlebotomists) and service workers (e.g., janitorial, security, and food service staff), who are among the lowest-wage workers and are overrepresented by women and people of color.[27] As the COVID-19 pandemic illustrated, these workers are typically underpaid and undervalued. Furthermore, they often lack the privileges and protections offered to direct employees.[28] By instituting policies that help contract workers stay healthy and safe, care for their families, and maintain economic stability, healthcare systems can make important strides toward equity for all their workers and the community overall.

Raising the bar for maternal health as an employer: Priority recommendations

Your leadership will be essential in prioritizing new objectives and strategies, securing needed resources, and facilitating the evolution of workforce policies so that they better align with the needs of the workforce, your patients, and the community.

Executive leadership

The executive leadership and the board of directors are essential to setting the vision for a better supported and more diverse workforce. Carrying out these essential responsibilities will require the involvement of others, especially in your senior leadership team and the HR department, and those responsible for your DEI work (if they aren't already included in HR). Procurement and contracting will likely involve your COO and facilities director or manager. It may also include the CFO and staff from the legal and contracts office.

- **Start with an assessment.** Ask your HR department to either review themselves or hire an external expert to analyze the demographic data and related metrics of your staff. Identify actions that you can undertake while this assessment is underway. The review should include:
  - **Establishing your baseline.** What is the current diversity of your maternal health workforce? Review their demographic data on race, gender, age, disability, and sexual orientation and gender identity (if known). Determine the extent to which demographics of your workforce aligns with the broader community in which you are located.
    - ☐ Analyze workforce diversity at various levels in your organization (known as vertical proportionate diversity).
    - ☐ If data are not available, distribute an anonymous survey to get them.
  - **Identifying disparities in employees' health outcomes.** To understand how health inequities are affecting your workforce and which policies are necessary, review deidentified employee health outcome data, stratified by race, gender, age, disability, and sexual orientation and gender identity (if available).
  - **Completing a voluntary DEI survey** for all staff, including contract workers, that includes questions about opportunity, satisfaction, inclusivity, and accessibility. Make sure you can segment and review the data by department, staff level, as well as along demographic groups. The survey should be anonymous and is best handled by an outside entity to ensure confidentiality and engender trust.

- **Auditing workplace policies and benefits that support the well-being of your pregnant and parenting employees and their beneficiaries.** These include policies and benefits specific to your organization (e.g., maternity care health insurance benefits), legal requirements (e.g., pregnancy and breastfeeding accommodations), and policies and programs that would benefit – but may not have been reaching – this population (e.g., doula support and paid leave). Assess the effectiveness and accessibility of workplace supports.
- **Auditing your policies for hiring and supporting contract workers.** Include eligibility and terms that ensure contractors are supporting the health and well-being of their workers. Audit how your organization supports the health and well-being of pregnant and parenting contract workers.

Once the assessment is complete and you have a baseline, distribute and discuss the findings – being transparent with regard to shortcomings – to identify priorities for action and investment, and mandate the creation of an implementation plan for leadership and department heads. The plan should be transparent, specific, measurable, and meaningful to your workforce and the community.

Invest in and support leaders who advance equity, quality, and value across the organization to improve maternal health.

This includes active efforts to dismantle existing structures of inequity within your institution by creating career pipelines, leadership pathways, and mentorship opportunities, among other programs and structures. (See Implementation Toolbox for detailed recommendations.)

- **Embed DEI into workplace culture and operations.**
  - **Why:** Resources, expertise, and commitment are necessary to embed equity into strategic planning and operations and effect sustainable institutional change.
  - **How (examples):**
    - ☐ Work directly with your board of directors to diversify your executive leadership and the institution as a whole
    - ☐ Ensure that the board has direct governance over meeting equity and diversification goals and prioritizes these goals as strongly as fiduciary responsibilities.
    - ☐ Work with the board to diversify itself, including ensuring that at least one, and optimally more, members bring birth justice[29] expertise.

- ☐ Adopt metrics tied to key performance indicators to monitor DEI progress and hold the C-suite and department heads accountable.
- ☐ If a senior DEI position does not exist, create it (preferably reporting directly to the executive office), and ensure appropriate staffing and resources. Clarify responsibilities, which could include hiring and retention, staff training, and data management.
- ☐ Hire and task a DEI leader dedicated to the organization's maternity services.

- **Provide career pathways and leadership opportunities for the people of color on staff.**
  - **Why:** Most healthcare leadership and staff are not representative of the communities they serve. Achieving diversity in senior and executive-level staff requires equitable opportunities for women, people of color, and other underrepresented groups.
  - **How (examples):**
    - ☐ Set and share goals to increase diversity in your organization's executive leadership, by race, ethnicity, gender, disability status, and other categories.
    - ☐ Develop and disseminate equitable criteria necessary for advancement.
    - ☐ Develop and resource mentorship programs, especially those that cultivate relationships between executive leadership and staff from communities of color.
    - ☐ Provide support for entry- and mid-level staff from underrepresented groups to participate in leadership development programs.

Employ and cultivate a representative workforce at all levels that is trained, equipped, and supported to advance maternal health.

- **Set a measurable expectation that all staff incorporate anti-racism in their work.**
  - **Why:** An anti-racist workplace is crucial for the wellness and retention of a diverse workforce, and is imperative for addressing the maternal and infant mortality crisis. Accountability metrics will help ensure that personnel actively work toward meeting these expectations.
  - **How:**
    - ☐ Provide anti-racist training for leadership and staff.
    - ☐ Set and share metrics for how success of anti-racist objectives will be measured.
    - ☐ Tie performance on equity and anti-racism metrics to performance reviews, with the potential to impact compensation and promotions.
    - ☐ Ensure that leaders across the organization model anti-racist practices.

- ☐ Seek educational opportunities for leadership and staff to understand how to use language to frame the maternal health crisis and relevant solutions that are rooted in the birth justice framework.

- **Set and pursue goals to cultivate a diverse maternal health workforce.**
  - **Why:** To establish accountability; build trust among staff, patients, and community members; and achieve more equitable maternity care, experiences, and outcomes.
  - **How (examples):**
    - ☐ Develop DEI metrics for staff, prioritizing the maternal health workforce.
    - ☐ For transparency and accountability, publicly report the assessment data and your goals.
    - ☐ Educate staff about the benefits of diversifying the maternal health workforce on patient care, experience, and outcomes.

- **Redesign recruitment and hiring practices to drive diversity across your organization, especially in roles that directly provide or support maternity care.**
  - **Why:** Traditional recruitment practices are often rooted in individual and structural biases and should be revisited to achieve goals for a diverse workforce.[30]
  - **How (examples):**
    - ☐ Develop a blind résumé review process, set standardized interview questions, and establish hiring criteria that exclude subjective perceptions of a candidate's "fit."
    - ☐ Diversify and expand network and referral pools, such as by partnering with minority-serving institutions (MSIs).
    - ☐ Hire recruitment firms with diverse personnel and a demonstrated track record of finding diverse candidates.

- **Develop programs, procedures, and personnel to address racism and discrimination in the workplace.**[31]
  - **Why:** To create a supportive workplace and improve staff experience and retention. This would go beyond bias training and show staff that you are committed to addressing equity and inclusion, and that the workplace is safe for employees.
  - **How (examples):**
    - ☐ Provide ongoing support for underrepresented groups in the organization, such as affinity groups and peer support programs.
    - ☐ Regularly seek and respond to staff feedback.
    - ☐ Develop a system for complaints that is not limited to what is prohibited by law, with strong protections against retaliation.

- **Address financial, time, and other barriers to education and professional development.**
  - **Why:** To foster the development of a diverse and robust maternity care workforce that is equipped to provide effective and equitable care.
  - **How (examples):**
    - ☐ Provide professional development stipends, tuition reimbursement, on-the-job training, and paid time off. These opportunities could include:
      - Training, certification, and related expenses for employment as doulas, midwives, childbirth educators, lactation personnel, and nursing assistants.
      - Opportunities to transition or cross-train, such as from doula to midwife or childbirth educator and lactation provider.
      - Support nursing staff to add credentials specific to maternal and infant health.
      - Encourage staff involvement in professional organizations.
      - Pay for conferences to provide education and networking opportunities.
      - Provide employees paid time off for community engagement and service learning opportunities.

- **Build the pipeline for a diverse maternal health workforce.**
  - **Why:** The U.S. is experiencing a shortage of obstetricians, midwives, and other women's health providers. The lack of diversity in the clinical professions and limited pathways for historically underrepresented communities to enter these roles will exacerbate this shortage, while the demand for non-clinical support outstrips supply.
  - **How (examples):**
    - ☐ Develop pipeline programs starting as early as middle school through college to raise awareness of the variety of maternal-infant career opportunities (including midwifery care, doula support, childbirth education, lactation support, obstetrics and pediatrics).
    - ☐ Create internships for health sciences graduates from MSIs.
    - ☐ Support community-based organizations in providing trainings and job opportunities for perinatal health worker roles (e.g., doulas, care navigators, and lactation counselors) (See Community Partner Role, page 60).

Create and sustain workplaces and jobs where employees can be healthy, thrive, and help guide effective and equitable maternal care.

Organizations committed to health equity should lead the way with workplace policies that promote health and help mitigate burnout, turnover, and inadequate staffing. These supports enable the workforce to provide high-quality care to all patients, especially birthing families. Healthcare institutions also employ many people of reproductive age, and thus can contribute to maternal and infant health by providing exemplary support for childbearing employees and their families. (See Implementation Toolbox for detailed recommendations.)

- **Create a workplace culture that support all staff, including pregnant and parenting staff, in maintaining their health and well-being and that of their families.**
  - **Why:** Improve maternal health of employees and beneficiaries by providing exemplary workplace policies and benefits.
  - **How (examples):**
    - ☐ Provide reasonable accommodations for pregnant workers.[32]
    - ☐ Guarantee space and time to support lactation.
    - ☐ Provide childcare benefits.
    - ☐ Include fertility care in health benefits.
    - ☐ Provide support for workers' reproductive healthcare needs.
- **Adopt paid leave policies and culture that promote the health, well-being, and economic security of all employees and families.**
  - **Why:** To improve retention, productivity, morale, and loyalty.[33] Paid leave is associated with crucial health benefits for both birthing people and their infants; longer paid leave is associated with greater benefits.[34]
  - **How (examples):**
    - ☐ Provide robust paid family and medical leave policies.[35]
    - ☐ Provide robust paid-sick-day programs and supportive time-off policies for attending prenatal, postpartum, and other healthcare visits and needs. Allowing sick workers to stay home also reduces the risk of spreading contagious illnesses to other staff and vulnerable patients.[36]

- **Model use of workplace benefits and signal strong support for family-friendly policies.**
  - **Why:** This gives permission to other employees to use their benefits to improve maternal and infant health and strengthen families. This can also incentivize staff who may have concerns about work-life balance to apply for leadership positions.
  - **How (examples):**
    - ☐ Leaders should model taking leave and needed time to take care themselves and their families (e.g., paternity leave, breastfeeding breaks, and short-term disability).
    - ☐ Leaders should encourage employees to use the full scope of their benefits.
    - ☐ Leaders should support culture change for pregnant and parenting residents and other clinicians that affirms the importance of, and rights to, needed pregnancy accommodations, the full scope of parental leave, and lactation supports.[37]

- **Ensure that the organization's health insurance plans provide excellent maternity and reproductive health coverage and benefits.**
  - **Why:** Maternity and reproductive care can have a major impact on maternal and newborn outcomes and play an important role in mitigating the maternal health crisis.
  - **How (examples):**
    - ☐ Ensure that employees and beneficiaries have access to the full complement of care that they may need from pregnancy through postpartum with affordable cost-sharing. This includes access to contraception and abortion care.
    - ☐ Provide employees and beneficiaries with a choice between midwifery and physician care, including maternal-fetal medicine specialists, as needed. Provide them with a choice among birth settings, including any available birth centers for which they may be eligible.
    - ☐ Ensure coverage of childbirth education, full-spectrum doula support, lactation personnel, and care navigators.
- **Provide and encourage the use of mental health and wellness services.**
  - **Why:** To support retention and resilience, translating to improved success, especially given the high levels of burnout and turnover within the healthcare workforce. Also, integration of mental and physical health benefits and services is often inadequate.[38]
  - **How (examples):**
    - ☐ Formalize peer support among traditionally underrepresented staff.
    - ☐ Formalize emotional support (including peer support) to prevent staff from quitting or leaving maternal health professions after an adverse patient outcome.
    - ☐ Include in-network mental health providers, telemedicine services for mental health, and community-based care providers (e.g., peer support and somatic and trauma therapy) that meet the needs of traditionally underserved communities.
    - ☐ Reinforce a workplace culture that supports using sick leave for mental health and self-care days to mitigate the impact of burnout.
    - ☐ Recognize the prevalence of anxiety, depression, and other mental health conditions during pregnancy and postpartum, and support the healing of childbearing staff and beneficiaries with these conditions. Make staff aware of, and encourage them to use, short-term disability benefits.

- **Reinforce institutional commitment to workplace safety, both physically and psychologically.**
  - **Why:** Mistreatment, threats, and workplace violence against healthcare workers have increased in recent years. In addition, underrepresented staff often experience discrimination, both by patients and other staff.[39] The emotional well-being of employees depends on support from leadership, not only setting policies, expectations, and accountability for workplace safety, but also in helping staff who experience harm.[40] Protecting and supporting the physical and psychological safety of staff is crucial to their ability to provide quality care.
  - **How (examples):**
    - ☐ Institute strong policies against retaliation.
    - ☐ Promote a culture where leadership and management support staff and champion their safety and security.
    - ☐ Develop, implement, and refine workplace policies to prevent and address harm from other staff and patients.
- **Pay a living wage and pay equitably across all roles.**
  - **Why:** To demonstrate an institutional commitment to economic security and to help with employee satisfaction and retention.
  - **How (examples):**
    - ☐ Provide fair pay to all employees at all levels of the organization by ending wage discrimination by race, gender, or other protected characteristics.
    - ☐ Offer a living wage with a comprehensive benefits package.
    - ☐ Regularly review compensation structures to ensure salaries are equitable and nondiscriminatory. Adhere to these criteria during hiring processes.
    - ☐ Provide pay transparency and transparent criteria for promotion and salary increase.
    - ☐ Refrain from using an applicant or employee's previous salary level to determine their current salary.
- **Ensure that employees and beneficiaries understand their benefits, their legal rights, and how to access these programs and services.**
  - **Why:** Childbearing employees may be unaware of benefits and programs of great value to their own and their infants' health. The complex constellation of relevant care and support options is specific to each healthcare employer, as well as applicable laws and regulations.

- **How (examples):**
  - ☐ HR staff should maintain up-to-date information about the programs and policies noted above, as well as community services that can assist with social needs, such as food, housing, transportation, economic, and other kinds of insecurity.
  - ☐ Up-to-date details of eligibility and access should be available and proactively directed to all pregnant and parenting staff and beneficiaries as web-based, mobile, and printed information.
  - ☐ Personnel such as care navigators and social workers should be tasked with assisting with information and access to the respective programs and services, for example, the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC).[41]

Leverage procurement to ensure the diversity and well-being of contract workers.

Use contracting and purchasing power to ensure diversity among your workforce and to guarantee that contract workers have the same security and opportunity as direct employees.

- **Hire racially and ethnically diverse vendors, as well as businesses owned by women, LGBTQIA+ individuals, and people with disabilities, and prioritize local organizations.**
  - **Why:** Hiring diverse vendors enhances an institution's ability to provide culturally congruent care and services. Hiring local businesses strengthens community assets and power.
  - **How (examples):**
    - ☐ Assess current bidding practices to ensure that community businesses learn about and submit proposals.
    - ☐ Involve DEI leaders in procurement efforts.
    - ☐ Solicit feedback from patients and staff who live in the community to identify trusted local businesses and community-based organizations.
    - ☐ Consider community vendors and organizations to provide services such as dieticians, community health, patient education, childbirth education, doula support, maternity care navigation, and lactation support.

- **Develop standard contractual language requiring contractors to employ and support underrepresented staff, and provide a minimum set of benefits and protections that support employee well-being and economic security.**
  - **Why:** Contracted workers are equally important to the diversity of the overall workforce and are essential to the functioning of healthcare provider institutions.
  - **How (examples):**
    - ☐ Include provisions requiring nondiscrimination and fair treatment of employees in contracts.
    - ☐ Interview potential vendors about their diversity and ability to help the institution meet its DEI goals.

Healthcare institutions can contribute to maternal and infant health by providing exemplary support for childbearing employees and their families.

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The Community Partner Role

Engage with individuals and organizations in the community to achieve maternal health equity

Healthcare provider institutions play essential roles as part of a broader ecosystem that affects the overall health of communities. There are significant opportunities to strengthen engagement, build trust, and increase support between healthcare institutions and their surrounding communities. Healthcare provider institutions are making growing commitments to health equity, including maternal health equity. In this context, it is important to acknowledge that communities of color have suffered well-documented, ongoing mistreatment, abuse, and discrimination at the hands of medical institutions. These issues loom large for reproductive and maternal health, given the history of forced sterilization,[1] abusive gynecological practices,[2] and longstanding patterns of racism and oppression in obstetric practice.[3] The resulting mistrust continues to hinder community health and well-being.

To raise the bar for maternal health equity, institutions must both provide exemplary clinical care and meaningfully engage with and support community residents and the organizations that serve them. This requires trusting relationships with communities. Community leaders and organizations are crucial, often under-resourced, assets that healthcare organizations should recognize and support via partnerships that value lived experiences, expertise, and community power. This engagement must prioritize communities disproportionately affected by the maternal health crisis, including communities of color, rural populations, LGBTQIA+ individuals, and people with disabilities.

Spotlight on Innovation

A Community Partnership to Support Childbearing Families

Who: HealthPartners and Everyday Miracles

Where: Minneapolis, MN

What: A healthcare system partnered with a community-based maternal health organization to expand access to culturally centered doula services

WHY: Even though Minnesota was one of the earliest states to cover doula services through Medicaid, disparities persist for birthing families of color, who experience higher rates of maternal mortality and morbidity.

Ensuring that birthing parents of color feel seen and heard during one of the most important moments in their lives is a critical first step to improve maternal health outcomes for all. Doulas who are Black, Indigenous, or other people of color (BIPOC) often bring a unique understanding of how a patient's cultural context and lived experiences may affect their health needs, communication patterns and beliefs, and therefore help mitigate health inequities.

GOAL: HealthPartners and Everyday Miracles sought to recruit, train, and help to certify more BIPOC doulas to better serve birthing families.

HOW: HealthPartners – a 65-year-old healthcare system owned by its members – has strategically located its hospitals in neighborhoods with the greatest need for healthcare access across Minnesota and Western Wisconsin, while also providing affordable health insurance.

Founded in 2003, Everyday Miracles provides a broad range of services to birthing families, including evidence-based education and wellness classes, compassionate and culturally informed support, and a nonjudgmental, caring community. Everyday Miracles clients have lower cesarean rates, higher breastfeeding initiation rates, and higher breastfeeding rates at six months postpartum than the national average.

When Minnesota passed doula legislation aimed at improving maternal healthcare equity in 2014, HealthPartners was already partnering with Everyday Miracles for non-doula supports, so it was a seamless transition to add doula services with the goal of increasing access to evidence-based prenatal supports regardless of age, race or socioeconomic status.

Beginning in 2015, HealthPartners and Everyday Miracles offered doula services during pregnancy and childbirth to any HealthPartners member with Medicaid or MinnesotaCare, a subsidized insurance program for Minnesotans with low-incomes. Covered services include six visits for childbirth education and support services, plus an additional birth support visit. An Everyday Miracles coordinator helps to match birthing people with a doula. At the start of the COVID-19 pandemic, HealthPartners approved payment for virtual visits to preserve members' access to needed support.

The partnership identified the need for a more effective payment system and equitable compensation for doulas. To this end, HealthPartners:

- Accelerated the timeline for paying claims.
- Increased the contracted payment rate for birth doulas beyond the state minimum.
- Made it easier for Everyday Miracles doulas to access information and support from HealthPartners by providing a dedicated point of contact.

These changes enhanced Everyday Miracles' ability to recruit and retain doulas. To achieve the clear health equity and outcomes benefits of doula support, more doulas were needed – especially those from BIPOC communities. Through the support of a grant from HealthPartners, Everyday Miracles worked to increase the supply of doulas.

RESULTS: In just two years, Everyday Miracles increased their number of certified BIPOC doulas from 40 percent of their roster at the start of 2020 to 70 percent in 2022.

The Takeaway

Intentional partnerships with community-based organizations must be based on a clear recognition of the needs of both partners – including the resources required. HealthPartners and Everyday Miracles demonstrate that healthcare providers, payers, and other organizations that want to effectively address maternal healthcare equity can do so by collaborating with local organizations and leaders who are closer to the needs and solutions required for all birthing people.

Actions that raise the bar for maternal health through community partnership

1. Achieving optimal maternal health in the communities most affected by the maternal health crisis requires healthcare institutions to partner with the communities they serve.

Community-level factors and the ongoing physiologic toll of racism and other structural inequities are some of the root causes of poor maternal and infant health.[4] Institutions should develop effective solutions with members of the community and the organizations that represent them. Inclusive engagement requires sustained rather than sporadic engagement with community members. Ongoing collaboration needs to include the full cycle from the identification of priorities, to the development and implementation of solutions, and their continuous evaluation and improvement.

To enable and support truly collaborative, equitable partnerships, institutions must create appropriate structures and allocate adequate resources. Solutions should be based on the expressed priorities of those most affected, and built on their knowledge, expertise, and skills. This requires changing the traditional hierarchies to share power with community organizations, members, and patient representatives. Community members should participate on an equal level in relevant governance boards and leadership and oversight committees, receive support that enables them to contribute fully, have opportunities to share their perspectives and recommendations, and contribute to decision-making. Community representation on governing and advisory boards should emphasize diversity, equity and inclusion (DEI) – by reflecting the broader community in which they are located and by ensuring that responsibility for representing a specific population or viewpoint does not rest with just one person, avoiding tokenism.

Community leaders and organizations are crucial assets that healthcare organizations should recognize and support.

2. Build trusting relationships with the community to improve maternal health.

Trusted relationships between healthcare institutions and the community are foundational to the high-quality, culturally centered, respectful care needed for the best possible outcomes for birthing families. Yet, for many – including people of color, people with disabilities, and LGBTQIA+ individuals, their experiences with healthcare institutions have not engendered trust.

Being trustworthy is the first step in building trust. Healthcare provider institutions can demonstrate their trustworthiness by following through on their commitments to equity and eliminating all forms of discrimination and by honoring agreements with the community. Institutions must be proactive in understanding the priorities and needs of communities and work with them to surface values, interests, and assets.[5] Effective, transparent, and respectful communication can also help build trust.[6] It is necessary to understand and mitigate the power dynamics at play,[7] and recognize the significant time investment required to build sustainable, trustworthy relationships. Lastly, institutions should demonstrate trust in community members as experts in their experiences and challenges and in articulating solutions.

3. Respect and build on the expertise and power of individuals and organizations in the community to advance optimal maternal health.

People and communities are the experts on their needs and the barriers they face. Effective and sustainable interventions respond to and are shaped by those most affected by the challenges.

Moreover, the medicalization of childbirth in the 20th century disrupted family- and community-centered birthing traditions. Whereas communities and families provided woman-to-woman support; developed strong Black, Indigenous, Latina, immigrant, and other midwifery traditions; and managed birth in community settings, childbirth shifted to hospitals, where it was directed by physicians – to the exclusion of community personnel. There is currently tremendous interest in reclaiming traditions of support in the form of doula services, and of community midwifery and birth settings. There are many ways for healthcare institutions to support these growing interests with the mutual goal of improving the experiences and health outcomes of community childbearing families.

Raising the bar for maternity care through community engagement: Priority recommendations

Raising the bar for optimal maternal health cannot and should not be undertaken by healthcare institutions in isolation. Continually engaging community members will provide critical information about birthing peoples'* experiences, priorities, needs, and potential solutions. Trusted partnerships with community-based organizations that understand the needs of their community and know how to address them will lead to significantly better outcomes while also supporting community leadership and assets.

For example, partnering with and supporting doula organizations, perinatal health worker groups, and other community-based birthworkers can increase access to trusted, respectful, culturally congruent support and contribute to improved health outcomes. Supporting greater access to community-based services can also help meet the needs of childbearing families at a time when many healthcare provider institutions are short-staffed and existing staff are worn out. Engaging the community is not a "nice thing to do" – it is imperative to achieve optimal maternal health.

Executive leadership

The executive leadership and the board of directors should set the vision and commitment to community engagement that facilitates whole-person, equity-centered maternity care. This includes consistently reinforcing messages that the institution is community-focused and setting expectations for staff to prioritize strong community partnerships.

- **Start with assessing your current relationships, initiatives, and reputation regarding community engagement.** An effective plan must be tailored to your organization's starting point and current activities. The plan should be transparent, specific, measurable, and meaningful to the community and your workforce, and clearly communicate the rationale of proposed changes.

  Assessments should involve available, relevant data and should be led by those who are most familiar with, or who can access, the information needed. This could include a combination of your community health department, patient experience team, and health equity and quality leaders. It should also include input from community leaders and residents.

* We recognize and respect that pregnant, birthing, postpartum, and parenting people have a range of gender identities, and do not always identify as "women" or "mothers." In recognition of the diversity of identities, this report uses both gendered terms, as well as gender-neutral terms such as "people," "pregnant people," and "birthing persons." In referencing studies, we use the typically gendered language of the authors.

The assessment should include:

- **Cataloging relevant community-based organizations and their current leadership, contact information, and activities.**
- **For nonprofit hospitals, reviewing the most recent triennial community health needs assessment (CHNA) or carry out the next CHNA,** including maternal-newborn health needs.
- **Reviewing their performance on the Lown Institute Hospitals Index** of social responsibility, which provides results for dozens of equity, value of care, and outcomes-of-care metrics.[8] (Maternity- and pediatric-specific data are expected in mid-2024.)
- **Assessing the composition of board members** for gaps in representation from the community and by various demographic subgroups, including people with disabilities and LGBTQIA+ individuals. Ensure representation of members with knowledge of maternal health issues.
- **Assessing the availability and composition of advisory committees and other governance structures, and performing the same representative and demographic analysis.**
- **Assessing policies and existing structural supports for engaging community members.** Identify and document whether and how the institution is facilitating community engagement (e.g., by compensating community members for their time and expertise, providing technical support, ensuring the accessibility of meetings, providing meals and childcare support, and other practices that enable and support their participation).

- **Create a responsive plan.** Once the assessment is complete, analyze the findings and distribute and discuss them among the institution's leadership, as well as community leaders, to thoughtfully identify priority areas for action and investment and create an implementation plan. The plan may involve the following strategies:
  - **Prioritizing and valuing community engagement across the enterprise.**
    - **Why:** This will influence the community outreach and relationship building efforts of the entire organization and foster culture change.
    - **How (examples):**
      - ☐ Consistently communicate internally and externally that the system should support and strengthen the community.
      - ☐ Defer to community expertise and elevate community leaders and initiatives during systemwide events, including board meetings.
      - ☐ Provide opportunities for staff to learn from community leaders.
      - ☐ Join community leaders in community settings, for example, serving on community boards or attending community-led health events.

- **Ensuring the creation of a plan for representation of diverse community members on the board of directors.**
  - **Why:** This is an added benefit and needed standard of practice for all leadership groups and is a powerful message of accountability from the highest level of authority in the organization.
  - **How (examples):**
    - ☐ Provide community members serving as board members with relevant support, such as mentorships and technical support.
- **Requiring proportionate community representation – based on race and ethnicity, ability, and sexual orientation and gender identity in the service area population – on advisory committees and other governance bodies with meaningful decision-making roles.**
  - **Why:** To build trust and enrich your institution's policies and services.
  - **How (examples):**
    - ☐ Bodies: boards of directors, committees reviewing sentinel maternal health events, facility modification committees, committees or working groups developing and implementing new policies and programs, working groups that develop and implement communication campaigns, and a maternity-specific patient and family advisory council.
    - ☐ Activities: reviewing data, creating agendas, decision-making about maternal health programs and quality care improvement initiatives, planning and implementing community outreach activities.
- **Approving flexible budgets with longer-term cycles to support community-based partners.**
  - **Why:** Trust-based philanthropy and support reduces barriers to resources that contribute to the well-being of communities. Longer timelines reflect the reality of processes needed for improvement and allow community-based organizations time to fully implement their programming.
  - **How (examples):**
    - ☐ When possible, extend grants and funding beyond one- to three-year cycles to provide time for community-based organizations to fully implement programming.
    - ☐ Ethically fund sustainable programs and general operating expenses.
    - ☐ Consider removing or minimizing burdensome grant application and reporting requirements.

- **Sharing non-financial institutional assets with community partners.**
  - **Why:** You have the infrastructure and resources that many community-based organizations lack, and that can help strengthen community organizations that support birthing families and maternal health (See Advocate Role, page 78)
  - **How (examples):** Consider in-kind donations of goods and services and pro bono support with professional services such as:
    - ☐ Information technology infrastructure and support.
    - ☐ Data collection and management.
    - ☐ Financial, legal, and governance guidance.
- **Hiring staff members responsible for engaging with the community.**
  - **Why:** To positively impact maternal and infant health, at least one full-time person in your organization should be dedicated to strengthening community partnerships and working continuously with community leaders.
  - **How (examples):**
    - ☐ Recruitment and hiring processes that include community leaders.
    - ☐ Proactive engagement across different departments and at all levels to build awareness and integrate community personnel and partnerships.
    - ☐ Training and support for all staff to support community relationships and integration.

Opportunities for Nonprofit Hospitals: Leveraging Community Health Needs Assessment and Benefit Requirements

Because of their tax-exempt status, nonprofit hospitals have a higher responsibility to invest in their communities. To maximize impact, support the following actions:

- **Committing to community engagement in the triennial community health needs assessment (CHNA) process** (IRS code section 501(r)(3), including the needs of childbearing families).
  - **Why:** Members of the community are experts in their life circumstances and health needs, and their full participation in this process is essential for a robust CHNA.[9]
- **Requiring public reporting of the CHNA results and ensuing plan, including meeting the needs of childbearing families.**
  - **Why:** Use the CHNA to develop a robust community health improvement plan, prioritizing activities and investments that will strengthen communities, advance equity, and improve birth outcomes. Full transparency requires that community assessments and resulting plans are readily available to community members and healthcare staff, discussed in relevant community and health system forums, and used to guide programming and resource allocation (See Advocate Role, page 78)

Senior leadership team

Once the executive leadership sets a direction, the next step is developing the budget and plans to carry out this commitment. Senior leadership may include director-level leaders in areas such as maternal/infant health, community health, patient experience, DEI, quality improvement, and human resources.

- **Create structures and opportunities to listen to birthing people with the goal of trusting their lived experience and expertise and incorporating these learnings into policy and program development.**
  - **Why:** Birthing people and their communities best understand their lives, bodies, experiences, needs, and preferences. Top-down assumptions may miss the mark and fail to optimally support them. Community members should be consistently engaged as valued partners in decision-making, planning, and execution, both to improve the effectiveness of policies and programs, as well as to actively build trust.
  - **How (examples):**
    - ☐ Establish and support a high-functioning maternity-specific patient and family advisory council (see page 72).
    - ☐ Create safe mechanisms for birthing people to provide negative feedback.
    - ☐ Cultivate community trust and improve maternal health with respectful dialogue and responsiveness to feedback.

Community members should be consistently engaged as valued partners in decision-making, planning, and execution, both to improve effectiveness and build trust.

- **Implement best practices for engaging community members, with a focus on mitigating the impact of racism, addressing social needs, and dismantling systemic racism and other structural inequities.**
  - **Why:** To repair trust with communities and improve maternal-newborn care, experiences, and outcomes.
  - **How (examples):**
    - ☐ Within the maternity unit, build understanding of the role of racism in history, policies, and interpersonal relationships within the enterprise, with maternal health as a focus. Bring in disaggregated data, community voices, staff observations and experiences, and other sources.
    - ☐ Examine how staff interact with childbearing families with regard to visit attendance and timeliness, compliance, and family relationships.
    - ☐ Engage community members with disabilities, LGBTQIA+ people, and individuals who have experienced harm in maternal care.
    - ☐ Plan collaboration with community members at accessible times and locations, including after work hours and on weekends, including virtual and telephone participation, and with consideration of location, childcare, and meals.
    - ☐ Provide orientation, onboarding, and mentoring to ensure that community members can help meet institutional quality, equity, and patient experience goals.
- **Create and support a maternity-specific patient and family advisory council (PFAC).**
  - **Why?** A maternity-specific PFAC can provide critical input and direction for all core maternity service activities and recognize opportunities for improvement across this important episode of care.
  - **How (examples):**
    - ☐ Adapt tools used to develop other service-specific PFACs[10] and benefit from existing PFAC research.[11]
    - ☐ Establish a maternity PFAC hospital team (e.g., lead, logistics coordinator, recruitment coordinator, scribe).
    - ☐ Draft the mission, vision, goals and structure of the maternity PFAC.
    - ☐ Determine the structure of the maternity PFAC (e.g., number of councilmembers, length of service, roles, and responsibilities).
    - ☐ Plan meeting logistics and adviser support, including mentorship and preparation for specific activities, financial compensation for time and expertise, flexibility in terms of time and ways to participate, and in-kind or financial support for transportation, meals, and childcare.

- ☐ Identify and recruit advisers from the community, including advocates and leaders of relevant community-based organizations.
- ☐ Aim for a high-functioning, well-integrated, impactful PFAC by integrating relevant activities and providing appropriate support. Activities include program planning and evaluation and performance data review, development of policies impacting childbearing families and their care teams, research priorities and processes, and guidance about relationships with and support of communities. To foster transparency and accountability, complete and make publicly available an annual report describing recruitment, membership, member support, meetings, and impact.[12]

- **Establish the necessary budget(s) and practices to compensate and support community leaders and residents for participation on boards and committees.**
  - **Why?** Community members' time and expertise is valuable and they should not be expected to provide this expertise for free.
  - **How (examples):**
    - ☐ Provide stipends for participation on boards and bodies.
    - ☐ Cover the costs of, or provide, travel, childcare, and meals.
    - ☐ Meet in convenient locations, such as community centers or libraries, with options for virtual participation.

- **Educate and support staff to engage with community members.**
  - **Why:** Staff can benefit from education, tools, and best practices to foster relationships with community members. This may include implicit and explicit bias training, active listening, respectful use of preferred pronouns, and accommodations for diverse abilities.
  - **How (examples):**
    - ☐ Leadership should model respectful care values and practices.
    - ☐ Offer trainings to combat explicit and implicit bias and enhance intercultural competence in perinatal and newborn healthcare.
    - ☐ Create regular opportunities for maternity staff to review, discuss, and address feedback from patients.
    - ☐ Create regular opportunities for staff to engage in dialogue with a maternity-specific PFAC.
    - ☐ Develop staff support mechanisms, such as peer groups and reflective supervision (See Employer Role, page 38).

- **Invest in and support diverse midwives, nurses, doulas, and health workers who have relationships with, or are from, the community.**
  - **Why?** To strengthen an institution's ability to provide culturally congruent maternity care that is aligned with birthing people's views and experiences (See Employer Role, page 38).
  - **How (examples)?**
    - ☐ Use the community asset map, relevant advisory bodies, and other mechanisms to identify the culturally centered community organizations that already provide support to birthing families across the spectrum of reproductive health, including:
      - Independent or community-based midwifery and reproductive health services.
      - Doula support (including birth, postpartum, and full spectrum doulas, as well as those providing extended prenatal to postpartum support).
      - Prenatal, childbirth, and newborn care education.
      - Home visits.
      - Car seat education.
      - Care navigation.
      - Peer breastfeeding support.
    - ☐ Identify ways to connect these organizations and health workers, in both clinical and support roles, to maternal healthcare teams and to appropriately compensate their services.
    - ☐ Provide support for training opportunities.
    - ☐ Provide mentorship and other support to facilitate effective integration of community members and expertise.
    - ☐ Eliminate barriers to collaboration, such as the inappropriate medicalization of non-clinical roles and requirements that would exclude community experts.

- **Create pipeline programs that engage with community members on maternity-specific activities.**
  - **Why?** To strengthen communities and benefit from their expertise by preparing community members to support childbearing families.[13] The development of professional skills and credentials is a form of community development; can increase access to trustworthy, respectful, culturally congruent support and care; and can address widespread staff shortages.[14]
  - **How (examples):**
    - ☐ Maternal-health focused programs for local high school students, supporting community-focused organizations in providing trainings for perinatal health worker roles, and providing scholarships for local nursing students.
    - ☐ Building on existing competencies and roles, for example, doula to midwife, or cross-training (e.g., doula and lactation support).

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The Advocate Role

Advocate for and invest in maternal health equity

The healthcare industry is a dominant political and economic force, with many powerful stakeholders able to shape public policies that impact people's health. This includes not only broad public policies that address social drivers of health, but also specific healthcare delivery and payment structures that affect the availability, quality, and equity of maternal and other healthcare services. In some areas, healthcare organizations are the leading employers – making them an influential institution in the community and a major contributor to the economy of the surrounding area. Healthcare organizations also have the ability to shape public perceptions and values and influence culture change.

Advocating for health equity is essential to improving maternal health. The disparate impact of the maternal health crisis on communities of color and the increasing maternity care deserts in rural and some urban communities[1] underscores the connection between maternal health and health equity. Healthcare provider institutions should use their investment and procurement resources to advance equity and community well-being and resilience. This includes addressing the effects of racism and other structural inequities in your role as policy, economic, and social drivers within your communities.

Spotlight on Innovation

A Comprehensive Care Model for Moms and Babies

Who: Ohio Department of Medicaid

Where: Ohio (statewide)

What: A comprehensive maternal care perinatal care program that introduces care delivery and payment reforms for obstetrical practices that build connection and support women with Medicaid.

WHY: In December 2020, Governor Mike DeWine established the Eliminating Racial Disparities in Infant Mortality Task Force, made up of local, state, and national leaders to identify needed changes to address Ohio's racial disparities in infant mortality. Given their role in covering a majority of Ohio births in recent years, the Ohio Department of Medicaid looked to improve infant outcomes by investing in the health of pregnant and postpartum women.

GOAL: Ohio Medicaid aims to improve maternal health outcomes by creating a new care model that deploys evidence-based services, including enhanced care coordination and home visiting, through partnerships between maternal healthcare providers and community-based organizations. The agency aims to support 35,000 childbearing moms and families in the first years of the program.

HOW: Ohio Medicaid developed a model that incentivizes the person-centered care, community engagement, and trust required for raising the bar for maternal health. As a starting point, they gathered input from multiple fields and community organizations. The resulting Comprehensive Maternal Care (CMC) model enables the state to work with healthcare providers and systems to narrow health disparities and reduce the infant mortality rate. The program introduces care delivery and payment reforms for obstetrical practices that build connection and support women as they and their families navigate pre- and postnatal care. The program emphasizes supporting women with higher-risk pregnancies.

The CMC model will reward providers who proactively address patient and family needs across the entire cycle of childbearing. Prospective per-member-per-month value-based payments align with the risk level of enrolled Medicaid members.

Providers who opt in to the program can earn financial incentives for developing and implementing a care model that demonstrates a commitment to personally engaging the patient, their family, and their community. Providers will be expected to collaborate with community partners to gain a better understanding of the cultural and social drivers affecting health.

To participate in the CMC, obstetrical practices will be required to establish a patient and family advisory council to hear first-hand accounts of how access to care, cultural competence, and effective communication affect patient outcomes. Practices must use information from these councils to improve patient experience and reduce disparities. Additional criteria for participation include:

- Conducting a mandatory pregnancy risk assessment for each patient.
- Engaging the community in developing a patient-centered approach that builds trust. Providing appropriate supports and fostering positive patient experiences throughout care.
- Monitoring progress and patient engagement.
- Formally assessing areas of strength and needs annually.

Ohio Medicaid expects that beyond the benefit of providing women and families clinical and community supports, the CMC initiative will use patient and community data to identify best practices, inform public policy, advance health outcomes, and strengthen healthcare — community relationships.

RESULTS: The CMC model was just deployed at the beginning of 2023. While it is too early to identify results, it highlights the importance of collaborating with community advocates, organizations, and members to develop new strategies for addressing seemingly intractable health challenges, and setting up payment structures that build on community assets.

The Takeaway

With compassion, conviction, and community collaboration, Medicaid agencies can turn the tide in maternal health equity by properly linking payment incentives to care and outcomes, supporting providers, and building genuine relationships with community groups. If successful, Ohio's CMC can serve as a model for other state Medicaid programs to advance maternal health equity.

Actions that raise the bar for maternal health through advocacy and investment.

1. Advocate for maternity care delivery and payment reforms that align resources and incentives with achieving maternal health equity, and incorporate effective models into your system.

Beyond insurance, the way we pay for maternity care in the United States is a major driver of the maternal health crisis. In general, providers get paid for the volume and technical intensity of the care they deliver, whether it is appropriate or not, and regardless of its quality. Today, about four out of every five dollars of maternity care is spent on the brief window of hospital care around the time of birth. A small fraction supports prenatal and postpartum care,[2] when mental health and social needs and opportunities to improve outcomes are abundant.[3] Current payment structures overvalue technology – intensive care – regardless of need or preference – and shortchange proven services such as midwifery care, birth center care, doula support, and culturally congruent community-based services – all of which improve equity and outcomes.[4] We must transform this payment structure to incentivize the kind of care we know works, in order to improve outcomes – especially for women of color and women in rural communities – and disincentivize unnecessary, low-value care. This includes creating pathways to move from volume to value and targeting additional resources to remedy generations of underinvestment in the health and healthcare of communities marginalized by racism and other structural inequities. Healthcare institutions can help to advance new models while utilizing existing payment and delivery models.

2. Incorporate into your advocacy strategies advancing public policies that address the social drivers that undermine maternal health.

Racism, structural inequities, and adverse social drivers of health play a well-documented role in fueling the maternal health crisis.[5] Truly raising the bar for optimal maternal health requires healthcare provider institutions to use their social and political capital to advocate for policies that improve the health[6] of birthing people*, while enhancing clinical care.

* We recognize and respect that pregnant, birthing, postpartum, and parenting people have a range of gender identities and do not always identify as "women" or "mothers." In recognition of the diversity of identities, this report uses both gendered terms, as well as gender-neutral terms such as "people," "pregnant person," and "birthing people." In referencing studies, we use the typically gendered language of the authors.

Policymakers rely on healthcare provider institutions' relationships, expertise, and guidance to develop and shape systems that will improve care delivery and quality and health equity. Healthcare institutions can and must advocate for a **robust public health infrastructure, affordable housing, equitable economic development and anti-poverty initiatives, and educational equity,** among other policies.

3. Use investment and procurement power: Audit and adjust your business model, investment and purchasing strategies, and philanthropy to improve communities' maternal health and overall resilience.

A guiding principle for healthcare provider institutions is to start in their communities. Institutions can support community-based and Black, Indigenous, and other people of color (BIPOC)-owned businesses through their procurement process. Furthermore, endowed institutions can leverage their investment strategy to align with improving health equity and advancing maternal health.

Restructuring health and healthcare to better and more equitably meet the needs of childbearing families requires significant resources. One of the core drivers of persistent racial and ethnic health inequities, including in maternal health, is the historical and ongoing disinvestment in communities of color, which has resulted in fewer health-generating resources and higher health risks. While healthcare provider institutions currently face inflation, increasing salary demands, and other financial stressors, the healthcare industry nonetheless makes up an enormous share – one-fifth – of the U.S. economy.

Using Community Benefit Dollars to Improve Maternal Health Equity

The majority of hospitals in the U.S. – two out of three beds – are nonprofit.[7] The Affordable Care Act requires these institutions to make community benefit investments in return for their tax-exempt status. An analysis found that in 2019, 82 percent of private nonprofit hospital systems spent less on charity care and community investment than the estimated value of their tax breaks. The total fair-share deficit amounted to $18.4 billion in a single year. These dollars can make an immense difference in meeting the social needs of childbearing families and others. About 85 percent of the more than $60 billion spent on community benefit involves medical care.[8] Despite a recent increase of community benefit dollars going toward programs that invest in structural community resources, they are a fraction of health systems' overall community benefit spending. Instead, hospitals are much more likely to screen and refer clients to existing community programs, which often struggle with underfunding and overcapacity.[9] The increasing recognition that social needs play a crucial and largely overlooked role in maternal-infant health and health overall should move healthcare institutions to invest the full value of tax-exempt status and shift the proportion from medical to social care.

4. Use your voice: Shape public understanding about the importance of maternal health equity and dismantling racism and all forms of discrimination.

Healthcare provider institutions shape public discourse and are a trusted source of information in policymaking. Using established marketing, public communications, and education budgets, institutions can leverage ongoing campaigns to raise awareness about how social drivers of health affect individuals, families and communities.

Raising the bar for maternity care using your organization's advocacy and investment power: Priority recommendations

Leveraging your organization's advocacy and investment resources to advance maternal health equity may require different actions and roles. Advocacy and investment are underutilized levers in advancing better maternal health but are critically important to drive the overall systems change needed. Start with understanding how your organization deploys its financial resources in the community, as well as the policy areas where your advocacy voice could make a tangible difference. We provide concrete strategies and tactics below, which align with growing health system accountability for and investment in advancing health equity.

It is imperative that executive-level decision makers are aligned with the vision, direction, and resources necessary to enable and drive the changes required for success. Those involved in implementing these initiatives will include the senior leadership (vice presidents and directors) and government affairs, community relations, and communications staff.

Executive leadership (chief executive/president/chair of the board)

You have a crucial opportunity to align your organization's advocacy and public education activities with your mission and values in a way that actively supports maternal health equity and improved outcomes.

Aligning and integrating social responsibility, philanthropic, and community engagement teams with government affairs teams maximizes impact and minimizes redundancies while also ensuring the teams are not working at cross-purposes. The goal would be to create a structure that allows for enterprise-wide decisions that are in the best interest of childbearing families.

Additionally, as community leaders your institution should develop strong stakeholder relationships with other healthcare provider entities; various professional organizations; purchasers; payers; and/or consumer, community and advocacy groups to provide the basis for sustainable community development.

Advocating for health equity is essential to improving maternal health.

Advocate for state and federal maternity care delivery and payment reforms that enable and incentivize achieving excellence and equity in maternal health, while also adopting specific reforms in your own institution.

Specific care delivery interventions and transformations improve maternal health outcomes, especially for women and birthing people of color. However, healthcare payment and accountability systems are not aligned to incentivize and invest in these transformations. Working to evolve your organization's maternity care services delivery and urging healthcare payers and purchasers — including state and federal governments — to adopt payment structures that make them sustainable go hand in hand. Even as decision-makers work to reform how care is paid for, and you work to influence this process, there are existing available payment models and programs you should leverage to improve maternal health within your institution. Along the way, share best practices and participate in testing, evaluating and strengthening new models. As you explore ways to build or use partnerships with public and private payers and purchasers to encourage them to adopt value-based payment systems that include some of the elements below. (See Implementation Toolbox for detailed recommendations.)

- **Maternity episode payment programs.**
  - **What:** Episode payment programs are Alternative Payment Models (APMs) designed to deliver high-quality cost-effective care by paying providers a projected cost for a single medical event or episode and incorporating performance accountability.[10]
  - **Why:** Maternity episode payment programs must be improved by embedding into their design elements that help reduce racial, ethnic, and other persistent inequities.
- **Robust person-centered maternity care home programs with improved payment models to support them.**
  - **What:** A maternity care home program is a team-based healthcare delivery model designed to complement standard clinical maternal and newborn care by helping childbearing families with care navigation and with identifying and meeting social and mental health needs.[11]
  - **Why:** Maternity care homes can be especially helpful in addressing the many factors that contribute to the persistent maternal health crisis, especially for people most at risk for poor outcomes and racial and ethnic health inequities.

- **APMs that integrate health-equity-centered care design, payment mechanisms, and performance measurement.**
  - **What:** APMs must be designed or modified to explicitly address inequities through their payment structures and via their accountability mechanisms.[12]
  - **Why:** APMs could accelerate disparity reduction if they are explicitly designed to measure and improve disparities and do so by providing high-quality, culturally centered equitable maternal-newborn health services. However, APMs *not* intentionally designed with this objective are likely to miss the mark and might even make inequities worse.

In addition to advocating for improved payment models and adopting those that already exist, you are in a unique position to advocate for ensuring that everyone has affordable health insurance coverage that covers the services they need. In the United States, health insurance coverage is a prerequisite – although not a guaranteee – for accessing timely, comprehensive, and high-quality healthcare. We include key policies to advocate for below. (See [TBD resource name and link here more detailed recommendations.)

- **Mandating extended Medicaid and CHIP coverage for at least 12 months postpartum.** Thirty percent of pregnancy-related deaths occur from days 43 to 365 days postpartum.[13] Postpartum complications requiring longer-term care include postpartum depression, anxiety, hypertension, and diabetes.
- **Expanding Medicaid in the remaining states.** Medicaid expansion is associated with improved economic security,[14] reduced medical debt, increased preventive healthcare, improved health outcomes, and lower infant mortality rates.[15]
- **Establishing pregnancy as a qualifying life event for special enrollment in the health insurance marketplace created by the Affordable Care Act.** Uninsured people may lack access to timely, comprehensive healthcare, including prenatal care. This is especially important for Black[16] and Native American women,[17] who are most likely to receive late prenatal care, if at all.
- **Requiring all forms of health insurance to cover the full range of reproductive health services, including pre-conception care, contraception, fertility treatment, and abortion care.** Being able to plan and control if and when to bear children is essential to improving overall maternal and infant health outcomes.

Use your organizational influence to advocate for broader public policies that support improved maternal and infant health beyond healthcare delivery.

Addressing the maternal health crisis, with its disproportionate impact on communities of color, requires action outside of the narrow healthcare sphere to eliminate structural drivers of poor health. Broader economic and social policies that build upon and support communities' health-generating assets and remedy pervasive health risks are part of a comprehensive solution to the maternal health crisis. Review your business and social responsibility goals for a "health equity in all policies" approach. Follow the lead of local community leaders to define and prioritize the policy solutions at all levels. This could include strong public health infrastructure, universal broadband access, affordable housing, equitable economic development and anti-poverty initiatives, and educational equity. Examples of policies you should consider championing are listed below.

- **National paid family and medical leave.** Paid leave is critical for health and economic security. For pregnant people and birthing families, it allows for medical care, postpartum recovery, and caring for and bonding with a newborn.

- **Minimum wage standards that provide a living wage.** Economic stability is indispensable to protecting and promoting the health of pregnant people and their families. (See Employer Role, page 38)
- **Universal and affordable broadband.** Reliable high-speed Internet access is a cornerstone to building health equity by increasing access to confidential and secure virtual care, widening the opportunity for health education, encouraging civic participation, and combating social isolation.
- **Policies to address the climate crisis.** Extreme heat will continue to increase pregnant people's risk of heat exposure nationwide, with alarming effects on maternal and infant health. In addition, pollution and more frequent and intense weather events are an increasing health threat to individuals and families across the country.
- **Affordable housing, including housing assistance.** Housing assistance programs are a critical safety net for pregnant people. Pregnant people experiencing homelessness are significantly more likely to have various pregnancy-related conditions and complications.
- **Transportation access.** Transportation barriers can affect a pregnant person's access to maternal healthcare services as well as to health promoting resources, such as healthy foods, education, and green spaces.
- **Food access and security.** Pregnant people experiencing food insecurity are at an increased risk of pregnancy complications and poor mental and physical health outcomes, and access to healthy nutrition is fundamental for young families.
- **Resources to address intimate partner violence (IPV).** Pregnancy and postpartum periods are particularly high-risk times for IPV. People who experience IPV, as well as their children, may face life-long effects, including physical and emotional trauma, chronic health problems, and even death.
- **Structures and processes in all policy development that respectfully include people with lived experience from the communities most adversely affected.** Including the voices, priorities, and needs of communities that have been systematically excluded from decision-making processes will lead to better solutions at all levels of government and in private enterprise that are effective for more people.
- **Interoperable IT systems for connecting healthcare, health, and economic and social data that enable seamless interaction, and that facilitate collecting and reporting self-identified data on race, ethnicity, and other demographic elements.** Our data systems are deeply siloed, full of redundancies, and fail to accurately capture people's self-identified data on a number of demographic categories that are critical for understanding the breadth and intensity of inequities.

Use investment and procurement power: Audit and adjust your business model, investment, purchasing strategies, and philanthropy to improve communities' maternal health and overall resilience.

Communities most affected by the maternal health crisis tend to also experience higher rates of poverty, especially concentrated poverty, which often translate into very limited health infrastructure, including educational and economic opportunities and the ability to remain safe. Your organization should respond in multiple ways: as an investor, a purchaser, and a donor.

- **In procurement and purchasing, prioritize local goods and services, with special attention to women, BIPOC-, and LGBTQIA+-owned businesses.[18]**
  - **Why:** Supply chain diversity has business value.[19] Supporting local commerce has an economic multiplier effect and builds the community as well as meeting the organization's needs for goods and services.
  - **How (examples):**
    - ☐ Publicly commit your institution to increase purchasing from minority-owned businesses.[20]
    - ☐ Work with legal counsel to develop standard contract language that is both respectful of local business and organizations and promotes high expectations regarding employment practices.
- **Assess endowment investments and divest from those that undermine maternal and infant health and community well-being.**
  - **Why:** All parts of your organization should align around the shared goal of health equity and not work at cross purposes.[21]
  - **How (examples):**
    - ☐ Seek opportunities to invest in local financial institutions and other entities that build community power and resilience.
    - ☐ Investment beyond local entities should prioritize socially responsible businesses, products, and services, in line with healthcare's traditional mission.

- **Collaborate with community leaders to design and fund programs** that respond to the concrete needs of community members, especially those most disadvantaged by racism and other structural inequities.
  - **Why:** Structurally marginalized communities are often rich in community assets and leadership that are chronically underused and under-resourced. Moreover, communities are the experts on their own needs and priorities. Building mechanisms that directly support these community assets will make an immediate difference in their overall health and well-being, including those of birthing people and their families.
  - **How (examples):**
    - ☐ Contract directly with community-based organizations (CBOs) providing needed maternal health and other health prevention, promotion, and social needs services.
    - ☐ Partner with local schools to fund school-based programs to promote healthier environments or better access to high quality STEM programs and pipeline programs for health professions careers.

Meeting the Mission of Nonprofit Hospitals: Leveraging Community Benefit Requirements to Drive Resources to the Communities that Need Them the Most.

Nonprofit hospitals agree to a higher level of investment in their communities in exchange for their tax-exempt status. Usually, this is met by providing charity care. However, they could be leveraging those resources more directly into communities to help improve overall health and resilience and minimize the need for charity care in the first place – especially when it comes to maternal and infant health. Concrete ways to do this are listed below.[22]

- Invest at minimum the full value of their tax-exempt status (excluding research, health professions training, and Medicaid shortfall), being guided by the most pressing social needs that emerge from their mandated Community Health Needs Assessment.
- Direct significant community benefit resources to community-based perinatal organizations to build capacity, provide culturally congruent services, strengthen families, increase reach and impact, and ultimately assume a significant role in community development and population health.

Use your voice to shape public understanding about the importance of maternal health equity and dismantling racism and all forms of discrimination.

Local and state leaders and organizations are declaring racism a public health emergency. These campaigns and declarations have been an important first step in advancing health equity and should be followed by taking strategic action and allocating resources. We encourage you to take the steps below.

- **Join and support efforts to declare racism a public health emergency.** In recent years, hundreds of governmental and private entities have made similar declarations to underscore the urgency of addressing this problem and mobilizing resources. These include the Centers for Disease Control and Prevention,[23] many healthcare institutions,[24] and jurisdictions as small as Ardmore, Oklahoma, and as large as the State of New York.[25]
- **Support public statements and adopt recommendations addressing the role of racism in the maternal health crisis.**[26] Professional organizations working in maternal care have issued statements identifying racism as a core driver of adverse maternal and newborn health outcomes, and have created guides and tools for providers to use. (See Implementation Toolbox for detailed recommendations.)
- **Consider acknowledging your institution's historic and ongoing role in perpetuating structural discrimination, with a focus on maternal and infant health.** Many healthcare provider institutions in this country were founded as segregated organizations. Many have a history of questionable healthcare research and practices that abused Black, Indigenous, and other people of color. In addition, people of color continue to report discriminatory treatment when accessing healthcare services, across all socioeconomic levels. Acknowledging your organization's role in this is critical to earning trust and models the actions that other institutions should take.
- **Engage, collaborate with, and build the capacity of BIPOC community leaders.** People are experts in their experiences, lives, and bodies, and in solutions to their challenges. Authentic representation from the community will support more effective policies and programs and improve outreach. Using your resources for the benefit of the community demonstrates your commitment to advancing equity and better health for everyone.
- **Create community-level educational programs on how racism undermines health,** including allostatic load (the cumulative physiological impact of chronic stress and deprivation), "weathering" (how toxic stress degrades ones' physical health and DNA) epigenetics, and adverse childhood events. This will deepen community-level understanding of the persistence of discrimination and the urgency of solving it.
- **Avoid performative allyship.** Institutional support for addressing root causes of the maternal health crisis must continue beyond communications efforts. Actions perceived as superficial or inauthentic will undermine trust. To build trust with your surrounding communities, direct sustained resources to solve these issues within your organization and out in the community.

Endnotes

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Raising the Bar

FOR MOMS & BABIES