Public Health Live!

Raising Community Voices to Reduce Maternal Mortality, March 28, 2019

Transcript

Moderator Rachel Breidster: Hello and welcome to *Public Health Live!* Celebrating twenty years of exemplary education for the public health workforce. I'm Rachel Breidster and I'll be your moderator today. Before we get started I'd like to ask that you please fill out your online evaluation at the end of the web cast. Continuing education credits are available for a limited time after you take our short posttest and your feedback is helpful in planning future programs. I also want to let you know that our planners and presenters of Public Health Live do not have any financial arrangements or affiliations with any commercial entities whose products, research, or services may be discussed during this activity. And no commercial funding has been accepted for this activity. As for today's program, we will be taking your questions throughout the hour by phone at 1-518-402-0330 or via e-mail at phlive.ny@gmail.com. Today's program is entitled Raising Community Voices to Reduce Maternal Mortality and our guests today are Meagan Carroll, health program administrator and family planning program manager at the New York State Department of Health Bureau of Women, Infant and Adolescent health. Colette Sturgis, the program manager at the Maternal Infant Community Collaborative at Urban Health Plan. And later, we'll be joined by Nina Rogers, a community participant in the New York State Listening Sessions. Thank you for joining us.

Moderator: We'd like to open today's show with a message from the New York State commissioner of Health Dr. Howard Zucker, He's made maternal mortality a priority topic in the state. Let's hear more about this initiative.

Dr. Howard Zucker: Thank you for visiting Public Health Live for the panel discussion on maternal mortality. A serious public health challenge for New York State and the nation. The United States maternal mortality rate has doubled over the past two decades making ours the world's only developed nation with a maternal mortality rate that keeps going up. We have a serious problem in maternal mortality in New York State, ranking 30th in the nation in 2016. What's worse, New York's black women are three times more likely to die from pregnancy or pregnancy related complicated than white women. Understanding the causes of rising maternal mortality requires access to quality data in a timely manner; something that has been limited in New York State and across the country. Why did maternal mortality remain relatively flat in the 1980's and 1990's and then go up in the beginning of 2000? We've seen increasing rates of cardiac disease, high blood pressure, and chronic medical conditions like diabetes and obesity. Other factors include increasing rates of cesarean section, over 30% nationwide, maternal age and time of pregnancy, and access to quality health care. But a more deeply rooted cause can be found looking at the social determinants of health across New York State. Last year I participated in an extensive listening tour of mothers across New York and helped launch the taskforce on maternal mortality and disparate racial outcomes. A key recommendation is creating a statewide maternal mortality review board. Another is implementing a statewide education and training program to reduce implicit bias. We need to closely observe all points along the spectrum of a patient's care to identify treatment decisions that may be racially biased and lead to adverse outcomes. A better understanding of the causes of racial disparities will help us strategize and implement policies aimed at addressing and preventing maternal

mortality. Thank you again for visiting and I hope you'll come away committed with how you can be part of our collective solution to this devastating problem.

Moderator: That was really great to start the morning off hearing that message from Dr. Zucker and I'm really looking forward to hearing from both of you and hearing what you have to say on the topic. So I'd like to welcome you to the show.

Meagan Carroll: Thanks for having us were excited to be here.

Colette Sturgis: Thank you I'm happy to be here as well.

Moderator: Excellent. So Meaghan can I start with you and ask you if you would review for us the objectives for this program?

Meagan Carroll: Yeah so today we're going to start by comparing racial disparities and outcomes in maternal mortality in New York State. We're going to talk about some of the themes voiced by women related to the disparities in maternal health and health care to help inform practice. And finally we're going to talk about some New York State initiatives, community approaches, and changes to how we approach clinical systems that can help address some of those disparities in maternal health.

Moderator: Excellent, thank you so much. One of the things I know you're going to be talking about is these listening sessions. I know they didn't always exist. So can you give us background on why these started and why they were needed?

Meagan Carroll: Sure. So as Dr. Zucker said, there has been a troubling increase in maternal mortality both nationally and specifically in New York State. New York State is actually ranked 30th in the nation for maternal mortality in 2016. And within those numbers we see more troubling trends when it comes to racial and ethnic disparities that are pointing out the fact that black women are three times more likely to die in child birth or as child birth related issues than white women. So we saw these listening sessions as an opportunity to continue our work on addressing maternal mortality but to uplift the voices for those individuals most impacted by these troubling statistics.

Moderator: Sure. And how does the maternal mortality fit into the work of the New York State Department of Health?

Meagan Carroll: Maternal mortality has always been a major focus for the New York State's Department of Health and recently it's become something that's been part of national conversations. Particularly related to disparities. So I work in the division of family health and it's been a major focus for us for several years and recently Governor Cuomo has announced a new initiative in April of 2018 that's further highlighted the importance of that work.

Moderator: And were there particular steps that Cuomo's office initiated to really prioritize the topic of maternal mortality?

Meagan Carroll: Yeah. Governor Cuomo's office had a very comprehensive and multi-pronged approach to addressing maternal mortality. This included the establishment of a maternal mortality task force. Advocacy for a maternal mortality review board. Support for some interventions like centering pregnancy and the expansion of Medicaid coverage for doulas. There was also a best practice summit for hospitals and OBGYN's to share their experience and expertise. Some work around medical education. Expansion of the New York State perinatal quality collaborative which is a group of birthing hospitals that work on quality improvement and quality assurance strategies. And in my opinion, kind of most interestingly was advocacy to launch the commissioners listening sessions. This was a series of listening sessions across the state. And out of all of these initiatives, this was really the opportunity for individuals in communities impacted by adverse birth outcomes to not only have a voice in the process but to be a part of developing strategies and solutions to improve health outcomes for mothers and children in New York State.

Moderator: Absolutely. So talk to us a bit more about those listening sessions and their being a real key focus of work in terms of trying to improve outcomes in maternal mortality.

Meagan Carroll: The listening sessions were based on a format developed by the New York State Office of Minority Health and that format sort of unlike a focus group, really emphasized participant lead discussions. So we viewed them as a way to get feedback from the community but really have the topics and themes driven by community members. Not completely structured by department of health staff. We really emphasized participant led discussions. We really wanted to find an opportunity to uplift those voices and a way to bring collaborative partners together in the community to understand the importance of this issue and to begin proactively addressing it together.

Moderator: Terrific. Thank you so much. Now Colette, let me turn to you. First of all, can you tell our viewers a little bit about the maternal infant community health collaborative program?

Colette Sturgis: Sure. The MICHC is The New York State funded initiative designed to improve infant and maternal mortality in the Bronx community and other communities across New York State and to improve the disparities in those outcomes.

Moderator: And can you describe for us what is your work in this outcome?

Colette Sturgis: Okay, so I'm the program director of the MICHC in the Bronx at Urban Health Plan and I oversee all the activities of the initiative. So I do the needs assessment, I create a budget, and I do an improvement plan and I also have a wonderful staff of community health workers. And along with their community health worker supervisor, we ensure that women in the community have access to services. So these community health workers conduct home visits just to make sure that they have services and to connect them to more services as needed.

Moderator: Terrific. Now, why do you think the maternal and infant community health collaborative, or MICHC as you called it, why did you think those programs would be a good fit for those New York State listening sessions?

Colette Sturgis: I think there was a good fit because we have access to clients, we have access to partners. MICHC is like a two-pronged approach where we have to create partnerships. It was a good fit because we had those things and we were making clients accessible to us.

Moderator: And beyond it being a good fit, when the listening sessions were announced, why was your organization eager to participate?

Colette Sturgis: We were eager to participate because we knew that it would be an opportunity for us to hear what women were saying as they went through their prenatal visits.

Moderator: Sure. And how did you collaborate with other organizations that were hosting their own forums?

Colette Sturgis: Well, we had training and planning sessions and other programs who had listening sessions that gave us tips and tricks. So we were all just listening and so it was great to hear that other programs were having this and they just, you know, gave us tips and tricks.

Moderator: Okay. And what kind of community partners did you collaborate with?

Colette Sturgis: We collaborated with other home visiting programs such as Early Head Start, Healthy Families, Nurse Family Partnerships and things like that.

Moderator: Terrific. And in what ways did you find them helpful in helping this come to fruition?

Colette Sturgis: They were extremely helpful. I went to one meeting and I said hey guys we're having a listening session can you help us recruit? So helping us recruit participants for this listening session was extremely helpful.

Moderator: Okay, terrific. We often hear that one of the major barriers to sessions like this or events of this kind is how to successfully recruit participants. And so you're talking about using other organizations to help you recruit participants. What did you do, with maybe the help of those other organizations that really worked well in overcoming that barrier?

Colette Sturgis: I think outreach was very important. So we asked some of our partners to outreach and to help us recruit for this initiative. And New York State also committed funds to this event. They gave us transportation assistance, food, child care, and incentives for the participants as well.

Moderator: And so what kind of factors did you have to take into account when you're thinking about how am I going to make this event accessible to the population I really need to hear from.

Colette Sturgis: Well to make it accessible, it has to be easy to get to. Fortunately we're located by train stations. And another thing is we have to have our participants bring their children. We

hear a lot of focus groups and stuff that say you can't bring your kids. If we did that, we're missing the population that we need to serve and get the information from.

Moderator: Sure. So in terms of the actual listening sessions, can you describe the flow of the day and how things actually took place?

Colette Sturgis: Sure. We had intro questions to get the conversation started. We had about 80 minutes of conversation broken into four topic areas. Which were planning for pregnancy, pregnancy, giving birth, and post-partum.

Moderator: And I would imagine, at least in some circumstances that some might be a little shy or reluctant to speak. So how did you encourage participants to contribute and speak up in these sessions?

Colette Sturgis: I think that it was important to let the participants know that it was a safe space and your input was needed and it was valid and there were no judgments.

Moderator: I would imagine that's a very reassuring thing for someone to hear. What about our commissioner Dr. Zucker, what role did he play in the listening session?

Colette Sturgis: Okay so he went from table to table. He asked questions and at the end he engaged in a 20 minute speak back where one representative from the table was chosen to tell him something that he really needed to hear and they really felt was important. This allowed the community members to speak directly to the commissioner. And he could hear their concerns first hand.

Moderator: Were there any stories or anything from the listening session that really stood out to you, whether it with was that person talking to Dr. Zucker or just in general that you'd like our audience to hear about?

Colette Sturgis: I think for the most part our families and our women are not being heard. And they wanted him to understand when we go to our prenatal appointments they're really not listening to us and we really want you to help us get the best care. So we feel like that was important.

Moderator: Absolutely. Now what did you hear from your community at the listening session?

Colette Sturgis: So what I heard was a lot of like I said, "We're not being listened to," "There's a long wait time," "None of my questions were ever answered," "They're really just looking at the monitor and computer," "They aren't engaging us," and moms need support after the pregnancy as well.

Moderator: Absolutely. So thinking back to the listening sessions what would you say was particularly successful about the sessions that you hosted?

Colette Sturgis: What was particularly successful was that we had the participants show up and I thought -- we had 39 participants, and they were excited to be there and I thought that was extremely successful.

Moderator: I would think so. I've been involved in several events where you're trying to engage people and sometimes you don't know if five people will show up when you're certainly hoping for fifty. But 39 people sounds like a great number. And how engaged were the participants during the session?

Colette Sturgis: Well it was remarkable. They were so ready to tell their story. They were – when we were talking about the first question they would listen intently and then as we got along in the conversation there was just this buzz at the table and they were so engaged. They were really excited to be there and they were happy that somebody was listening to them.

Moderator: That's excellent. Now what if anything would you change about how you ran the session? Is there anything that you would do differently knowing now what you know then?

Colette Sturgis: Actually no. I wouldn't change a thing. I was happily overwhelmed with the outcome and I think because we had tips and tricks from previous sessions it made this one run more smoothly so I wouldn't change a thing.

Moderator: That is a terrific response to that question. Let me ask you about the participants and some of the things that they were sharing. Did anything that the women say surprise you?

Colette Sturgis: Nothing surprised me. I heard all of this for a really long time so I wasn't surprised by anything they had to say.

Moderator: And in terms of the people that attended the sessions, you mentioned that they seemed engaged in the process. Tell us a little bit more about that.

Colette Sturgis: So we did the intro questions and then they listened to that and then you heard a murmur at the table. And then I'd say okay now I'm going to do the follow up question for this and there would be an excited buzz across the room and they were sharing and they felt a sense of togetherness, connectivity because they realized they weren't alone so that really helped them become more engaged with the process.

Moderator: Sure. I would imagine the feeling of being listened to and the feeling of having other people that could relate to what you were saying must be a very powerful experience. Based on the engagement that you describe in the sessions, could you see the sessions continuing moving forward?

Colette Sturgis: I think so. It was such a powerful experience that we would love to have more of those sessions continue.

Moderator: Excellent. Was there anything that you learned or heard during the sessions that you think you would incorporate with the existing work that you're doing?

Colette Sturgis: Well I think that it's important that we coach our families on how to be advocators for themselves. That's one thing that stood out. So that's one thing I would like to incorporate, is teaching our families how to get what they need when they go to their provider.

Moderator: Sure. Anything else that a participant might have said that made you want to change what you're doing as a listening session organizer?

Colette Sturgis: Well, I think that we met the goal of women being heard. So I want to continue that. We want to continue having people heard so their needs can be addressed.

Moderator: Absolutely. It sounds terrific. I'm excited to hear more. To give us a sense of what takes place in a listening session, let's take a look at a session held in Syracuse, New York.

Ashley Odom: I actually got a phone call telling me about the listening group and I felt that it was a good thing to do. It would be a good experience to meet new people. Not only that, but to hear other people's perspectives on different things or different experiences that they have had.

Person A: Was your caesarian section scheduled? Or did they have to do an emergency?

Person B: No, so they wanted to do an induction because my body had started to go into labor. On my due date they checked me and they were like "Are you sure you don't feel that?" And I was like feel what? I feel fine. Can I go home now?

Ashley Odom: it actually helped me. Some of the stories that I heard, I could relate to. I just felt like I just met a whole group of new friends. So yeah I was referred and it was fun.

Netti Brewer: She came out pretty healthy. She was a small birth. 6 pounds 7 ounces and my other two were small as well. I've had to go to high risk clinics. They said each pregnancy would be different, it wasn't true. What my experience was, was hyperemesis which was a big thing for me. They didn't have an answer. They said it just happens. Kind of like your appendix, it just happens. So I had to do research on it and look up support groups. Something to keep myself going because I thought it was only me, I've never heard of such a thing. It got really depressing but I even went to different hospitals to see how they would treat me, some didn't even know what it was. I have three girls that I birthed and each pregnancy was tough. I've had what they call hyperemesis and it's basically like projectile vomiting the entire pregnancy, continuous IV fluids. Not able to take any prenatal vitamins or eat. The preschool. They had a listen in or sit in in the gym one day and they asked me if I wanted to come in and I said sure. It was something to get out because I've been in the house my whole pregnancy. And I've met a lot of new people.

Person A: That's what they did with my daughter. She kept going in and having complaints and they would send her home. And she would go right back, they'd send her home, shed go right back. That night they had to take the baby. They had to do an emergency cesarean. There were different complications that they could have caught. She was on the table for so long she was shaking and cold and I said well that's not the same doctor that she's been visiting you know,

who is that doctor? Who is doing the surgery? A student?! Did she sign off on that? Does she know anything about that? Finally she got off the table. And in two weeks she had to go back in and they found a cyst as big as a tennis ball. They had to go in there and take out. It's just… *sigh*

Ashley Odom: So my water broke on its own. I started to labor. I'm not even going to lie to you. At the beginning, I panicked. I cried a little bit. The care I received prior to this pregnancy, it was my first pregnancy, I would have liked for it to be better. I'm nervous about this pregnancy because for one I'm high risk. I developed gestational diabetes with her, and not only that but my kidneys twice were inflamed. I felt like I was being pushed aside. Like I wasn't being listened to. Hey, come in for an appointment. We'll check and see the baby. Any questions that you have for us, we don't have the time to answer because we have like a ton of people in the waiting room. So we don't have time to take the time to understand and listen to how you feel. You know, but I explained that to the perinatal center, my doctor there and she is really understanding. We're working together to try to develop a plan where I don't have to get induced and where I don't have to get a c-section. I feel like this time was so much better. I have someone listen to me. They take their time with me and now rushing like let's get her out of here. So I wish I would have had a doula for my first pregnancy.

Netti Brewer: How did you learn about it? Did you look it up or did the doctor provide it?

Ashley Odom: No, I actually know my doula very well. I've known her for years. Some of the stories I heard, I could relate to. So I felt like I met a whole group of new friends.

Netti Brewer: I was able to learn that other women were going through the same thing and it wasn't just me.

Moderator: So Colette, after watching that short video of that session that was held in Syracuse, did you see similarities or what similarities did you see to the session that you held in the Bronx?

Colette Sturgis: Well I did see similarities. A lot of the women in the Syracuse session said they weren't listened to and their concerns weren't met. That was some of the similar things that we heard in the Bronx, they just felt ignored.

Moderator: It seems fairly consistent then, at least from these examples that's one of the main themes that we are hearing. To highlight that I want to welcome you, Nina to the show. Thank you for joining us.

Nina Rogers: Thank you for having me.

Moderator: I wonder if we could begin by having you talk about your experience participating in one of the Bronx listening sessions. And why did you want to be part of the session?

Nina Rogers: Well, the program I'm in, the South Bronx Early Start program, said there's a listening session in the Bronx and if I wanted to attend. I was like sure, can I bring the kids

though? Because I had my two year old at the time. She was like yeah, you can bring them they have somebody to watch but the main reason I wanted to go was I wanted to voice my opinion about my pregnancies pretty much, throughout the past 18 years. So that's another reason why I wanted to go and I wasn't too sure if it with was going to be crowded because, you know, a lot of times when these things come up in urban neighborhoods, a lot of people tend not to go. So even if it's a small crowd I still want to be heard so that's another reason why I went.

Moderator: Okay. And can you share with us experiences with care while you were pregnant or while you were giving birth?

Nina Rogers: Well my son is 13 now so I had him at 19. So he was easy. Like I had a midwife with him. So he was an easy pregnancy. With him, though, I got to the hospital and the nurse was like "Why is she here?" I was like well I'm in labor. She said take her upstairs. I was like okay you're kind of mean. So we went upstairs and everything and I was nervous about being there by myself because my son's father walked off. I was nervous about being there, I was like can somebody stay with me? They said no we have other patients to tend to. I was like I have nobody here with me right now. I was in labor with him for two days before I finally had a c-section. I got to nine centimeters and he was like I'm not coming down anymore. So I had a c-section with him, he was an easy pregnancy. And then after that I had five miscarriages after that. After having him. The first miscarriage they said was normal. I'm like, okay, I'm only 21, it's normal. The second miscarriage was like, okay, sometimes 2 or 3 miscarriages can happen. Okay, it's normal. Third miscarriage, I'm like something isn't right. What's going on? They were like well you're still kind of young, maybe you're not ovulating like you are supposed to. And I was like well something has to be going on. They didn't run any tests. It was my fifth miscarriage in 2014. I was 12 weeks and I went to full term labor and they were like your water broke. I was like how did that even happen? They were like we don't know but your water broke, we don't see a heartbeat. I was like I'm tired of this. Fifth miscarriage. They took me into the labor and delivery room. I said are you going to perform a D&C? They said no, you have to actually have this baby. I said are you going to make me go through all of this pain? They were like you're 12 weeks along, we don't want to put you through a surgery. We're going to let you have him naturally. So I'm like, okay. I'm in pain, screaming, I'm like can I get something for the pain and they're like just give us a second. An hour goes by, still nothing. Eventually I have the baby. They come and tell me I have a boy. This was not supposed to happen again. Everything was fine. There shouldn't have been another miscarriage. So I got to hold my son crying, upset, like why -- why do I keep having miscarriage. Something has to be wrong. I give birth to him. The placenta breaks and they're like now you have a D&C because they couldn't get it. I go to surgery. Get the D&C. In pain, wake up. I can't take this anymore. I was crying because I was in the room with a mother and they brought her baby in. I said why are you doing this to me? I just lost mine and you would bring this lady's in. So they gave me pain meds and I went to sleep. I waited a couple of months and I went back and I said I want to have another baby. They said what should we do? I said you're the doctor, you should know what to do. I was like well, I have been on goggle. Because that's my best friend since you guys are not helping me. So I google all kinds of ways that you can miscarry, different types of tests they can do. I asked for hormonal testing and genetic testing for not only me but my partner. To see if maybe it was genetics of why I kept having miscarriages. We were both fine with that but when it came to hormones. They said my estrogen was really low. She said have you heard of

PCOS and I'm like no, and she said, well you're showing signs of PCOS. Which is polycystic ovarian syndrome. She said technically you have a little bit of more male hormones than female hormones. So they're fighting each other. First they thought my body was taking -- like I'd be pregnant and they would see the baby as an invader. Like a germ. So I'm like I've never heard of that. So they said were going to do Clomid. Which is a fertility treatment to help me conceive. So I did my research on Clomid and they said if it doesn't work the first time to try it again. So I'm like okay. Did it the first time, I conceive, she's two years old now. Her pregnancy was really, really rough. I didn't see the doctor until September but I was pregnant in July. The reason I didn't see a doctor until September is they were fully booked over July and August. So I was like, that's a long time to wait but me being in the Bronx and everything, the hospital sporadic all over the place I was like, I can make it to September. So I did and before the doctor's appointment I had some spotting. I was like, I'm not going to lose another baby. Here we go again. Called my mother crying, she was like Nina just relax. It's okay. Don't worry about it. I said no I'm tired of going through this. She was like just relax. Get to the doctor, everything is fine, you're good. I said I want a midwife. It was like sure, you can have one. I got a midwife. I met my high risk doctor one time. I didn't meet her after that. And then they asked if I was going to need any shots to help with my hormones. They were like no, levels are good. We don't need that. They were like do you want to get your cervix sewn? I said no. They said that's good because if you do that, there's a risk of miscarriage. I said I got too far. I'm not doing this. I'm fine. She had me nauseous the whole pregnancy. I couldn't even keep water down. That's how bad it was with her. I failed the test for diabetes the first time. I failed it. It was like oh, no, I don't want that. So she was like you're going to come back in and do another test. I was like all right. I come back. I'm sitting there and I haven't eaten since midnight. I'm hungry, I'm aggravated, and you keep drawing my blood. I'm like stop sticking me. But I was in there, three hours was the longest three hours ever. They finally did it and they said you failed. I said I knew I was going to fail, I failed the first time. I'm not shocked by that at all. She put me through it, the whole pregnancy and then I was admitted in December or November I think I was admitted. I stayed for five days. I had a pessary put in to hold my cervix up. Because she caught herself kicking. I got a pessary, all the antibiotics, the stuff for her heart, lungs, brain, in case she came early. I think I was 26 when she tried to come and make her grand entrance. And they said if you keep contracting we are going to keep you. And I said for how long? And they said for the rest of the pregnancy. I'm like I have a son at home I can't be here. And they said well you have to find a baby sitter. I'm making phone calls. But I was only in there for five days and I went back home. They were like no nothing, no sex, nothing. I'm like well I've been on pelvic rest since day one. So what you're saying doesn't really bother me. So I go home and I'm on bedrest and then she was born January 16th. I'm like, this little girl she just can't wait. And that labor was fast but the only thing was I didn't see the doctor until it was time to push and I never saw him during pregnancy. He was the doctor that delivered my baby. And then my midwife, the only reason she was able to come was because she saw that I was in the hospital and she came downstairs. I said I thought you were off today and I said no and I saw you were here I came down here and I'm here to help you push. I was like I'm so happy you're here and I don't know him. He was down there and I was like I don't know him so I'm glad she was there. So I had her, she was 3 pounds 6 ounces and in NICU for a month. But she's 2 and she's beautiful and feisty.

Moderator: She certainly is. So in your brief story, you shared a lot of things that we can probably spend all day talking about but one of the things I want to focus on and the topic of the show is why do you think some of these outcomes and situations in particular are worse for black women when dealing with pregnancy and giving birth?

Nina Rogers: Well, because, lack of education. That's pretty much what it is. I'm a 80s baby, early 90s, our parents -- they weren't taught that okay you should -- you need certain services. These things slowly started to come into the communities but that's only if you knew somebody or knew somebody that knew somebody. So that's pretty much how it went. I lucked out with my son the first time because I was just looking for a doctor. I didn't know she was a midwife. I lucked out the first time. With my daughter, I was like no, I definitely want a midwife. It's a lack of resources in a neighborhood, and we're just not educated.

Moderator: Okay. So with all of that in mind I want to thank you so much for sharing. Now, Colette, I'm going to turn back to you and shift our focus back to the listening sessions and what other locations besides the Bronx were selected to host these sessions?

Colette Sturgis: Well, initially we were going to have five listening sessions but the New York State Department of Health decided we needed more because we wanted to hear the local and the unique stories of the community. So we ended up having seven across New York State. Brooklyn, Albany, Bronx, Buffalo, Queens, Harlem and Syracuse.

Moderator: And how were those locations chosen?

Colette Sturgis: They were chosen because these are the neighborhoods that the New York State had a MICHC program in. So because MICHC programs were in these areas and these area already had poor health outcomes, it was a no brainer across the board.

Moderator: Sure. And did the session events or the activities in each session vary from location to location?

Colette Sturgis: I was able to participate in some of the planning activities. And we all worked together to host the sessions. We had to understand the uniqueness of each community but for the most part, most of the listening sessions for the same.

Moderator: Pretty consistent across the board, okay. Now I want to pause for a moment to remind the audience that if you have questions for our speakers you may e-mail them to us at any time during the web cast at phlive.ny@gmail.com or call us at 518-402-0330. So Meaghan let me turn back to you and talk about after the sessions were conducted, how did you begin the process of collecting and analyzing the data that was gathered?

Meagan Carroll: So at each of the tables at the session there was a scribe taking notes of everything the participants were saying. So the first thing that we did was transcribe them by date and location. After we did that we started to analyze and identify what we called our big bucket themes. So those were just overarching concepts that we saw repeated frequently. Once we had the big buckets, we started to then go into each theme and identify unique thoughts and

ideas and then we began grouping those by keyword or subject and then after we had buckets and themes and subjects we started to do what we called a frequency count and we actually tallied how often each of those unique ideas were brought up so that we could take the things said the most and rise them to the top of what we were doing. And after we conducted the analysis, we actually worked on writing a report of all the information that we gathered across the states.

Moderator: So considering how important that information is. What are the plans for releasing that report statewide?

Meagan Carroll: We're working on releasing it, it should be available on the New York State Department of Health website sometime in the near future. But what we have done is we've shared the broader themes and ideas from that report with the maternal mortality task force. And we've shared them with professional groups of OBGYN at the hospital best practice summit. And we've been sharing them with the people who are in a position to make some policy change and decision about what we're doing.

Moderator: Sure. And how do you plan to use this information to inform the work that you do at the New York State Department of Health?

Meagan Carroll: We have been sharing it a lot internally to help us when we develop procurements or programs. Essentially, our hope is that this feedback from the community really drives the substance of the work that we do in the division of family health moving forward.

Moderator: Perfect. Now across New York State, did you see any persistent or recurring themes?

Meagan Carroll: Yeah. So I was fortunate enough to attend all 7 sessions and I would say the biggest surprise for me is how similar many of them were. Across each of the sessions, no matter where we were, we did tend to hear over and over again some of the same feedback. The six biggest things we heard were issues related to health systems. Issues with health care providers, the persistent impact of racism and bias. Just like Nina said, issues around lack of information and education. I would say out of every word that was said, disrespect was probably the most common word I heard. And the last thing we heard was really the need for and the desire to connect more with social supports.

Moderator: Sure. And within those six themes, was there much variation in each of the listening sessions?

Meagan Carroll: Every session had its own unique flavor. The health system one, we did see a lot of variance. Depending on if it was New York City of Upstate. That really just has to do with the structure of how health care is accessed. New York City has public hospital systems, most places upstate, you have one or two major birthing hospitals. There's not as much choice. It's not so much about hospital A vs hospital B, but that was a lot more about source.

Moderator: Okay. Now how did participants describe their experiences receiving care or interacting with the existing health systems?

Meagan Carroll: So with hospitals there was a lot of discussion about two systems of care. One for private paying patients and one for public paying patients. One for people at public hospitals and one for private hospitals. Like Nina mentioned, a desire to get into certain practices and being told they were full for months or that they wouldn't accept a Medicaid patient. A lot of issues around quality of care and we heard a lot about decision making. About a feeling that decisions about health care. Whether or not to have a c-section. Whether or not to be given pitocin. Decisions like that being made for the patient rather than with the patient. And people even saying they felt those decisions were being made to keep them compliant. Like I was given an epidural so I couldn't get out of bed. We heard that story a lot. Also issues around how folks access care. Again and again we heard about incredibly long wait times. People had to take an entire day off work to go for one 30 minute appointment. And some folks sharing that they didn't get paid time off so they were losing a full day's pay just to go to the doctor once.

Moderator: Especially if you're not a salaried employee, if you're getting paid by the hour it's really a tremendous impact. So what kind of feedback did the participants share about the health care providers themselves?

Meagan Carroll: So this was really interesting. The biggest issue participants brought up was communication. Feeling that they were not given time to develop a rapport with their provider. Again, to echo what Nina said, we heard the story time and time again. I didn't meet the provider until I was giving birth or I saw so many different doctors I didn't know who was going to be there for me. Many people feeling like they didn't have a chance to ask questions. A lot of mistrust. A lot of communication gaps. We heard one thing that really interested me is we heard from a lot of women that they had been told or under the impression that they were infertile or their fertility was compromised only to then very easily and maybe in an unplanned way find themselves pregnant and being very shocked by that. We heard a lot about judgment. That came from providers themselves but also kind of provider offices too. I had a woman tell me that every time she went to fill out paperwork the front desk person automatically checked single for her even though she was married and she expressed that she was married. Really persistently, everywhere we went, time was the biggest thing. Folks want more time with their providers to ask questions and build a rapport and people feel like they're being with rushed out the door.

Moderator: Sure. Was there any difference based on the type of provider?

Meagan Carroll: I would say, generally speaking, midwives and doulas were talked about more positively. We did use some midwives and doulas to recruit participants so there's a little asterisk there. For the most part it really was pretty consistent whether it was a doctor, a nurse, a NP, whatever. I think the time issue seems so pervasive across the health care system, it sort of didn't matter who you were going to see. It just seemed like they weren't given enough time.

Moderator: Okay. Now let's talk about how often the issue of race and racism presented itself in the feedback.

Meagan Carroll: Okay. Racism came out really explicitly, consistently in every session. It manifested in a couple of different ways. The first was talking about unequal treatment. Feeling that people were not given access to the highest quality of care because of their race and ethnicity. And participants identified both personal and institutional racism as an underlying cause for the maternal mortality issue. So being treated differently by individuals and kind of the idea that the system has been designed and set up to oppress people of color. There were so many incidences of bias. So that your skin color is going to dictate the type of care that you get. I think one of the most powerful sentences we had is somebody said, “We're high risk because we're black.” Really tying the lived experience with racism with unequal treatment it is driving a lot of this mortality. And then the other issues, we heard women talk a lot about feeling the need to proactively advocate equal treatment. So women even talked about how they had to put out a “white voice” or act in a certain way and they to dress up to go to the doctor just to be taken seriously and all of those things exacerbating the other issues of time and access.

Moderator: Absolutely. How did participants see racism impacting their health and birth outcomes?

Meagan Carroll: I think participants drew a drew a very clear line between racism, both interpersonal with the bias interaction with a provider, and also the systemic institutional lifelong experience of not being given access to the same type of care as creating chronic health conditions that impacted their pregnancy and also exacerbating their stress while they were pregnant. A lot of women talk about the stress of their everyday lives just exacerbated the level of stress and concern and anxiety they had for themselves and their baby.

Moderator: Sure. Now what did participants mean when the referenced information and education and that’s something that Nina brought up which she thinks is a major issue. So what were some of the issues presented that you heard?

Meagan Carroll: The big thing was with the lack of time with providers people felt they weren't able to ask a lot of questions. Some people even felt providers got annoyed when they tried to ask questions. That they were brushed off. We heard so many women said my pregnancy was high risk. Could you tell us what condition that was? Many often couldn't point you to a specific condition, they were told they were high risk but weren't given information why. A lot of people talk about the need for more classes. They want to take prenatal classes and they want to take parenting classes, but they weren't accessible. Either they were too expensive. They were at times when folks worked. Again, another great quote is, “If somebody can get it on 86th street you should be able to get it on 116th street.” Underlying the fact that where you live is often dictating what you have care for. And I think the most common thing we heard, which Nina also echoed, is people have to be self-taught. Google came up consistently. Different apps and websites. We also heard people talking about moms groups on Facebook. Trying to tap into different existing resources. I heard a woman talk about how she went and laminated a card with her information on it. And some questions so that she could take it to the doctor so that it wouldn't waste so much time going over all of her blood pressure

or whatever. She wanted to ask all of these questions so she got a laminated card "here's about me" so she could spend more time actually asking questions.

Moderator: Wow. So given everything that you have shared I wonder how are most participants accessing information about their health if they don't get enough time to ask them to the doctor.

Meagan Carroll: I'd say Google and some apps. Also friends and family. Hearing stories from your friends who've had babies, your sister, your mother, which is all important but may not actually be applicable to your health. But I'd say google is probably the number one thing that we heard.

Moderator: Okay. Certainly worth paying attention to. If folks are getting their information from the internet rather than the health care provider. So let's take a look at Mount Sinai hospital in New York City. Mount Sinai is quickly becoming a leader in addressing implicit bias across its health care system. Let's see what impact it's having on addressing eternal mortality.

Pamela Abner: Mount Sinai embarked on addressing unconscious bias primarily stemming from discussions we had on our medical school around matters of faculty and diversity and other entitlements for either people of color or women. Unconscious bias as we define is the tendency or reaction that someone has based on associations, right? So things that someone may have been exposed to in their lives. Associations they have and they're not aware. So they're unintentional and unaware. And from that we started to research what could we do to address these biases that contribute to some of the decision making and we took on in March of 2015 a more comprehensive approach to look at bias as it impacts medical care, and outcomes, and disparities as well as other factors in the organization. So our dean of the school of medicine at Mount Sinai, the Icahn School of Medicine, asked us to address bias to look at the issues that were brought forward and it became a priority very quickly. We have a focus in our medical school to address and disrupt the pattern of bias stereotypes and generalizations and how those stereotypes get overused and become part of how we practice and teach medicine. Likewise, within the organization and our hospitals and other departments. So it could be in social work, nursing, other aspects, we think of the totality of the organization and every employee we want to touch and make sure that they have some exposure to this unconscious bias education. In terms of women and their outcomes. Now there is a big focus on maternal mortality in terms of some of it is basic understanding and listening. Women are not listened to. Women of color in particular, it might seem pretty simple and basic but when we think about why they're not considered and why they're not heard and why they're not listened to, some of that is predicated on bias. Our approach is to customize education around unconscious bias and work pretty much department by department. So we also have, within our organization, about 13 individuals including myself that are trained on unconscious bias education. We also engaged other partners in the organization so we have members of our medical ed department, security, social work and others that are training people in their divisions to be what we call certified trainers so they can go out and do that work. We customize the education so we use examples that educate and are relevant for that. We make it relevant for the participant. Mount Sinai Health System is huge. So we have our medical school, 8 hospitals, about 42,000

employees. We have taken on this journey to address unconscious bias. We have probably touched over 4,000 employees at this point. Our internal partners are very excited and they come forth and ask us to work with them so it's really keeping up with the demand. Those that participate in the education also become our spokespersons. So people will say to one another wow this is really great. Have you done that? So we think that in terms of our communities throughout the Mount Sinai Health System that this is a focus and energy and initiative that most people are really embracing. And overall, based on our assessment in terms of what we get back from folks, people are quite satisfied with the education and we want to make sure that it brings them value and that the objectives that we set forth that the objectives we set at the beginning of the session, that those are being met. Our patient experience must be better. We've sensitized the organization and still have a long way to go. And some of these matters around maternal mortality are just being discussed now. So as we align our work around unconscious bias along with some of the recommendations coming from CDC and other organizations to address maternal mortality, I that will be important and they're making that collaboration or correlation very key in terms of the success of using some of the strategies from maternal mortality. People often ask us how do you do that? What are you doing? Why is it working so well? I think what is most important is even after you have a session or whatever the number may be on unconscious bias, it doesn't end there. We have made unconscious bias present and as much as we can in the organization. So when we go in and talk about anything now we bring that UB lens and it becomes part of our speak, and we've also made it part fabric and the organization as we can when working with patient experience for instance, collaborating with them on some of their key initiatives for the organization to effect patient outcomes. A lot of other organizations or people see it as a onetime education and they move on but you can't. You have to keep going back and back and revisiting and keeping those discussions, fresh.

Moderator: So, Mount Sinai is taking these system wide steps to address bias in its hospitals and its medical school. What impact do you think that people have on positive outcomes? And ill post this question to the group?

Nina Rogers: Well it gives people who feel like services are offered to them other than just being in their neighborhood. So they might feel like the quality of service would be better for them if they travel a little bit further. So that opens up for, I know a lot of African American women in Harlem and the Bronx who feel like they're more comfortable going here. So that is going to be a positive outcome because they will spread the word that these services are being offered. So the more patient outcome, they will spread the word that more services are being offered. The more positive response, the more patients that come. And it's going to be a fire storm from there. It's going to be good.

Moderator: I like your positivity. Do you guys have any thoughts?

Colette Sturgis: I think the implicit bias training work that they're doing is a great thing and it should help patients feel better because they'll understand that their provider is fair and listening and respectful.

Moderator: anything that you want to add?

Meagan Carroll: I just think it's a great way to integrate the concepts that we talked about in the listening forum. Not just in the outward facing about how the patients are treated, but also in their hiring practices, who is working there? Who is at the front desk? I've heard from folks that the whole experience can be really fraught. So I like that they're addressing every aspect of their organization.

Moderator: Sure. So going back to the themes you were identifying during the listening sessions, talk to me about some of the other themes that you heard that were identified across each one.

Meagan Carroll: So disrespect was the most common one. Really just feeling like there wasn't a bedside manner. I think people were looking for a type of respect for their providers that they weren't getting. Feeling that their concerns are just getting brushed off. Somebody even said "You should treat me like you treat your mother." And a lot of that too also came back to feeling like the providers didn't understand or represent the lived experience of their patients. People at the listening forums really did talk about wanting to have providers who better represented themselves and their communities. They felt like that would help them understand and be more empathetic.

Moderator: Sure. And how did women feel that the disrespect they were experiencing impacted the quality of care that they received?

Meagan Carroll: a lot of women talked about how it exacerbated their stress and it created tension during, you know, it's supposed to be the most joyful part of your life. We heard people talking about that their children were told that they couldn't stay, they were threatened with CPS. That it created an aggressive back and forth between them and hospital staff. A lot of it was rooted in misunderstandings too. Not having communication. Not having a lot of trust so everybody was coming in a little bit defensive, really being something that really ruined this day for them.

Moderator: And Nina let me ask you, how does it compare to what you heard or shared during the listening sessions?

Nina Rogers: During the listening sessions I heard what was common throughout the show, disrespect. Not listening. Being Rushed. Being scheduled for an appointment at 10:30 and not being seen until 12:00. So you're sitting there for hours, it's crowded. You might be there for your sugar test but you're sitting there waiting to be called to do blood work but there's like five people in front of you. So you went sitting there waiting. So one mother was complaining about the wait time, and that was another thing for me as well, the wait time. Going and being scheduled for an appointment and not being seen or getting to assume that you're going to see your doctor and that doctor is not there. You weren't given a heads up. So they are going to have to look through your chart you have to re-explain yourself all over again to someone who had never seen your chart before. That was another thing. And one mother that was there was I think she was a doula and she stuck to her guns. She was not letting them push her or anything. She had her home birth and she was going to do it and I was like I wish I could do that but she

did it. She was like I wasn't allowing them to push me and that was pretty much the main concern. Disrespect and long hours of waiting, and not seeing your consistent provider.

Moderator: So Meaghan, were other issues highlighted outside of the system?

Meagan Carroll: Yeah. I think one of the biggest things we also heard about was the need for social supports. You know, that people are kind of living a little bit further away from families than they used to and really going into child birth and into that really post-partum period without having a strong network of support. I remember a women talked about getting discharged from the hospital at 2:00 PM and had her husband bring her and her baby home and then he had to go to work at 4:00 PM. And she was left alone three days after a c-section with a new baby and nobody to help her. We had somebody say something, I think at the Harlem listening session that was really powerful that "We used to have a village and now that's gone." People talked about the need for social supports. Whether that was friends, family, advocates, a dual or community health worker and also folks wanted ways to build that community together through classes or a place to meet other moms with babies their same age.

Moderator: Sure. And what were some of the families saying that they felt they needed to improve birth outcomes?

Meagan Carroll: It was simple things. People to demonstrate that they cared. People to check in on them. A lot of women talked about that six week post-partum period waiting to see the doctor being too long. That there was an opportunity to find yourself being depressed, to maybe have a health complication that wasn't looked into because you had to wait to go to the doctor. And really just people to talk to, to get that type of emotional logistical support that you need when you're home with a newborn.

Moderator: Sure. Thank you for sharing on the different themes that were identified. And Nina I want to go back to the Bronx listening session that you were part of, and I wonder, did you hear anyone share positive birth experiences?

Nina Rogers: The one mom I said earlier about her being able to have a home birth, which, you know, not too many of us know about and I think the one positive thing on my end was when I had my daughter and she was in the NICU I was able to sign up with a program in south Bronx Early Head Start Program and I was able to attend classes every Wednesday with my baby. Even if I had my son I was able to attend with him. So that was good because I didn't want to be home all day and just be doing nothing but tending to the baby. So I still needed like adult interaction. So to have other moms there that really helped. Because you got to bond with moms who is maybe going through similar things and not only that, but my daughter was able to interact with kids. During the day her brother is in school and it's just me and her and she was so tiny I couldn't really take her outside, so for her to be able to bond with other kids was good and I had another mom called her NICU neighbor, because they were in the NICU together and they are like best friends. And they go to class every Wednesday. That was another great thing was being able to find classes or being on mom groups on Facebook and being able to express your concerns and it being confidential. That was a good thing that I heard as well.

Moderator: So there were a few positives in the overall. Colette, let me ask you the same question. Did you hear any women sharing positive experiences?

Colette Sturgis: Some women shared positive experiences and some women talked about their community health worker and they were appreciative that they had this community health worker in their life so that was positive and it was great for us to hear because I have community health workers and so they knew that the work that they're doing is doing some good.

Moderator: Absolutely. Did you notice any recurring themes or trends in the positive birth experiences that you didn't hear about?

Colette Sturgis: I think the positives experiences that I heard was when they had a doctor who actually took the time to listen to them, address their questions, and also make them feel comfortable. So that’s some of the things that I heard.

Moderator: That sounds like the idea of being listened to, which I think anyone can relate to, feeling like someone is genuinely hearing you and taking you seriously is really coming across in this program. So let's pause here and turn to another group. The Durham Baby Café in Buffalo New York. This model found success after incorporating suggestions from its participants. Let's take a look.

Reverend Diann Holt: Well a baby café is actually a health initiative that we became involved in in 2012 and became licensed in 2013 after the CDC completed research studies that showed that African American females scored at the bottom of every testing they did with breast feeding when it came to it to initiation, duration, and exclusivities. Our main focus was to assist moms with breastfeeding, however they weren't going to come if that's the only thing that the program did. What we had to do was not allow it to appear to be a total medical or breast feeding initiative. The majority of our mothers have what I would call, service jobs. So when they come home they're exhausted. We got together and said if we can give them a way where they can come and learn, come relax, eat, have their children fed, we basically cater and take care of them. A couple of our mothers told us baby café is a fun place, baby café is a safe place. And they learn everything they need to know about breastfeeding, and then we open the café up to pregnant mothers. And then that's when it became important that we start looking at duals. We can't just bring them in and not have services for them other than if you're going to breastfeed or not. So we’ve totally have have gone full spectrum. African American mothers die at a 3 to 4 times greater rate than our Caucasian sisters during child birth or shortly thereafter. So it's very important that they receive that kind of support that's going to assist them when they're feeling comfortable, they’re relieved of the stress. They are around someone that they know. Someone that they trust. Someone that they can share with. The majority of the women that work in this program are African Americans, are mothers, and have had babies and also had those experiences themselves. Our mothers have no problem speaking up. Because as doulas, we're there with them and we give them a copy of their birthing plan. We give the partner or the father or the husband a copy of the birthing plan and anyone else that goes into the hospital with them. We make sure that they're equipped with what it was that they said prior to going into labor.

Reverend Diann Holt: Tonight you're going to see Baby Café in action. Tonight we'll have our doulas, our certified lactation counselors and our mothers. We'll have a couple of research people that will come in. We have a young lady, Ms. Volker who's going to come in and she's going to teach on eclampsia to our mothers. We have students from Yale University. They're spending time their time at Baby Café volunteering, setting up meals, setting up activities for the younger children that will come to the moms tonight.

Reverend Diann Holt: Alight, the gospel chorus from Yale. Y'all get yourselves together and sing me happy girls!

Singing

Reverend Diann Holt: You never know, I always tell everybody you never know who is going to drop in at Babe Café when you're here. We really have to take this seriously because it's a matter of life and death. Because people are lacking in knowledge, and that's across the board from the doctors all the way down to the mothers. It's a true new educational piece that's going to take place in New York State. I'm so proud of our state.

Moderator: I just love watching that clip. I think It's such a dynamic program so I wonder turning to you guys that are the experts in this work, is there anything that stands out to you after watching that video regarding its success?

Meagan Carroll: For us it's something that's proven effective. It doesn't really require a huge amount of infrastructure or sometimes even financial support. Just a space with people that are there to provide support and background knowledge and information. It could organically come from a community organization, a faith based organization and, you know, again women want that sense of community and they have done such a good job creating that without a whole bunch of stuff, you know?

Nina Rogers: Well, I love the video, actually. I love it so much because the fact that you can just go in there and be yourself and your kids can roam around freely, you don't have to be like stop, don't touch that. Don't eat that. They can go in there and be themselves. You get in like the support that breastfeeding is okay. Formula feeding is okay. I love that video. I want something like that in the Bronx so, so, so bad. It's just exciting, when I saw I was smiling from ear to ear. This is a great supportive group. And I could see that growing and getting big sooner rather than later. The support is awesome.

Moderator: Hopefully with the conversations we're having this morning it will encourage others to feel the same way. So Nina, given everything that you have shared with us this morning about your experience and everything that you heard from other women, what are some of the things that you would say can be done to improve the health and wellbeing of black mothers and their children?

Nina Rogers: More education, more classes, more support. More proper bedside manner. Not always pushing medication or surgeries or no you can't do this because of this. No is not in my

vocabulary. I don't want to be told no if I think it can be done. More programs definitely. Not only for just mommy's but daddy too. Daddy gets involved as well sometimes. But fathers should be able to participate. I just think we need more support. That's pretty much what it is. When you have a great support system, it flourishes. When you don't have that it falls to the background and so do your feelings. As a mother that's when post-partum depression kicks in. You feel that everything you do is wrong. I just need more support from anybody. A church, a participant in a school that my older child goes to, or flyers of mothers that can have a small group of mothers that can come and sit down and be comfortable that would be awesome.

Moderator: To follow up to that question, can you think of anything that you heard at your session or from other women you know even about how to improve the lives of black women and infants?

Nina Rogers: I think we need to be there for each other. As a community. There's no community anymore. We tend to think we can do everything on our own. So we need a community setting around us. And be able to be comfortable. When you're able to be comfortable that's when you can be a better mother. If you're not yourself you can't raise your child. So a community is what we truly need for black mothers all across the board.

Moderator: Sure. Thank you. Now Colette, were there other solutions that participants shared that you heard and took note of?

Colette Sturgis: I think that more women wanted more of providers that looked like them and understood the disparities so if the providers looked like them they felt more comfortable and didn't feel judged so I think if we do that, it would be very helpful.

Moderator: Yeah. Certainly. Were there any things that were suggested that could be implemented fairly easily?

Colette Sturgis: I think the things that could be implemented fairly easily are probably the mommy groups because I heard a lot about the mommy groups and those are something simple that we can do on a Saturday or Sunday.

Moderator: Okay. So there's lots of things coming up and some of the solutions are really things that probably wouldn't take that much work to implement. So Meagan, now that the department of health has collected all of this information, what are you going to do with it?

Meagan Carroll: We've been trying to share it as much as possible, which is way we are glad to be here today. We did see that we were able to share with the maternal mortality task force, they created a report that was released a few weeks ago that's available on the New York State Department of Health's website. It's also available through the governor's website. And they created ten recommendations that kind of run the gamete from increase support for CHW's on maternal mortality, a maternal mortality review board, and actually to Colette's point, some ways to help promote access to medical school or midwifery training programs for young people of color. To help make providers a bit more representative of communities. There's also some things in the governor's executive budget proposal to support increased access to

community health worker programs like the one that Colette runs. We're working on creating local reports on each of the listening sessions so we can give folks in the Bronx and Brooklyn and Queens a report that really speaks to what their specific community wanted with the hope that community members and CBO’s could work together to fund some of those activities. And last but not least. At the health department we're trying to again use this feedback as really kind of the guiding star for what we are going to do in the coming months and years, whether that's in a procurement, or the prevention agenda or other planning that we're doing. We're trying to incorporate this feedback as much as possible.

Moderator: Terrific, and has there been partners with you in doing this work?

Meagan Carroll: Absolutely. First and foremost, the maternal and infant community health collaborative organizations, the MICHC, they did the leg work on the ground. But we couldn’t have done with like other partners like the Greater New York Hospital Association, HANYS the Health Care Association of New York State, and the American College of Obstetrician and Gynecologists (ACOG). And they attended the forums and helped support the forums. And really the New York State task force on maternal mortality on dispirit racial outcomes, they were who we reported to. They were the organization that took a lot of these suggestions and were able to translate them into recommendations. I think seeing what women across the state said kind of came to fruition in a powerful way, it was great to be a part of.

Moderator: Excellent. Now are there any resources related to today’s discussion that our viewers can turn to for more information?

Meagan Carroll: Absolutely. Governor Cuomo has his maternal mortality announcement that goes through all the initiatives in a lot of detail. The maternal mortality task force also has a web page on the health department website that talks about their work and there's a section with the report so you can actually give background on the issue of mortality and also has the recommendations and then the New York State perinatal collaborative is an ongoing quality collaborative that engages birthing hospitals across New York State in different qi projects so what they're doing is always very interesting and very innovative, they are always looking to engage more birthing hospitals so that's a great resource.

Moderator: Terrific. Thank you so much and thank you all for sharing. We have some time to take questions from our audience now. We have a few that have come in. So the first question, and I believe this is probably to you Meaghan, where does the state ranking data showing that New York State is 30th come from? Is it vital statistics data?

Meagan Carroll: Yes I believe there is vital statistics data. Also the CDC compiles a lot of that data too so it may also be from there.

Moderator: Okay, let's see. Our next question that we have. For Nina, knowing what you know now, what are some educational suggestions you have for other black women pregnant or thinking about getting pregnant?

Nina Rogers: Do your research a little bit. If you want a doula or a midwife or if you want to go to a certain hospital, join a mommy group. I did. Join a mommy group because you can ask questions and if they're unable to answer it, you know, they'll say talk to the doctor. Join a mommy group and see if you can not only mommy group online but one you can attend once you have your child. It can be a group on Facebook called melanin mommas. It's a group for African American moms. You can join that group. They're really good. They're really, really good and then another group is mommas and bubs. That's another great Facebook group I'm a part of. So join groups. Find anything that can support you because being a parent is not easy. Joining a group, a community listening party like we just did and state how you feel.

Moderator: Thank you. The next question that we have, what influence are these listening sessions expected to have on state and local public health. And this is a three part question so I'll ask that part first.

Meagan Carroll: I mean, I know at the state-wide level, we're looking at them to inform the development of procurements at the health department because it really was through the governor's office there's potential for impact at a lot of different state agencies and initiatives. Moving forward, I know the Women's Justice Agenda that the governor's office put out had some things related to what we had heard in the listening sessions. And our intention with the local reports is to also to create evidence that a local organization could use and would go to a mayor or city councilman or foundation to try and kick start that on the ground.

Moderator: Sure. Now the second part is, are participants being connected with resources or services for issues that can't be fully addressed during the listening session and if so, can you provide some examples?

Colette Sturgis: Sure. So I'll give you a simple example. So if a participant came to the listening session and they had a small baby and they needed WIC. So a community health worker was on sight at the listening session and they referred them to the local WIC program.

Moderator: Okay. Excellent. And are the listening sessions safe spaces for participants to identify and discuss experiences with racism, especially in the health care system?

Nina Rogers: Definitely. It was good. We didn't have a problem. It ran smoothly actually. So it was a safe space for everybody. It definitely was.

Meagan Carroll: That's why, from our perspective, why we worked with the MICHC organizations. They're already embedded in the community. Their community health workers are folks that are representatives of the communities they serve. So we look to them for their expertise not only to do the referral piece if somebody had an issue but really it was their kind of community connections and their kind of reputation in the community that we were able to leverage to have the conversations.

Moderator: Okay. Terrific. Could Colette talk a bit about how breastfeeding can help lead to improved birth outcomes?

Colette Sturgis: Oh. Well, breast feeding and birth outcomes -- well I'll talk from my personal experience because I breastfed my daughter and I think that because of the breastfeeding she was growing, she was thriving. We would go to the doctor every appointment and they would say she's doing really well what are you doing? And I would say I'm breastfeeding, I'm breastfeeding on demand! And so I think that she was growing and prospered, and she rarely ever got sick. So that's for me. Having that information prior to breastfeeding it helped me realize that that's what I wanted to do and would probably the best thing for my child and help her grow and flourish.

Moderator: Okay. Terrific. So our next question. One of the themes that you said came out of the listening sessions was racism. What are some of the steps that can be taken in a systems based approach particularly with limited funding to address this?

Meagan Carroll: That's a great question. I think the Mount Sinai example is one that is really proactively addressing bias throughout the entire system. It's part of the hiring practices, it's part of how they are training employees. But I think the way they have internally done that to look at hiring and staff is a really interesting system's approach to the issue. I, you know, I think there's some really great organizations that are can provide technical support to do internal assessments of policies and procedures. Even looking at your intake forms. Looking at the language that is used on them. Again, anecdotally, we heard people say I mentioned the thing about checking the single box. We also heard women say that their husbands were always referred to as boyfriends. I mean just small changes people can make. I think in how staff are trained and who you're hiring, how you're promoting and how you're making those accessible to folks that represent your community are all important.

Moderator: So even though this is a very large and pervasive problem that we're talking about, there are some very small and manageable solutions that can be implemented. Our next question, what tools does New York State Department of Health have if you want to hold a community listening session?

Meagan Carroll: We're working on creating a template from this but this is based on work that the Office of Minority Health first developed. They had a series of listening sessions called voice your vision and did them in minority service areas across the state. I believe some of their reports are also available online too. But I think the most important thing we did was we tried to make it as participant lead as possible. Working with the community is the best thing that you can do.

Moderator: Okay. Are you able to share the questions that were used during the listening session?

Meagan Carroll: I think we have some examples of the questions in the report when it goes to be published. But to be honest we had a few prompting questions but for the most part we never had to ask follow up questions. You know you just put women around a table and say tell me what happened when you had a baby and they talk.

Nina Rogers: They do. Even with the smallest little question, you would get 100 words because you want it to be like I want to be known. Like I want them understand what I'm saying so let me just jot down my feelings. So it was good.

Moderator: And I think you had mentioned earlier that it was one of the things that was different from a focus group. That it didn't have much structure because you wanted to hear what and you wanted to hear what the folks had to say rather than impose an external agenda on the conversation.

Meagan Carroll: Yeah we didn't want to limit it to things that the health department could address. So transportation was talked about everywhere. How you access transportation, how accessible it is when you have a stroller. Things that are out of the scope of what we can control at the health department. But it was important to the women there and we want that feedback. We consciously made an effort to not be directive with the questions or with the follow up.

Moderator: Alright, the next question. How will participants in the listening sessions be included in the development of programs and solutions moving forward?

Meagan Carroll: So our intention is to share back the reports with each of the communities where we did the listening sessions. Whether we will be able to go back in-person were not sure. I think working through the MICHC organization, because they really recruited a lot of the participants. We're hoping to continue to leverage that relationship so they can work with their communities as part of their program requirements to develop plans and solutions for their work plans and procurement responses and things like that.

Moderator: What can we do as providers, nurses, midwifes, doctors, in areas with limited resources to help African American women? And I think you've already shared some things but anything that anyone wants to add to this?

Nina Rogers: Really, it all comes with funding. Because as a doctor or a midwife anybody in the community you want to take your own and try to support but can you afford to do that? You tend to want to be on call all the time but can you really afford to do that? It all comes in trying to raise the money to put into these minority neighborhoods and when the funds are limited that's when stuff starts to kind of go downhill and then that's when the problems kind of occur. So it's not so much of how they can help, it's the funding. And it's also how you present yourself to the patient. When you come off with a certain attitude you're not going to get a good response. And when that happens, then word of mouth comes around and everything tends to go downhill from there.

Colette Sturgis: I think that also get yourself some implicit bias training. And listen to us. We have the answers. We're going through this and we have allies and we need you to help us. So take the time to learn about us and not just judge us and create a safe space for us to give birth and have a happy healthy birth.

Moderator: Terrific. We have time for one last question, how did you pick the potential areas for the listening session?

Meagan Carroll: We looked at data on birth outcomes across the state. So maternal mortality. We looked at other factors like infant mortality, pre-term birth, and low birth weight. And those are actually used to determine funding for the maternal and infant community health collaborative organizations. So they overlapped very well. So we wanted to go into communities where we knew that there were some challenging outcomes, where we knew there were disparate outcomes. And then we also made a really concerted effort to try to talk to women across the state and recognize some of the unique local issues. Colette mentioned earlier, at first there were going to be five sessions but we realized you know, we can't combine Brooklyn and Queens, they are very different. So we tried to really honor the need for local specific.

Moderator: We do have one more question that I can answer, saying this webinar was great. So that is feedback for all of you and will it be archived for others to watch later and in fact, it will be available on our website very shortly and I'll discuss that in just a few moments. I want to thank all of you. This was a terrific conversation and great way to build awareness and help move the listening sessions and the valuable content from them to a greater audience to keep moving this forward. Thank you for joining us this morning.

All: Thank you.

Moderator: You're very welcome and also thank you very much for joining us today. Please remember to fill out your evaluation online. Your feedback is always helpful to the development of our programs. And continuing education credits are available for today's program for a limited time. To obtain CNE, CME, CHES, or social work continuing education hour's learners must visit www.phlive.org and complete an evaluation and posttest for today's offering. This web cast will be available on demand on our website within two weeks of today's show. Our next web cast on April 18th is about adult immunizations. Upcoming topics are available at phlive.org. Information on public health Live and other relevant public health topics can also be found on our CPHCE Facebook page and twitter feed. Don't forget to like us on Facebook to stay up to date. You can also let us know how you use Public Health Live by taking a brief survey at phlive.org. I'm Rachel Breidster, thanks for joining us on *Public Health Live!*