Part 1: Maternal Mortality & Morbidity Skill-Building Session

Healthy Start Regions 1, 2, & 3 Meeting

Monday, April 24 from 11:45-12:45

HRSA Maternal & Child Health

NICHQ National Institute for Children's Health Quality

HEALTHY start TA & SUPPORT CENTER

Addressing Maternal Mortality through Community Clinical Integration

Susan Kendig, JD, WHNP-BC, FAANP
Clinical Community Integration & Patient Safety Implementation Strategist
AIM-CCI

Objectives: Part 1

Upon completion of this skill building session, participants will be able to:

- Articulate how our work within the community has potential to impact the effects of social and structural determinants on maternal health
- Utilize the CCI pathway as a framework to guide power shifting strategies
- Consider approaches to leveraging existing resources to inform communities about maternal mortality and preventive measures

"If the baby dies, the mother cannot be well .

If the mother dies, the baby cannot be well."

Dr. Albert Tuyishime, Manager of Planning, Monitoring and Evaluation and Business Strategy, Rwanda Biomedical Center, June 18, 2019

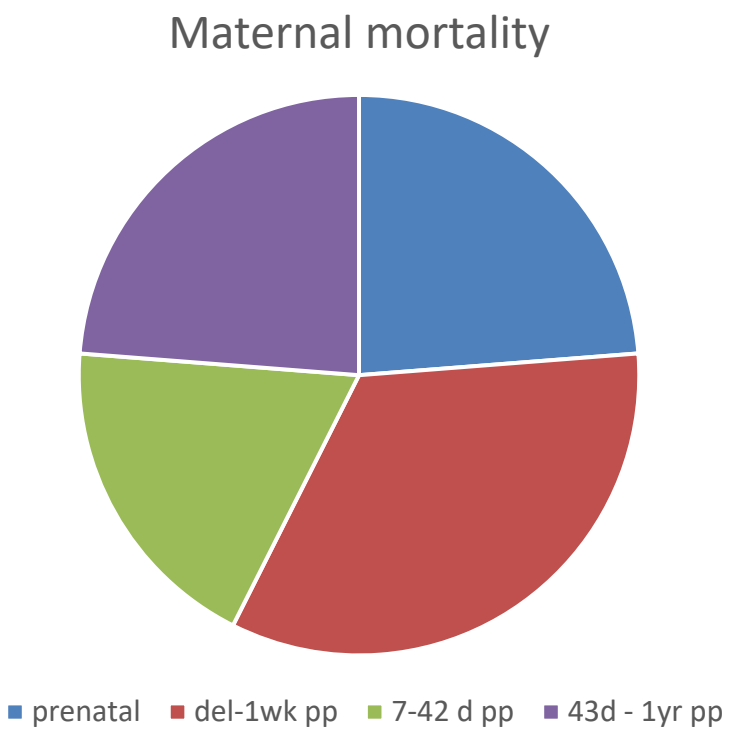
Maternal Mortality Rates

Regions 1, 2 & 3

State	Maternal Deaths/100,000 Births
New Jersey	24.1
Virginia	22.3
Puerto Rico	21*
New York	20.2
Maryland	18.6
Pennsylvania	15
Connecticut	NR
District of Columbia	NR
West Virginia	NR

https://www.cdc.gov/nchs/maternal-mortality/mmr-2018-2020-state-data.pdf;
*https://www.macrotrends.net/countries/PRI/puerto-rico/maternal-mortality-rate

Why Do We Need a Continuous, Comprehensive Approach to Birthing People's Health Care?



Cardiovascular conditions, hemorrhage, infection, embolism, cardiomyopathy, mental health, SUD, preeclampsia leading causes of death nationwide in first year postpartum.

Petersen, EE, Davis, NL, Goodman, D, et al. Vital Signs: Pregnancy-Related Deaths, United States, 2011–2015, and Strategies for Prevention, 13 States, 2013–2017. MMWR. 2019: 68(18): 423-429.

What About Those Who Live?

Severe Maternal Morbidity (SMM) – unexpected outcomes of labor and delivery (CDC)

"Any health condition attributed to and/or aggravated by pregnancy and childbirth that has a negative impact on the woman's well-being". WHO Maternal Morbidity Working Group)

Recognizing SMM

- CDC identifies 21 indicators that comprise the most widely used measures for SMM
- Approximately 1.4% of birthing persons in 2016-2017 experienced one of those indicators
- Affects approximately 60,000 birthing people annually (Commonwealth Fund, 2021)

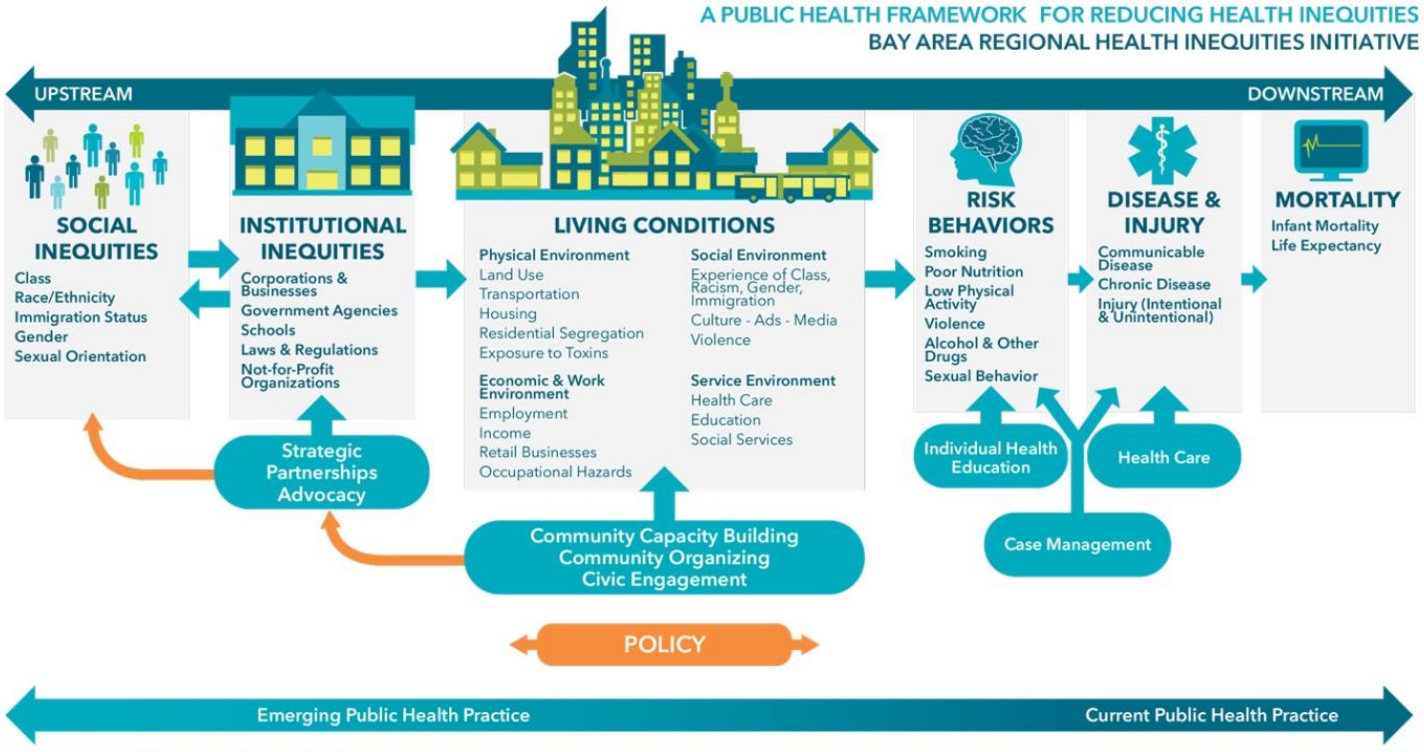
What We Do Here Today ……..
and Every Day
Matters More Than We Know

DO SOCIAL AND STRUCTURAL DETERMINANTS IMPACT MATERNAL HEALTH?

Defining “Determinants”

- Social Determinants of Health (SDOH) – Community-level conditions in environments where people live, learn, work, play, worship, and age that affect health and health outcomes. (CDC, 2019)
- Health-related social needs (HRSN) - nonmedical circumstances that impact individuals and their disease outcomes. (Castrucci & Auerbach, Health Affairs, 2019)
- Structural Determinants - the ‘root causes’ of health inequities. They affect whether the resources necessary to support health are equitably distributed.
  - Shape the quality of the social determinants of health experienced by individuals
  - Include the governing process, economic and social policies that affect pay, working conditions, housing, and education. (IDPH, 2020)

The context of health inequities does not exist only within healthcare

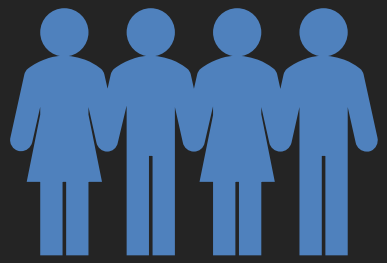


Thank you to Vijaya Hogan, DrPH for the use of this slide

Systemic Drivers of Social Inequities

- Barriers to care, provider shortages, quality of care gaps
- Unstructured environments produce a higher prevalence of unhealthy behaviors
- Lag in educational attainment resulting in a concentration of resources among a small population
- Built environment
  - More racially segregated communities
  - Does not encourage healthy behaviors

Crear-Perry, J et al., 2021, Journal of Women's Health.



Structural Racism as a Root Cause of SDoH

Racism is “a system of structuring opportunity and assigning value based on the social interpretation of how one looks that unfairly disadvantages some individuals and communities unfairly, advantages other individuals and communities, and unfairly saps the strength of the whole society through the waste of human resources.” (Dr. Camara Phyllis Jones, 2018)

How Do SDoH Impact Maternal Health?

"SDoH help shape the proximal risk factors that affect our health, functioning and quality of life."
(Dagher & Linares, 2022, Children)

They are the "but for…." factors

- Study examining population level factors and increased maternal deaths 1997-2012
  - Increased prevalence of obesity, diabetes, chronic disease only partially explained outcomes
  - Also attributable to SDoH factors at multiple levels, such as
    - Less than high school educational attainment
    - Attended less prenatal visits

SDOH and Maternal Health: Additional Considerations

- Cumulative exposure to SDoH over time can lead to accelerated biologic aging, or “weathering”. (Howell, 2018, Clin Obstet Gynecol; Fishman, 2020, Demogr Res)
- Link between adverse childhood events and chronic health problems.(Lu, 2018, JAMA)
- Preliminary evidence shows potential relationship between maternal mortality and morbidity and “neighborhood deprivation”.(Dagher & Linares, 2022, Children)
- National study of data from 2007-2015 found a 9% higher probability of severe maternal mortality and morbidity among rural residents as compared to urban residents. (Kozhimamil, 2019, Health Affairs)
  - Lower initiation of first trimester prenatal care
  - Less than ½ live within 30 min. drive to perinatal center
  - Report highest rates of no or delayed care due to cost (ACOG. 2014. Committee Opinion 586)

Screening for Social Determinants of Health
CMS IPPS Rule 2023

SDOH-1 – Screening for social drivers of health

SDOH-2 – Screen positive rate for social drivers of health

Food insecurity	Unstable housing	Transportation	Utility difficulties	Interpersonal safety

https://www.federalregister.gov/documents/2022/08/10/2022-16472/medicare-program-hospital-inpatient-prospective-payment-systems-for-acute-care-hospitals-and-the

Does Screening for the "Big 5" SDoH Tell the Whole Story?

- Experience of living with low income and material hardship influences parental stress and mental illness. (Gershoff et al., 2007, Child Development)
- Food insufficiency was shown to increase risk for depression in poor Black women, even after adjusting for unemployment, unstable housing, childcare availability, transportation and discrimination.(Seifert, et al., 2007, Am J Orthopsychiatry)
- Mothers experiencing diaper need exhibited higher depression scores than those with food insecurity.(Austin, A & Smith, 2017, Health Equity; Smith, MV et al, 2013, Pediatrics.

- What do birthing people know?
- How can we incorporate prevention strategies into community education?

COMMUNITY EDUCATION REGARDING MATERNAL MORTALITY

Considerations in Planning Community Education Targeting Maternal Mortality

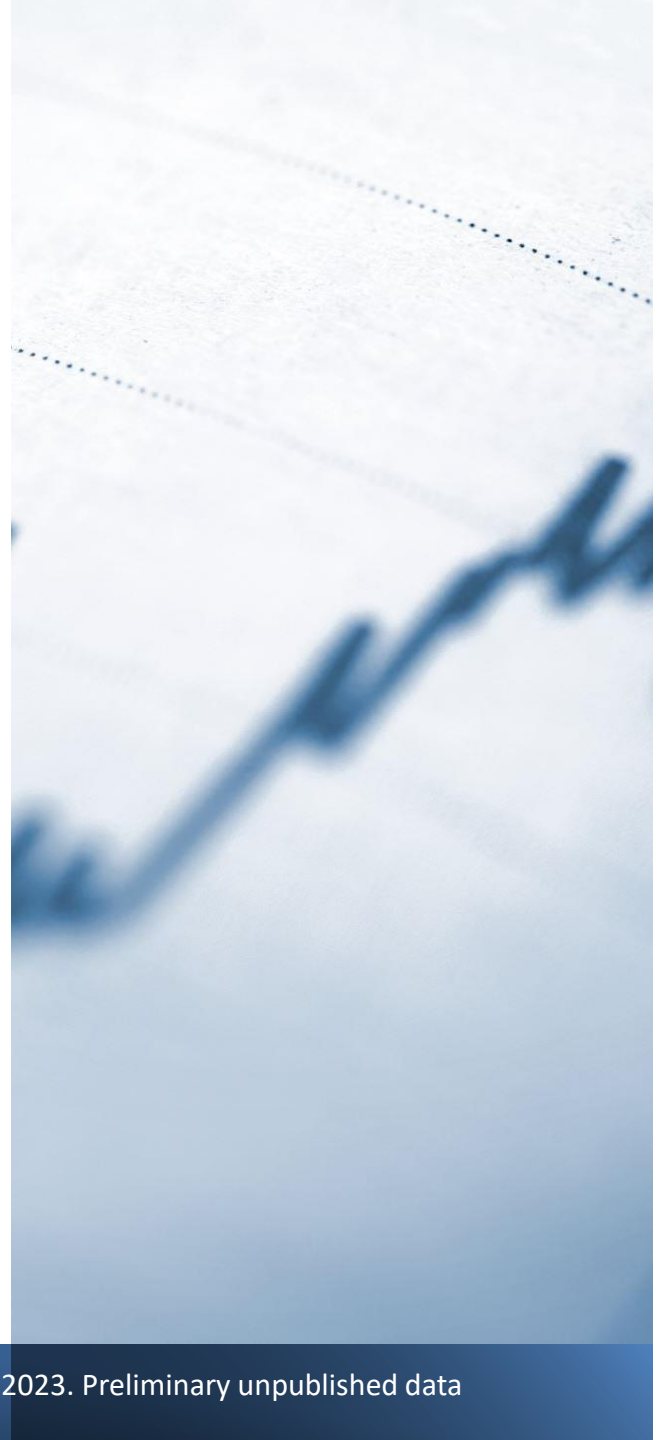
Patient education to enhance risk awareness, activate health promoting behaviors and improve communication with clinicians are common strategies to improve maternal outcomes.

Birthing people's health related decisions are affected by perceptions of respectful care, health literacy, personal health risk, and cultural or community differences in lived experience.

Perceptions of Maternal Mortality in a Missouri Birthing Population*

Goal: Capture community voice and explore birthing person's understanding of local maternal mortality rates, groups affected, and causal perceptions

Methods: Anonymous, cross-sectional survey conducted from May to August 2022. Target population included individuals ≥18 living in a Missouri zip code. 1,738 qualified respondents completed the survey



*Florio, et al. 2023. Preliminary unpublished data

Perceptions of Maternal Mortality in a Missouri Birthing Population: Selected Data*

Question	Answer(*n*=1738)	Percent
Are you aware there are deaths due to pregnancy in your state?	Yes	78%
Do you know someone who has died in pregnancy?	Yes	14.7%
Do you think there is a certain group that suffers more from pregnancy related deaths?	Yes • Black • Poor • Uninsured	66.4% 58.7% 71.0% 61.9%
What time period do you believe has the highest risk of death?	Delivery/pushing After discharge After PP visit	42.4% 3.6% 1.6%
What health problems do you think can happen as a result of pregnancy?	Depression/anxiety High BP Blood clots Diabetes	79.6% 78.5% 63.2% 59.8%

Florio, et al. (2023).Preliminary, unpublished data

Perceptions of Maternal Mortality: Preliminary Findings*

- Birthing people know that people are dying in pregnancy
- Birthing people recognize that Black birthing people experience maternal mortality at greater rates than white people
- Birthing people can name the top drivers of maternal mortality
- Birthing people are less sure of the timing of maternal deaths

Florio, et al. 2023. Preliminary unpublished data

CDC Centers for Disease Control and Prevention

HEAR HER™ Campaign

Español (Spanish) | Print

Learn the Warning Signs

It could help save a life

Learn More

Pregnant & Postpartum People

Partners, Friends & Family

Healthcare Professionals

Pregnant now or within the last year?

Get medical care right away if you experience any of the following symptoms:

Headache that won't go away or gets worse over time

Dizziness or fainting

Changes in your vision

Fever of 100.4˚F or higher

Extreme swelling of your hands or face

Thoughts of harming yourself or your baby

Trouble breathing

Chest pain or fast beating heart

Severe nausea and throwing up

Severe belly pain that doesn't go away

Baby's movement stopping or slowing during pregnancy

Severe swelling, redness or pain of your leg or arm

Vaginal bleeding or fluid leaking *during* pregnancy

Heavy vaginal bleeding or discharge *after* pregnancy

Overwhelming tiredness

These could be signs of very serious complications. If you can't reach a healthcare provider, go to the emergency room. Be sure to tell them you are pregnant or were pregnant within the last year.

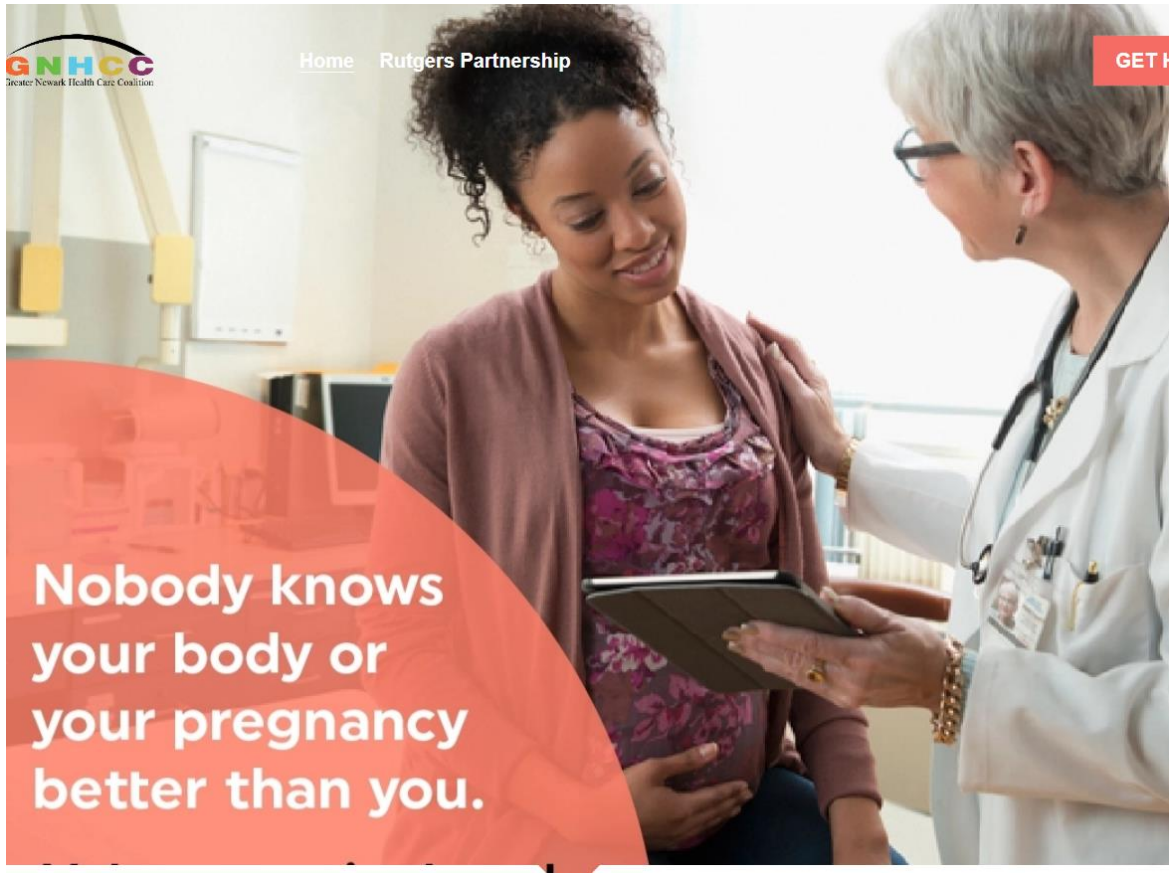
Learn more at www.cdc.gov/HearHer

CDC

HEAR™
HEAR HER CONCERNS

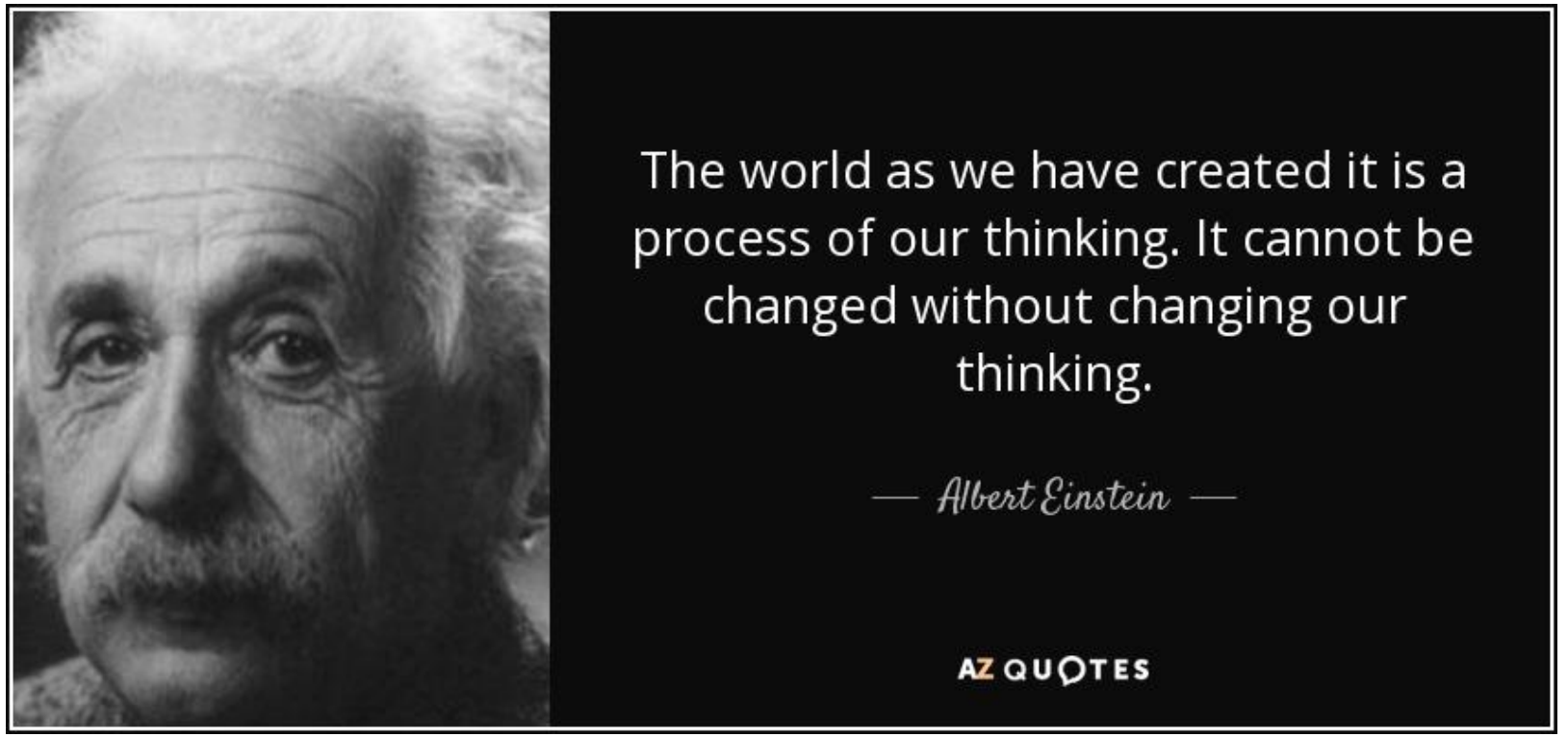
This list of urgent maternal warning signs was developed by the Council on Patient Safety in Women's Health Care.

Greater Newark Health Care Coalition

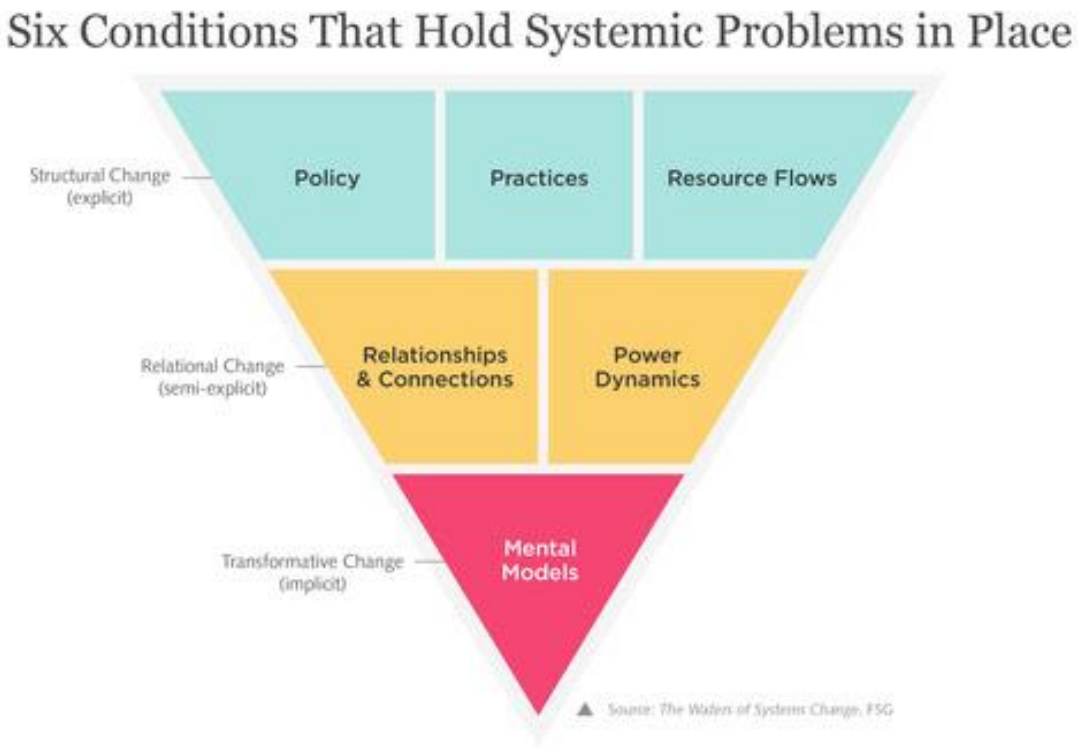


Clinician Accountability

SHIFTING POWER THROUGH CLINICAL COMMUNITY INTEGRATION


The world as we have created it is a process of our thinking. It cannot be changed without changing our thinking.
— Albert Einstein —
AZ QUOTES

System Change



Kania J., Kramer M., Senge P. (2018) *The Water of Systems Change.* Retrieved from http://efc.issuelab.org/resources/30855/30855.pdf

Indicator vs. Framework

Indicator is a Data Point

- Measurement limited by current reality
- A product of our past understanding of health and science
- Systems are more apt to adhere to specific prescribed indicators than to determine alternatives

Framework is a Vision

- Expands understanding of current reality
- Allows freedom to explore language of indicators
- Exploration of alternatives to traditional data collection
- Questions historical construction of health systems

Thank you to Dr. Joia Crear Perry for sharing this concept

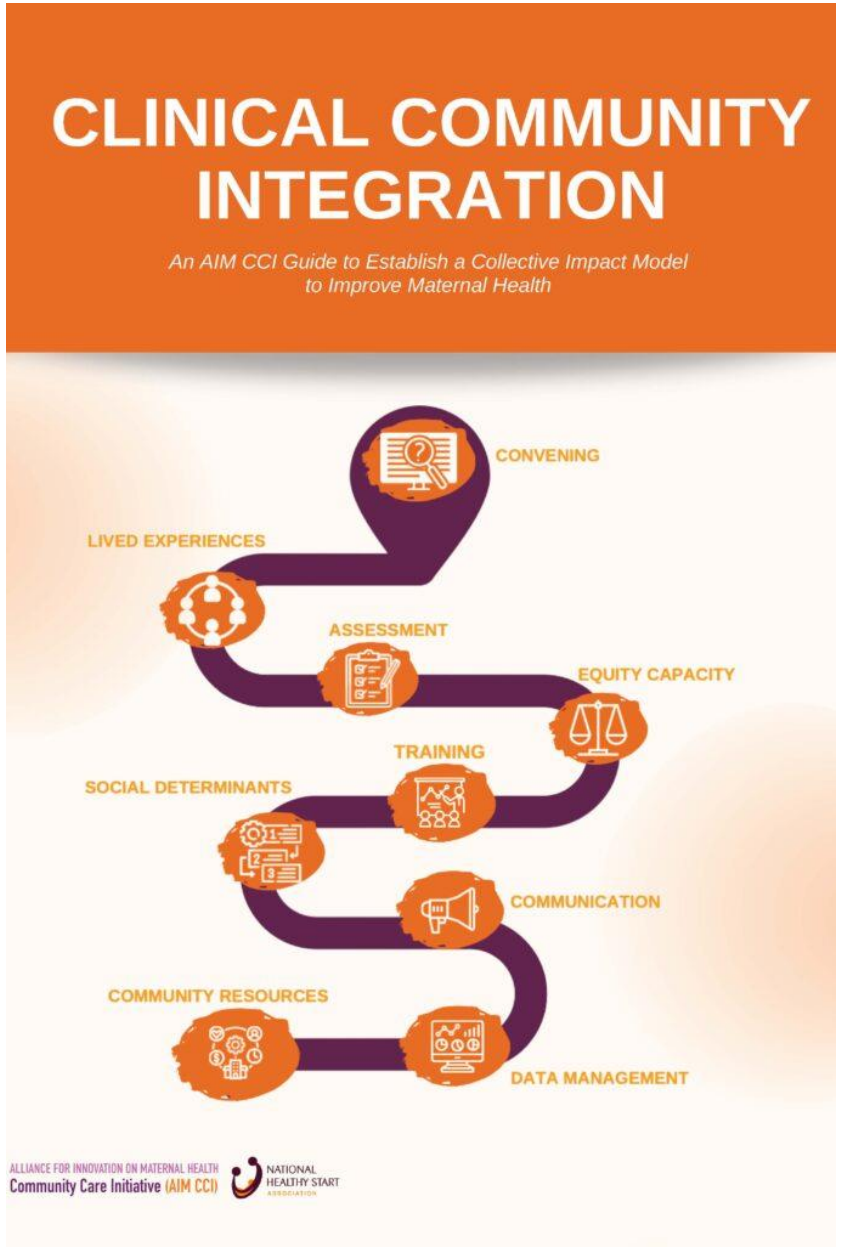
What is Clinical Community Integration?

- Provides an architecture to engage with patients and their communities as partners in shaping health care and improving public health. (Krist et al., 2013)
- “Intentional strategies to connect traditional healthcare structure with community-based organizations and programs.” (Bascom, 2017)
- Encourages tailoring of clinical services to fit the individual’s and community’s unique experiences to address unmet social needs. (Connecticut Health Foundation, 2018)

Why Clinical Community Integration?

- Core features of Clinical Community Integration
  - At least one step occurs in each setting
  - Activities coordinated among participants
  - Participants reinforce and support all steps
  - Shared resources
  - Shared accountability (Krist et al, 2012)
- Examples of successful clinical-community integration efforts:
  - Breast cancer screening rates in creased from 5% to 29% after intervention.
  - Bundled delivery of preventive services increased with Clinical-Community interventions (Krist et al, 2012)
  - Initiative designed to integrate community health into primary care improved referral to community organizations, changed local practice and policy (Lachance et al, 2016)

How is AIM CCI Working to Foster Clinical Community Integration?

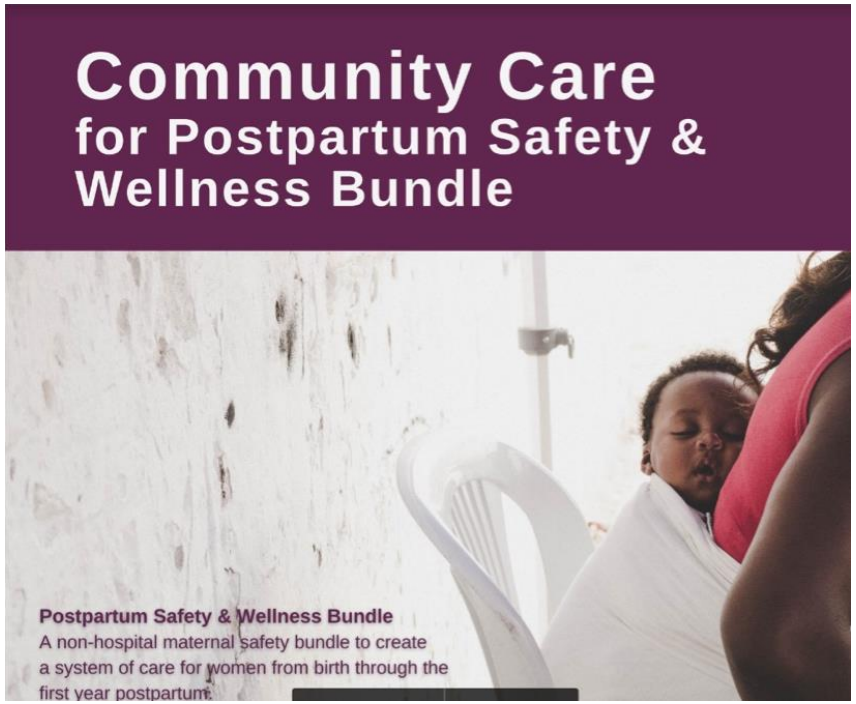


AIM CCI Maternal Safety Bundles

- A Bundle is a small set of evidence-based interventions that combines medical and improvement science to achieve improved outcomes
- When care processes are grouped into simple bundles, caregivers are more likely to implement them by making fundamental changes in how the work is done.
- When the care processes are evidence based, subsequent outcomes will improve.
- Encourages interdisciplinary teams to organize work, adapt the delivery system, and deliver bundle components reliably.

Maternal Safety Bundles - Alliance for Innovation on Maternal Health Community Care Initiative (aimcci.org)

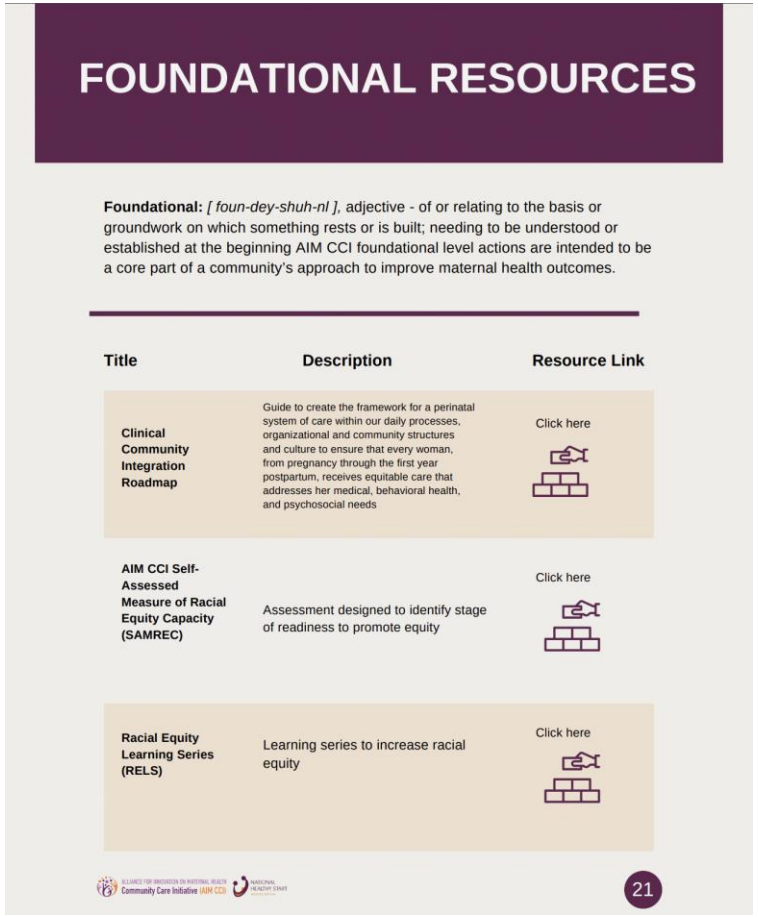
AIM CCI
Bundles Designed for Community



ALLIANCE FOR INNOVATION ON MATERNAL HEALTH
Community Care Initiative (AIM CCI)

- **Community Care for Maternal Mental Health & Wellness**
- **IPV**
  - Depression, Anxiety, Stress
- **Managing Chronic Conditions**
  - Hypertension, Diabetes, Healthy Weight
  - Prenatal and postpartum period

Bundles Designed for Community



Rural Maternity and Obstetrics Management Strategies (RMOMS)

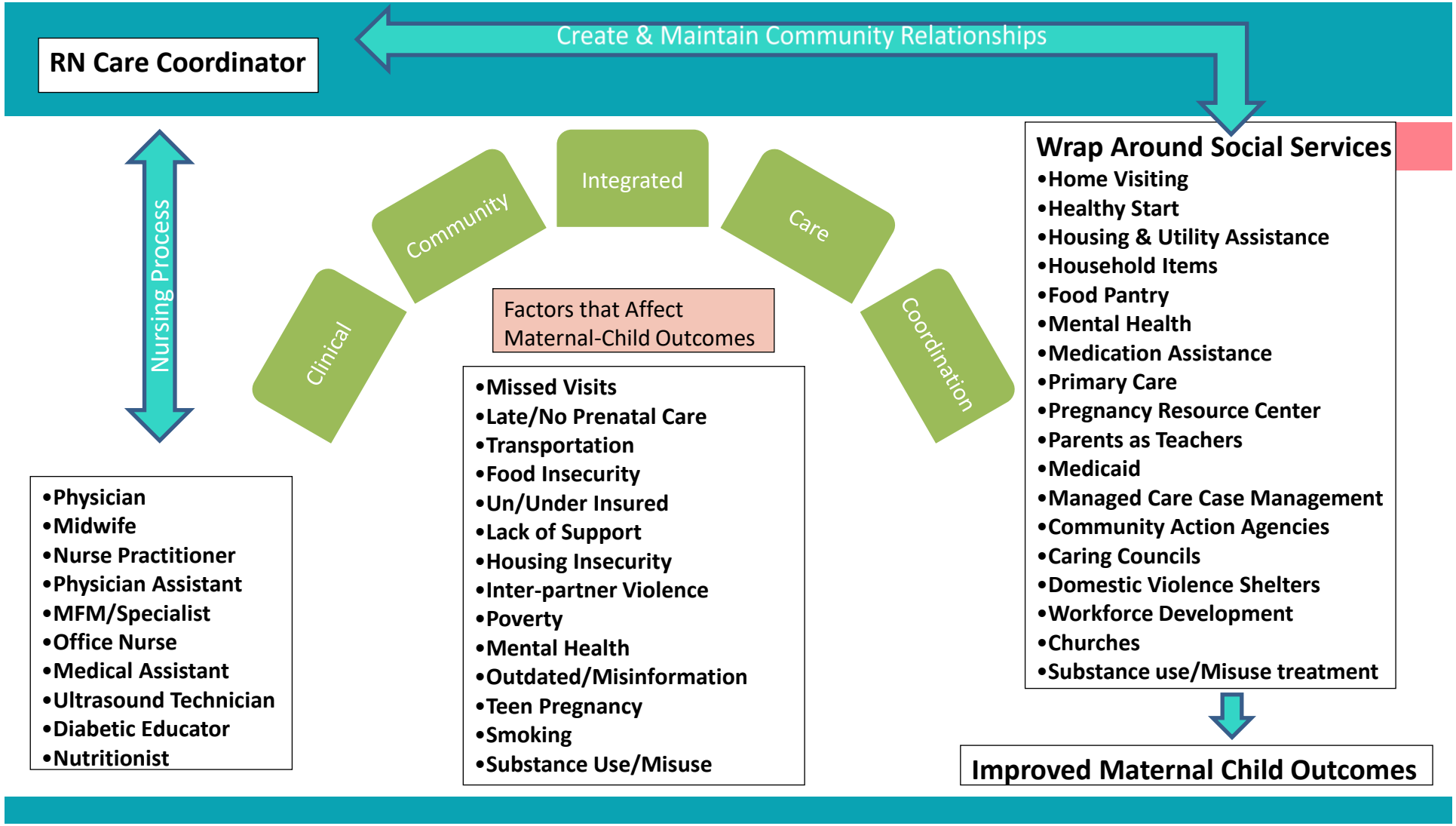
- Develop a perinatal system of care to increase access, impact continuity of care from pregnancy through 6 mo. postpartum and improve outcomes in rural areas.
- Network composition **must** include:
  - At least 2 rural hospitals or CAHs
  - At least one FQHC or FQHC look-alike
  - State home visiting and **Healthy Start** programs if regionally available
  - The state Medicaid agency

Thank you to the BPN Team for sharing their story on the following slides

- Barbara Gleason, RN, MSN – Project Director, Bootheel Perinatal Network, RMOMS HRSA Grant
  cell: 573-275-4101 bgleason@sfmc.net

- Rebecca Burger, RN, BSN, System Care Coordinator, Bootheel Perinatal Network, RMOMS HRSA Grant
  cell: 573-979-9203 rburger@sfmc.net

bpn Bootheel Perinatal Network


RN Care Coordinator
Create & Maintain Community Relationships
Nursing Process
Integrated
Community
Care
Clinical
Coordination
Factors that Affect Maternal-Child Outcomes
•Physician
•Midwife
•Nurse Practitioner
•Physician Assistant
•MFM/Specialist
•Office Nurse
•Medical Assistant
•Ultrasound Technician
•Diabetic Educator
•Nutritionist
•Missed Visits
•Late/No Prenatal Care
•Transportation
•Food Insecurity
•Un/Under Insured
•Lack of Support
•Housing Insecurity
•Inter-partner Violence
•Poverty
•Mental Health
•Outdated/Misinformation
•Teen Pregnancy
•Smoking
•Substance Use/Misuse
Wrap Around Social Services
•Home Visiting
•Healthy Start
•Housing & Utility Assistance
•Household Items
•Food Pantry
•Mental Health
•Medication Assistance
•Primary Care
•Pregnancy Resource Center
•Parents as Teachers
•Medicaid
•Managed Care Case Management
•Community Action Agencies
•Caring Councils
•Domestic Violence Shelters
•Workforce Development
•Churches
•Substance use/Misuse treatment
Improved Maternal Child Outcomes

Care Coordination Campaign

You Matter! Your Voice Matters!

Gives mothers the opportunity to share their unique stories of success, challenges, and gaps in pregnancy care and beyond while giving them a voice in improving maternal care

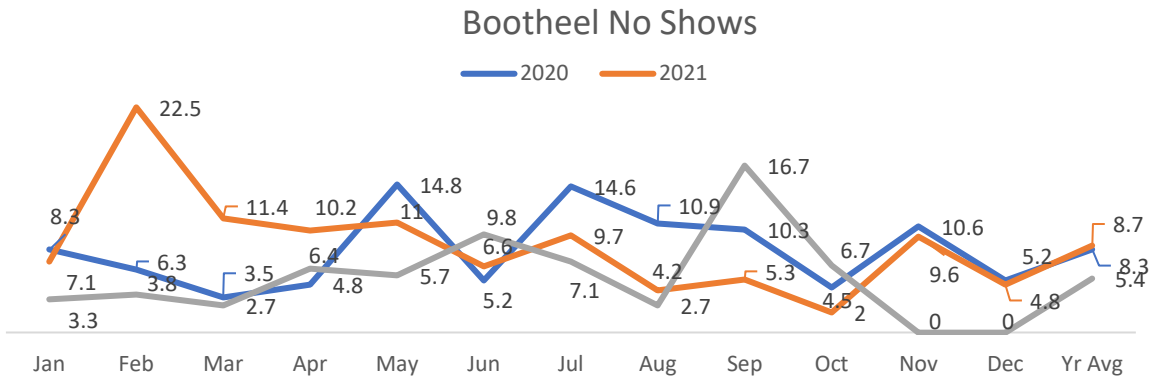
Build rapport with clients and ensure that clients feel comfortable and secure no matter the situation.

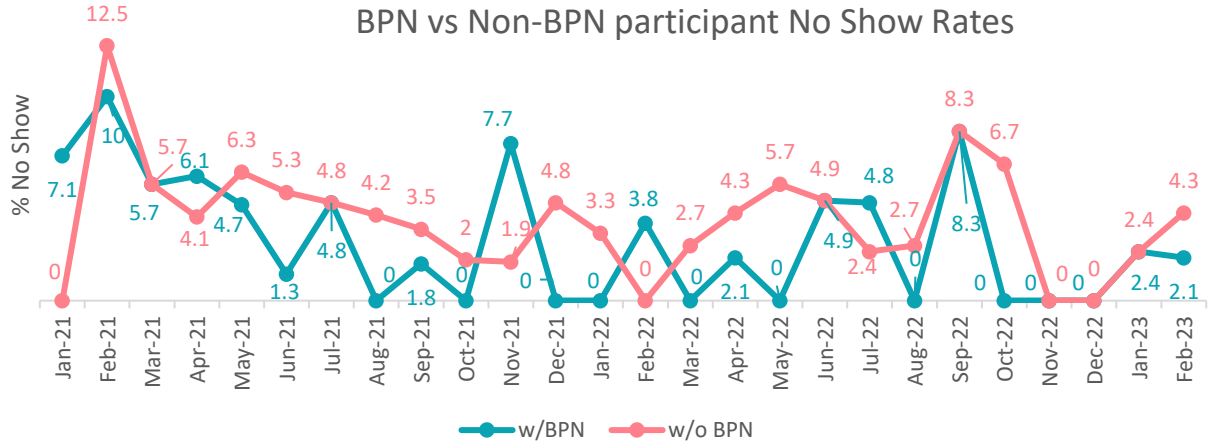
Care Coordinators use their nursing skillset to identify mental and physical risk factors, listen to clients' stories, identify social service needs, and connect them to existing community resources, creating a bridge between clinical care and community health

Time spent with mothers is uniquely tailored to their needs and guided by evidence-based assessment tools.

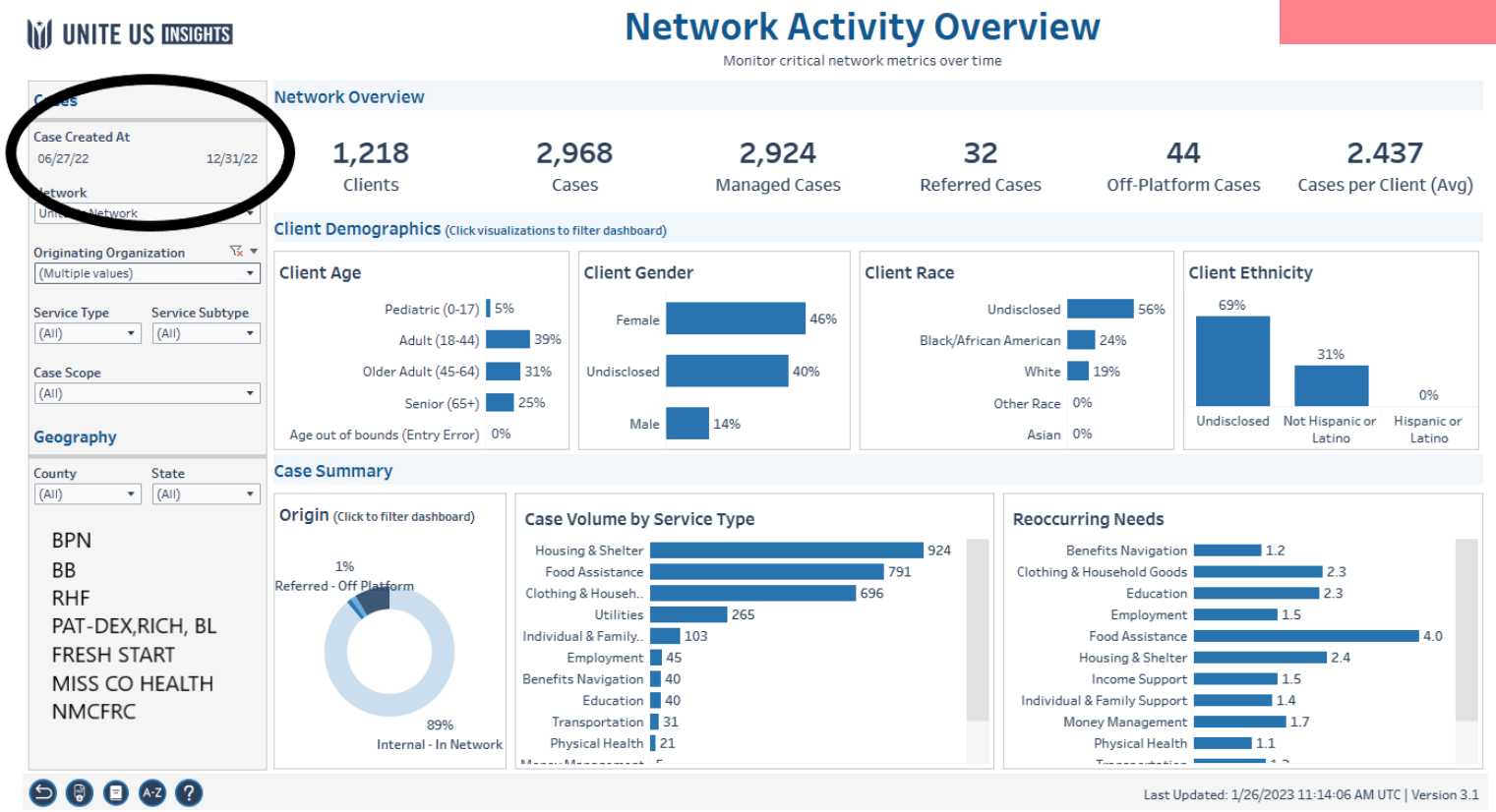
Touchpoints & Follow Ups well into the post-partum period

MFM Clinic No Show Rates





BoRN Q2 Data


UNITE US INSIGHTS
Network Activity Overview
Monitor critical network metrics over time
Case Created At
06/27/22
12/31/22
Network
Originating Organization
(Multiple values)
Service Type
(All)
Service Subtype
(All)
Case Scope
(All)
Geography
County
(All)
State
(All)
BPN
BB
RHF
PAT-DEX,RICH, BL
FRESH START
MISS CO HEALTH
NMCFRC
Network Overview
1,218
Clients
2,968
Cases
2,924
Managed Cases
32
Referred Cases
44
Off-Platform Cases
2.437
Cases per Client (Avg)
Client Demographics (Click visualizations to filter dashboard)
Client Age
Pediatric (0-17) 5%
Adult (18-44) 39%
Older Adult (45-64) 31%
Senior (65+) 25%
Age out of bounds (Entry Error) 0%
Client Gender
Female 46%
Undisclosed 40%
Male 14%
Client Race
Undisclosed 56%
Black/African American 24%
White 19%
Other Race 0%
Asian 0%
Client Ethnicity
69%
31%
0%
Undisclosed
Not Hispanic or Latino
Hispanic or Latino
Case Summary
Origin (Click to filter dashboard)
1%
Referred - Off Platform
89%
Internal - In Network
Case Volume by Service Type
Housing & Shelter 924
Food Assistance 791
Clothing & Househ.. 696
Utilities 265
Individual & Family.. 103
Employment 45
Benefits Navigation 40
Education 40
Transportation 31
Physical Health 21
Reoccurring Needs
Benefits Navigation 1.2
Clothing & Household Goods 2.3
Education 2.3
Employment 1.5
Food Assistance 4.0
Housing & Shelter 2.4
Income Support 1.5
Individual & Family Support 1.4
Money Management 1.7
Physical Health 1.1
Last Updated: 1/26/2023 11:14:06 AM UTC | Version 3.1

Telling Our Story: Defining Evidence

Evidence Based Medicine (EBM) –"conscientious, explicit Judicious, and reasonable use of modern, best evidence in making decisions about the care of individual patients."

Experiential Evidence – Derived from professional insight, understanding, skill and expertise accumulated over time.

Contextual Evidence – Derived from actors that address whether a strategy is useful, feasible to implement, and accepted by a given community

Celebrating Our Story!

- Michigan study showed strong evidence for the effectiveness of a Medicaid sponsored population-based home visiting programs in improving maternal and infant care. (Meghea, et al. 2013, AM J of Prev Med)
- Home visitors in rural areas address community wide issues by adapting content to meet the needs of rural families. (Whittaker, etal, 2021, JPHMP)
- Specific features of trust based CHW-client relationships may mitigate the burden of stress and facilitate health promoting behaviors in perinatal people with chronic conditions. (Boyd, et al. 2021, Maternal and Child Health Journal.)

Stay Tuned for Part 2!!

INTERACTIVE COLLABORATIVE LEARNING

APPLICATION OF THE AIM CCI CLINICAL COMMUNITY INTEGRATION ROADMAP TO SUPPORT POWER SHIFTING

A DEEPER DIVE INTO CLINICIAN ACCOUNTABILITY

IDEAS FOR COMMUNITY EDUCATION STRATEGIES

AND MORE…..

Susan Kendig, JD, WHNP-BC, FAANP
suekendig@gmail.com

Addressing Maternal Mortality through Community Clinical Integration:
Skill Building Activities

Susan Kendig, JD, WHNP-BC, FAANP Clinical Community Integration & Patient Safety Implementation Strategist, AIM-CCI

Lidyvez Sawyer, EdD, MPH
Equity Implementation Strategist, AIM-CCI

Objectives: Part 2

- Utilize the Clinical Community Integration pathway as a guide to develop strategies to shift power dynamics and foster equitable collaboration
- Articulate how community-based strategies have potential to impact the effects of social and structural determinants on maternal health
- Identify strategies to inform communities about maternal mortality and preventive measures

- Please tell us:
  - Your name
  - Where you are from
  - Roll in Healthy Start
  - One thing you hope to gain from this workshop

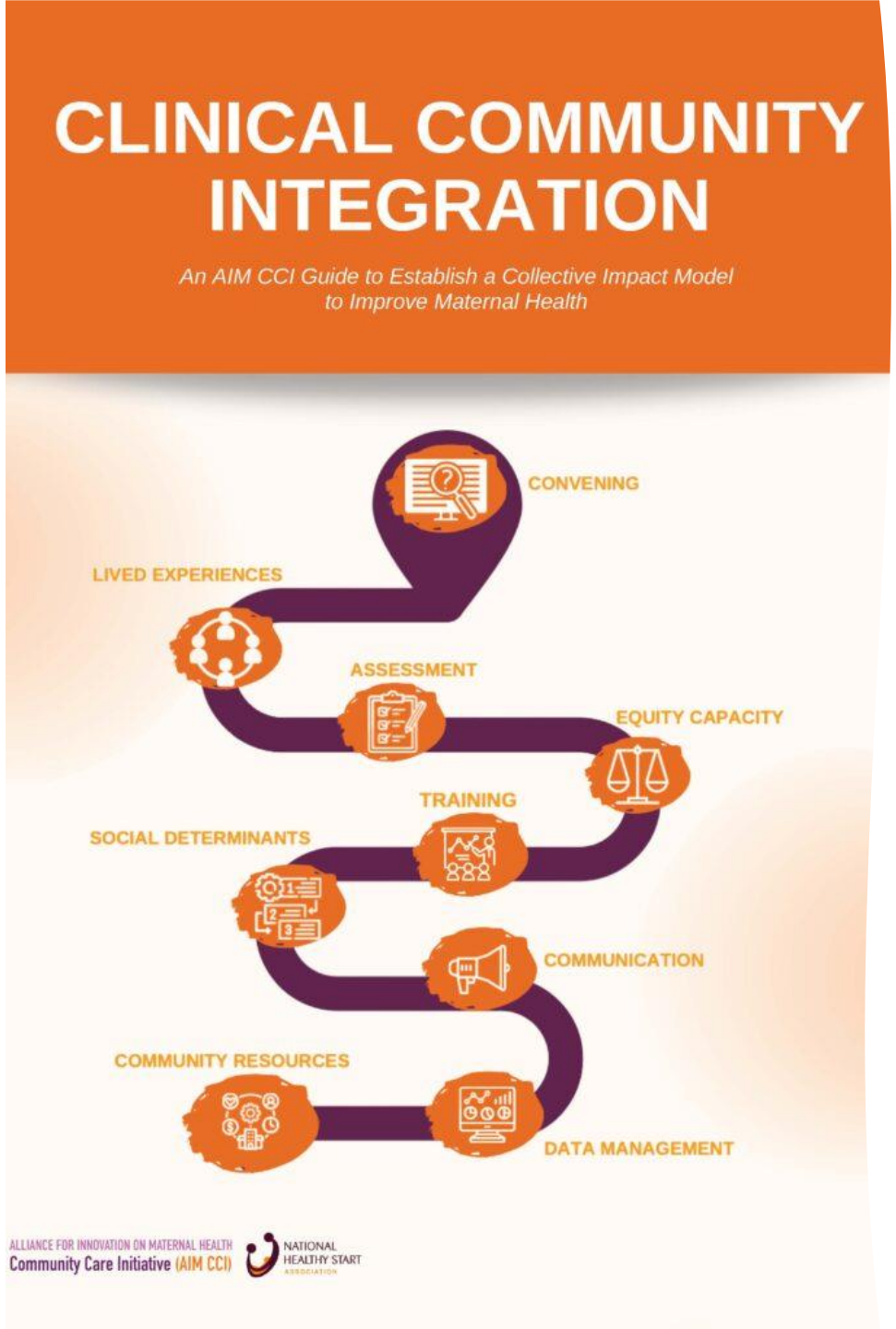
Survey Deep Dive

Thank you to those of you who have already completed the pre-session survey. If you have not completed the survey, please take a few minutes now to review the questions in preparation for our discussion.

Discussion Questions

- How do you believe that Social and Structural Determinants Impact maternal health outcomes?
- How do you believe that racism drives SDoH and contributes to maternal mortality and morbidity?
- Please share the types of maternal mortality prevention strategies your community has implemented? What would you like to try?
- What does “clinician accountability” mean?
  - What clinicians?
  - What are the challenges in holding clinicians accountable for maternal mortality and morbidity prevention?
  - How can you help to develop shared accountability?

CHANGING THE NARRATIVE



Utilizing the CCI Pathway to Support Power Shifting

Convening

Identifying and engaging community partners using a collective impact approach will help to build a network of community members, organizations, and institutions who advance equity by learning together, aligning, and integrating actions to achieve system level change.

AIM CCI Clinical Community Integration Roadmap, https://www.aimcci.org/resources/

Refresher: Collective Impact

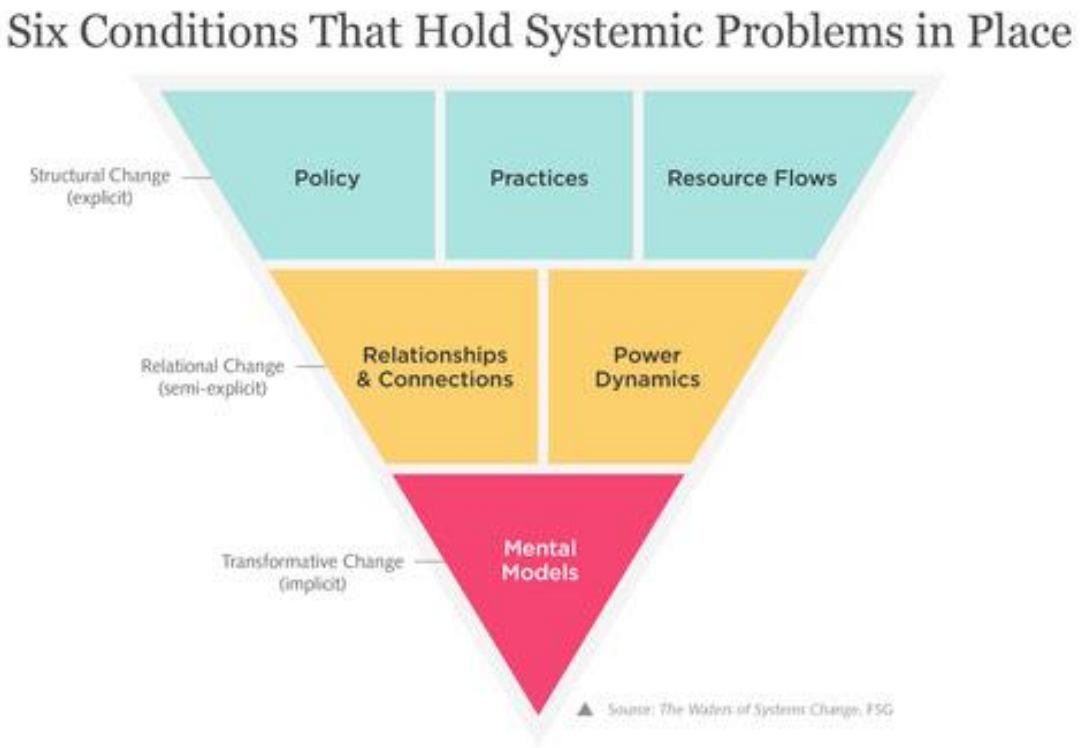
"a structured approach to organizing collaboration of organizations from different sectors to address a specific social issue. "Collective Impact is a network of community members, organizations, and institutions who advance equity by learning together, aligning, and integrating their actions to achieve population and systems-level change. This definition identifies **EQUITY** as the North Star for why and how collective impact work takes place, specifically names community members as key actors along with other partners and emphasizes the importance of systems change in this work."

Five Pillars of Collective Impact

- Common agenda
- Shared measurement
- Mutually reinforcing activities
- Continuous communication
- Backbone support organization

Kania, J., & Kramer, M. (2011). Collective Impact. *Stanford Social Innovation Review*, *9*(1), 36–41. https://doi.org/10.48558/5900-KN19

Refresher: System Change



Kania J., Kramer M., Senge P. (2018) *The Water of Systems Change.* Retrieved from http://efc.issuelab.org/resources/30855/30855.pdf

Lived Experience

Community members are key players, along with other community partners. Regarding women, birthing persons, their families and supporters as experts in their own right enhances the learning, strategy and collaborative work.

AIM CCI Clinical Community Integration Roadmap, https://www.aimcci.org/resources/

Assessment

Assess organizational and individual capacity to participate in or lead collaborative initiatives.

Assessment: Group Discussion

A local hospital is beginning a new maternal health initiative and your agency is invited to partner. You want to do this as your Healthy Start program has not been invited to partner with any of the hospital entities before and multiple linkages to partners that would be helpful.

- What types of internal questions might be helpful as you make your decisions?
- What types of questions might be helpful to ask the potential partner as you make your decisions?

Equity Capacity

By establishing and developing ongoing sessions centered on equity, collaborative partners can assess racial equity capacity and build a plan for ongoing education and conversations centered on equity to measure equitable practice and implementation among teams, organizations and systems.

- Self-Assessed Measurement of Racial Equity Capacity (SAMREC)
- Racial Equity Learning Series (RELS)

AIM CCI Clinical Community Integration Roadmap, https://www.aimcci.org/resources/

AIM CCI Health Equity Framework

The Racial Equity Learning Series: Our Journey & Evolution

https://youtu.be/_GDkc-rN1Ss

Stretch Break

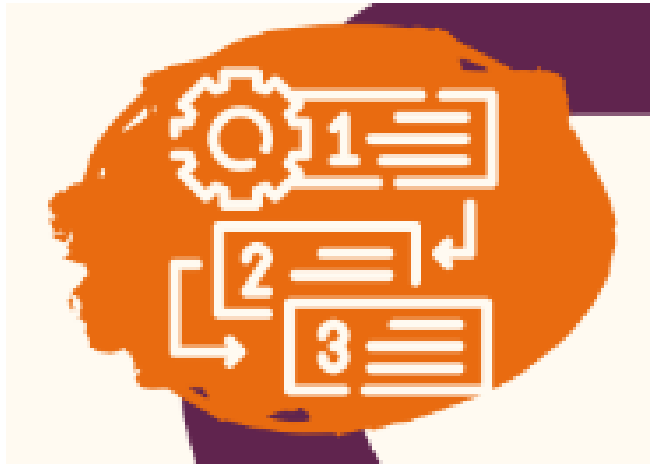
GROUP CASE STUDIES

Training

Inculcating equitable practice is a journey. It must be fundamental to an organization and prioritized among leadership. Developing or contributing to a training plan that supports this concept, such as incorporating RELS into collaborative work, can support equity goals.

Discussion Question

Your agency is a partner in a community wide effort to improve maternal and infant mortality and morbidity. How can you help to assure that equity is at the forefront?



Social Determinants

Data on race, ethnicity and indicators related to social determinants of health must be collected to guide efforts and to help determine if we are making a difference in building health equity.

AIM CCI Clinical Community Integration Roadmap, https://www.aimcci.org/resources/

Communication

Clinical Community Integration efforts necessitate a communication pathway that links inpatient, outpatient and community-based partners to ensure continuity of care and closed loop referrals.

AIM CCI Clinical Community Integration Roadmap, https://www.aimcci.org/resources/

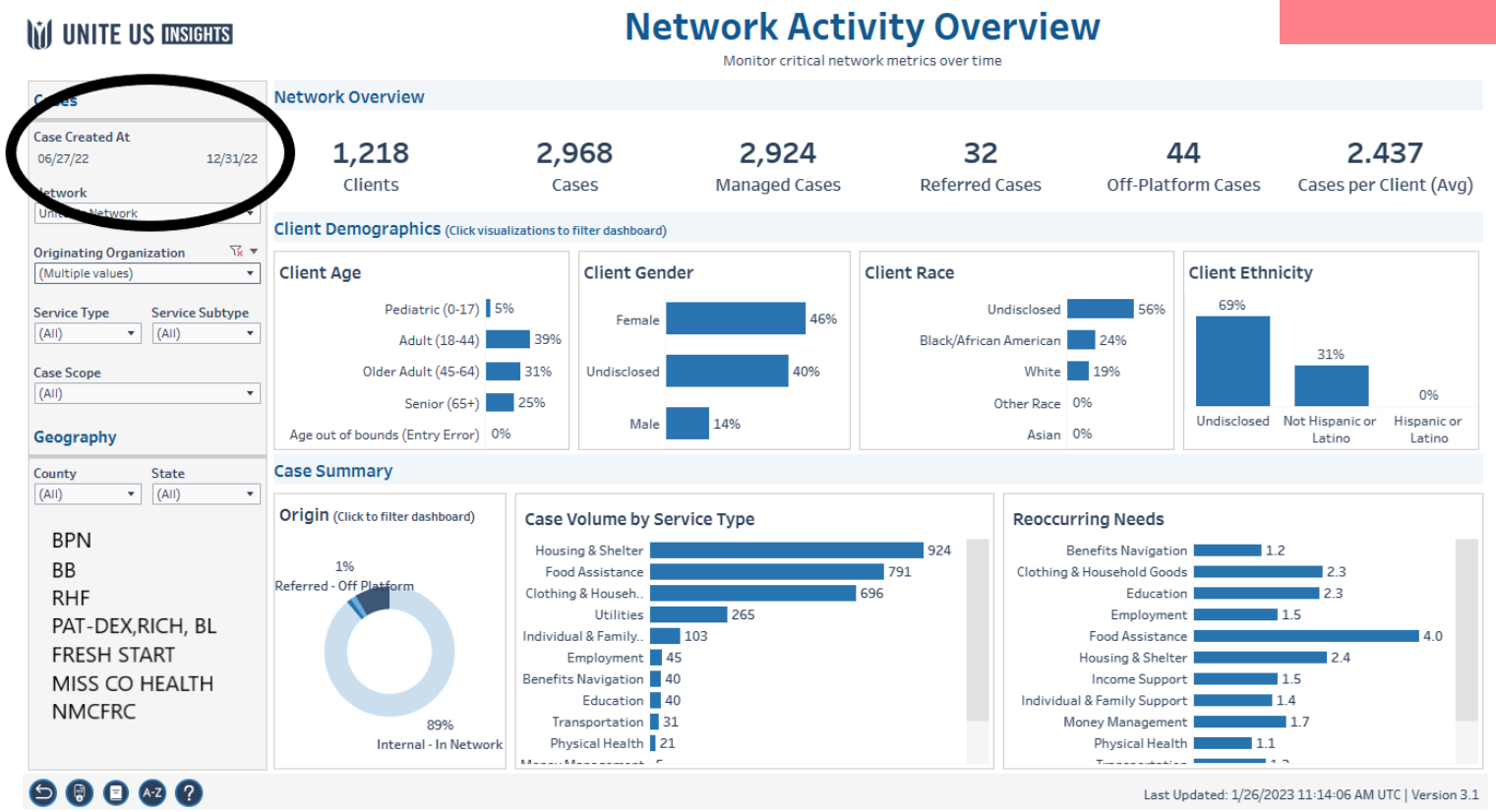
Data Management

Initiatives that lead to system change are driven by what the data tells us. As we are invited to participate in or lead collaborative work, it is important to consider how shared mechanisms for data collection, analysis and reporting can occur.

Discussion Questions

- What advantages can you see for participating in a shared data mechanism?
- What barriers might you encounter?

Example of a Closed Loop Resource and Referral System BoRN Q2 Data



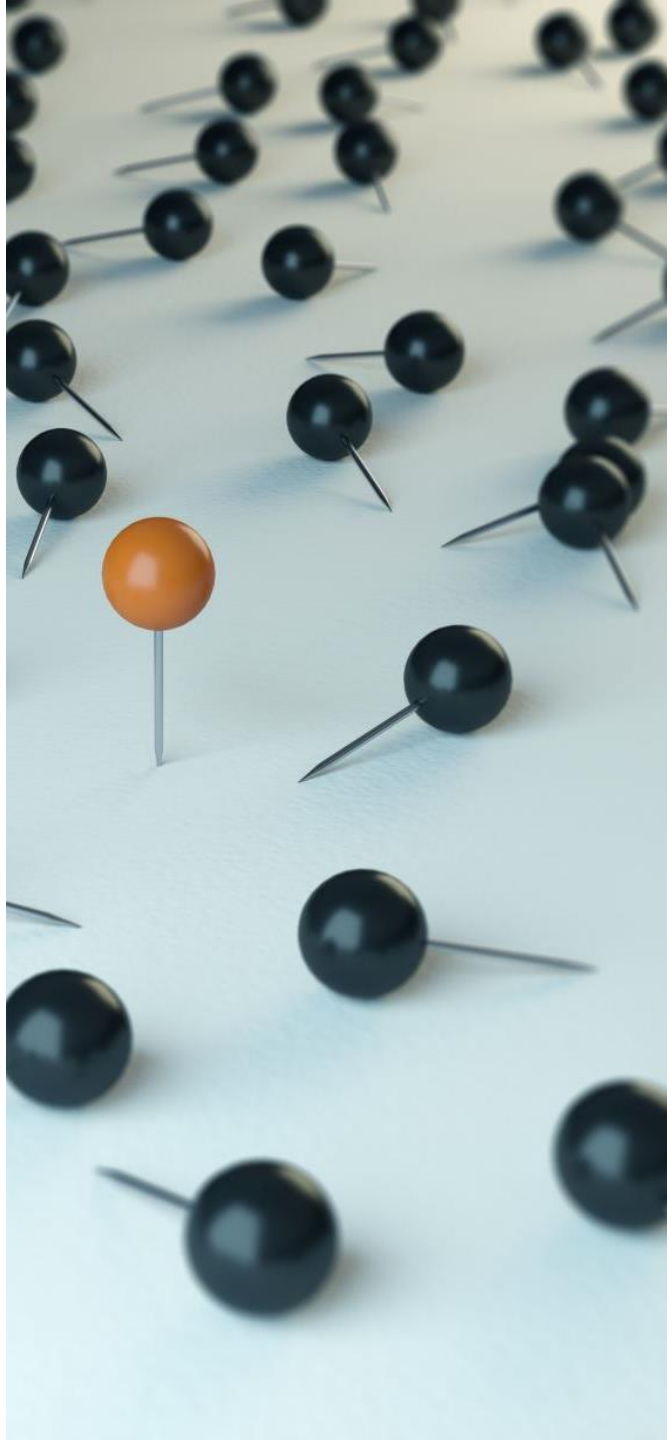
Community Resources

Working with partners to identify and systematically update and share resources can facilitate referrals for social, material and practical support and remove barriers to care.

Discussion Question

In addition to assisting clients with improved access to current and reliable resources, how can participation in developing a collaborative community resource help to support your program?

AIM CCI Clinical Community Integration Roadmap, https://www.aimcci.org/resources/



Community Education Strategies

Group discussion exercise:

Each group please select a facilitator and a reporter who will capture your discussion on the flip chart and report out.

Please discuss:

1.Provide an example of your proudest community education effort on maternal mortality? What made this successful? How did you overcome barriers?

2.What barriers have you experienced in trying to plan community education related to maternal mortality?

3. Please share at least one resource on maternal mortality that you have found helpful in facilitating community education on this topic.

AIM CCI Community Education Resources

Planning for Pregnancy and Beyond -This is a FREE learning series to guide pre-pregnancy and interpregnancy planning and patient education (P4P). Course topics range from reproductive anatomy and self-care to pregnancy complications and loss. CE are available

Maternal Monologues for Community Conversation and Action- Community presentations of stories by women/birthing persons, their partners, and supporters along the journey of birthing and maternal health. These stories are based on real experiences. They are designed to serve as a tool for communities to tell their own stories for healing, raising awareness, and mobilizing for change.

Available at: Resources - Alliance for Innovation on Maternal Health Community Care Initiative (aimcci.org)

Final Check in

- What additional information would you like to have about application of the Clinical Community Integration Roadmap in facilitating power sharing and system change?
- What additional information would you like to have about utilizing the SAMREC and RELS to drive improvements in equity?
- Anything else you would like to say?

Susan Kendig, JD, WHNP-BC, FAANP

suekendig@gmail.com

Lidyvez Sawyer

Lsawyer@nationalhealthystart.org

Thank you!

Healthy Start Regions 1, 2, & 3 Regional Meeting
Hosted by the Healthy Start TA & Support Center at NICHQ

NICHQ
National Institute for Children's Health Quality

HEALTHY start
TA & SUPPORT CENTER