The Chicago Collaborative for Maternal Health

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SAFER CHILDBIRTH CITIES INITIATIVE

The U.S. is the only high-income country where maternal mortality is on the rise. Racial disparities are stark and persistent. According to the CDC, Black, American Indian, and Alaska Native women are two to three times more likely to die from pregnancy-related causes than White women, a risk that increases when your lens focuses on cities across the U.S.

The Safer Childbirth Cities Initiative aims to support community-based organizations in U.S. cities with a high burden of maternal mortality and morbidity to implement evidence-based interventions and innovative approaches to reverse the country's maternal health trends.

Launched in October 2018 by Merck for Mothers, Safer Childbirth Cities fosters local solutions that help cities become safer – and more equitable – places to give birth.

Safer Childbirth Cities

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CCMH Overview

- ***Mission:*** The Chicago Collaborative for Maternal Health seeks to combat the maternal mortality and morbidity crisis in Chicago by building awareness in communities and government, fostering collaboration among health and social service providers, and driving quality of care in ambulatory care settings.

- ***Vision:*** The CCMH envisions a Chicago where all people and all communities thrive because healthcare providers, policymakers, community organizations, individuals, and families partner with intention to improve maternal health.

- ***Aims***

  - *Aim 1:* Develop a QI collaborative for ambulatory care providers focused on best practices in maternal health for systems and culture change

  - *Aim 2:* Implement a complementary community engagement effort that informs families and community, social service providers about maternal morbidity and mortality prevention

  - *Aim 3:* Determine and advocate for policy recommendations based on the learnings from Aims 1 and 2

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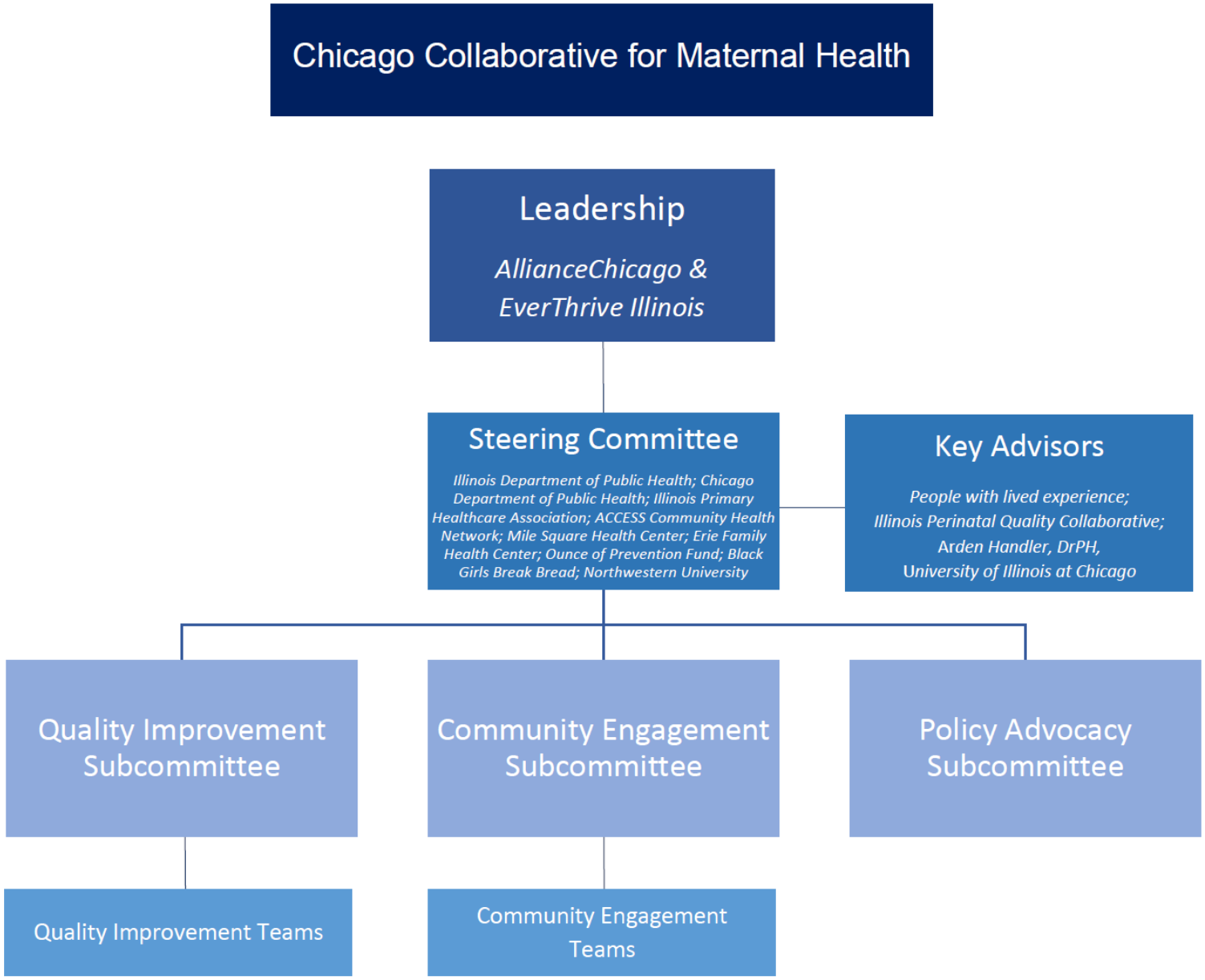
Chicago Collaborative for Maternal Health
Leadership
AllianceChicago & EverThrive Illinois
Steering Committee
Illinois Department of Public Health; Chicago Department of Public Health; Illinois Primary Healthcare Association; ACCESS Community Health Network; Mile Square Health Center; Erie Family Health Center; Ounce of Prevention Fund; Black Girls Break Bread; Northwestern University
Key Advisors
People with lived experience; Illinois Perinatal Quality Collaborative; Arden Handler, DrPH, University of Illinois at Chicago
Quality Improvement Subcommittee
Community Engagement Subcommittee
Policy Advocacy Subcommittee
Quality Improvement Teams
Community Engagement Teams

Key Accomplishments

- Aim 1
  - Development of QI Cohort
  - Implementation of QI Initiative
- Aim 2
  - Trained 89 social service providers on maternal mortality and morbidity
  - Increased understanding of community need through 330 surveys in priority neighborhoods
- Aim 3
  - Expansion of IL Medicaid postpartum coverage from 60 days to twelve months
  - Expansion of IL Medicaid to cover doula and home visiting services

Aim 1

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QI Roadmap

Step	Deliverables	Not Started	In Process	Completed	Delayed
Identify Topic	•Community Needs Assessment				
Develop Stakeholder Committee	•Engage and invite potential stakeholders •Survey stakeholders				
Inform Topic	•Review literature •Assess clinical guidelines/evidence-based practice •Connect with quality collaboratives on resources and lessons learned				
Develop Standardized Protocol	•Select intervention to test •Establish aim and measures for testing •Develop key driver diagram •Develop Toolkit & Resources •Review Protocol and revise as needed •Finalize Standardized protocol				
Implement/Test Standardized Protocol	•Data collection and reporting to track progress towards outcomes and monitor adherence to protocol •PDSA Cycles/tests of change •Protocol revision (as needed)				
Wrap up Implementation Period	•Review outcomes and acknowledge successes •Continued site support				
Sustainability	•Determine timeline for sustainability •Continue data collection as capacity allows				

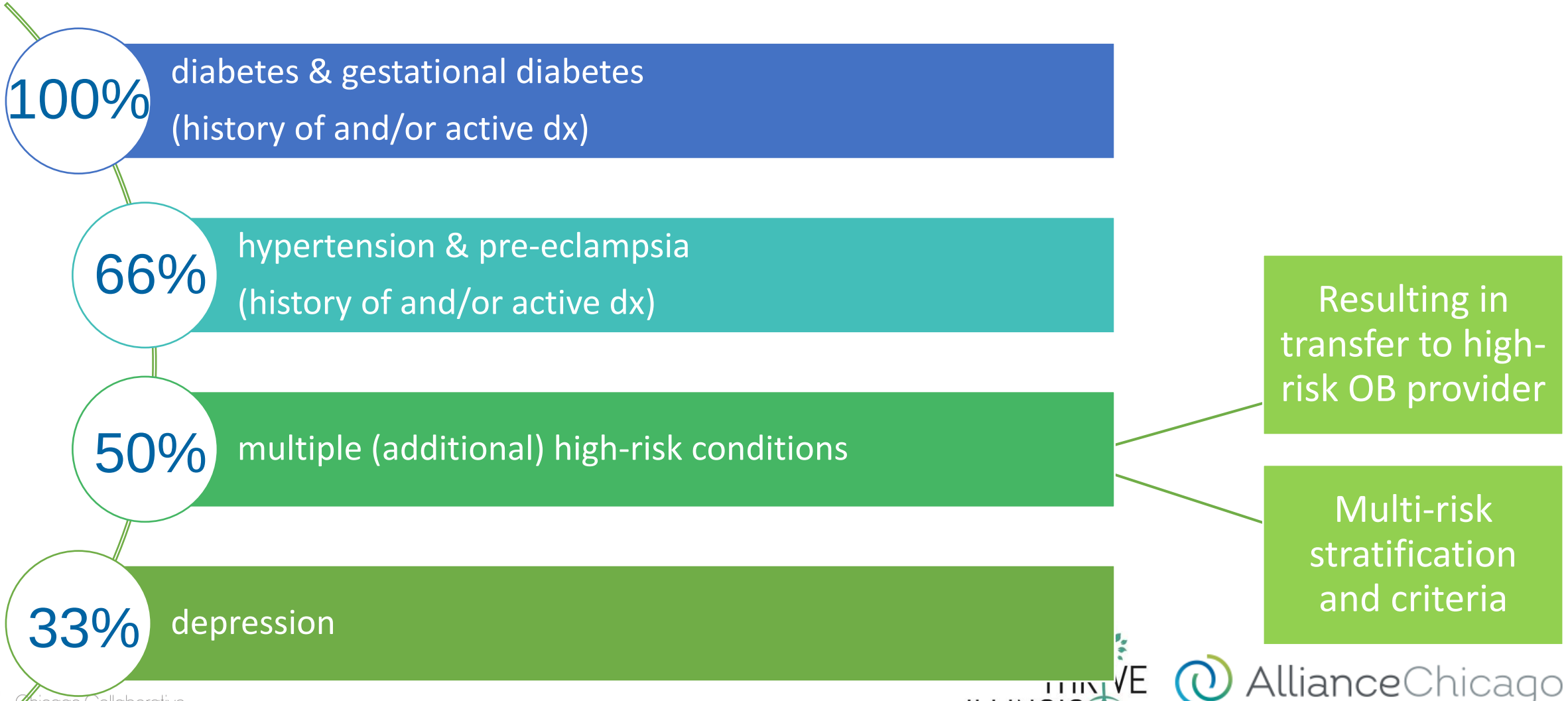
Engagement and Outreach

- 18 FQHCs, CHCs, ambulatory care centers engaged
  - 13 health centers participating in QI Subcommittee
  - 3 health centers participating in QI Development Team
  - 6 health centers fully implementing QI Initiative
- Engagement approaches
  - Email recruitment
  - One-on-one recruitment calls
  - QI Subcommittee Meetings

CCMH Aims/Measures

Aim	Driver	Strategy	Measure
Global Aim: Improve number of patients with pregnancies complicated by medical conditions who linked to PCP by 6 months.	Identify and follow high-risk pregnancies	Establish criteria for identifying high-risk/medically complex patients.	**STRUCTURE:** Are criteria for identifying high-risk patients defined?
		Develop registry of high-risk/medically complex patients during pregnancy	**STRUCTURE:** Is a registry in place to identify high-risk patients in place?
		Realign workflow to identify patients and coordinate care through postpartum follow up	**STRUCTURE:** Is a process in place to coordinate care for high risk patients?
			PROCESS: # of cumulative locations of care to date implementing this process
	Training on process	Train providers and staff on the importance of and process of care coordination for patients with high risk pregnancies	**PROCESS**: % of staff trained (by type)
	Ensure delivery of prioritized health services (postpartum care)	Ensure postpartum visit scheduled and attended.	**OUTCOME:** % patients who attended a postpartum appointment
		Create a process for establishing primary/well-person care following initial postpartum visit	**OUTCOME:** % patients linked to PCP at delivery discharge and completed appt within 6 months
		Establish checklist of appropriate postpartum services necessary for patients on high-risk list	**OUTCOME:** % of patients from registry who received care per checklist item

CHC High-Risk Criteria



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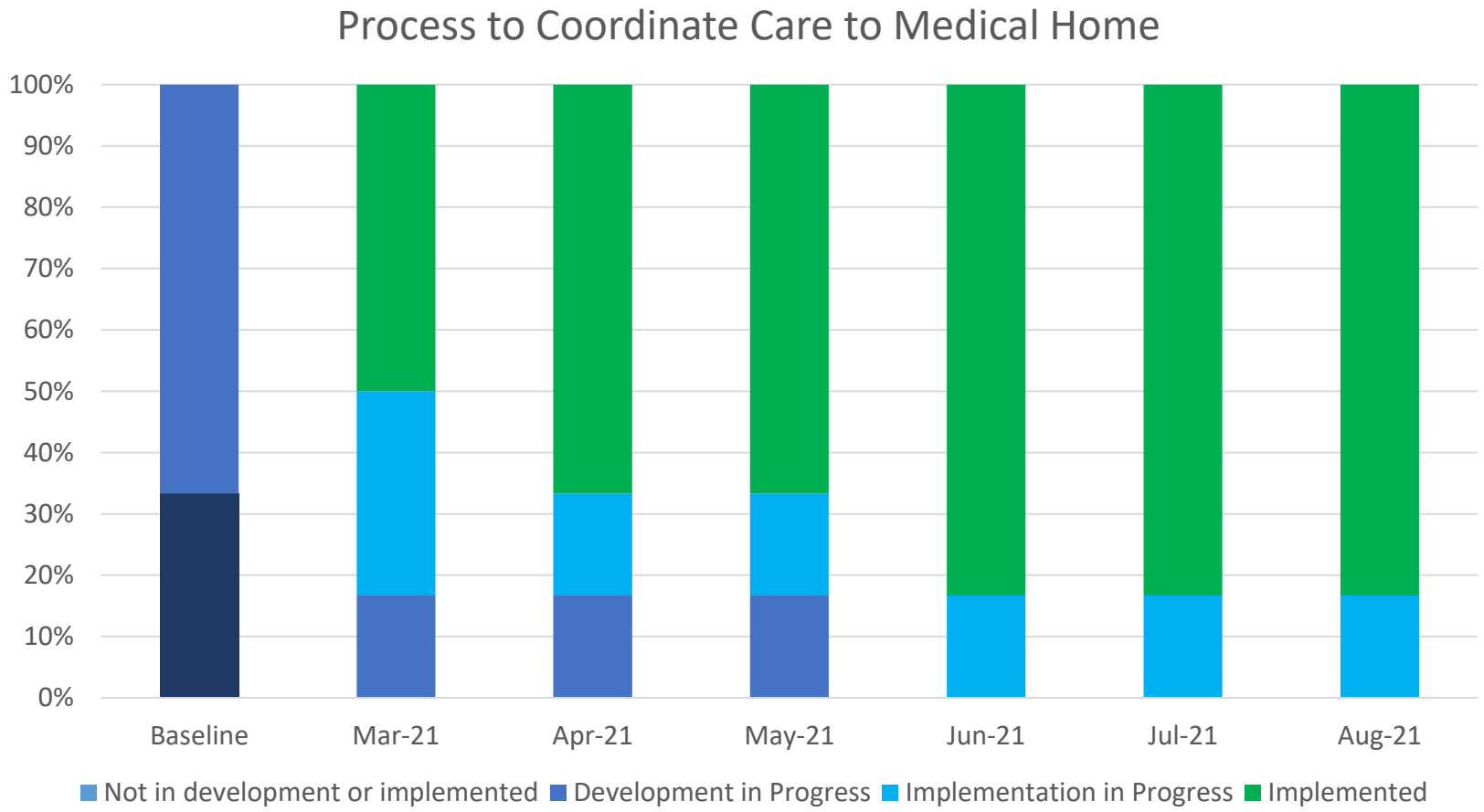
Data: Structure Measures Progress

Implemented: processes are in place and are currently being implemented (at least one location of care)

Implementation in progress: processes are in place but not yet implemented

Development in progress: processes are currently in development

Not in development or implemented



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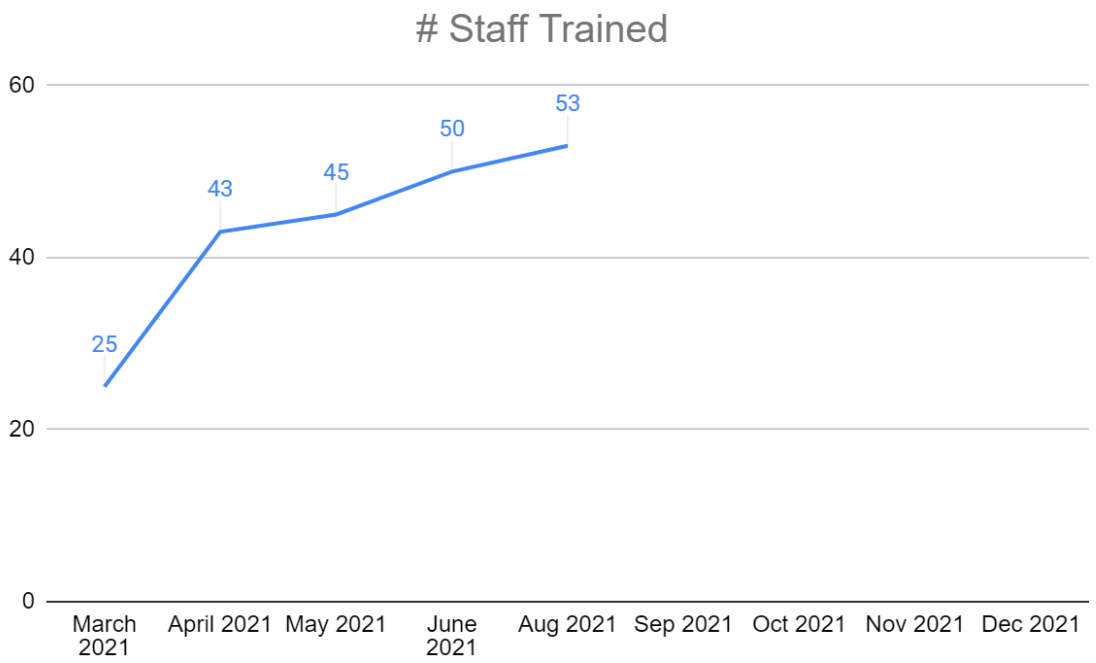
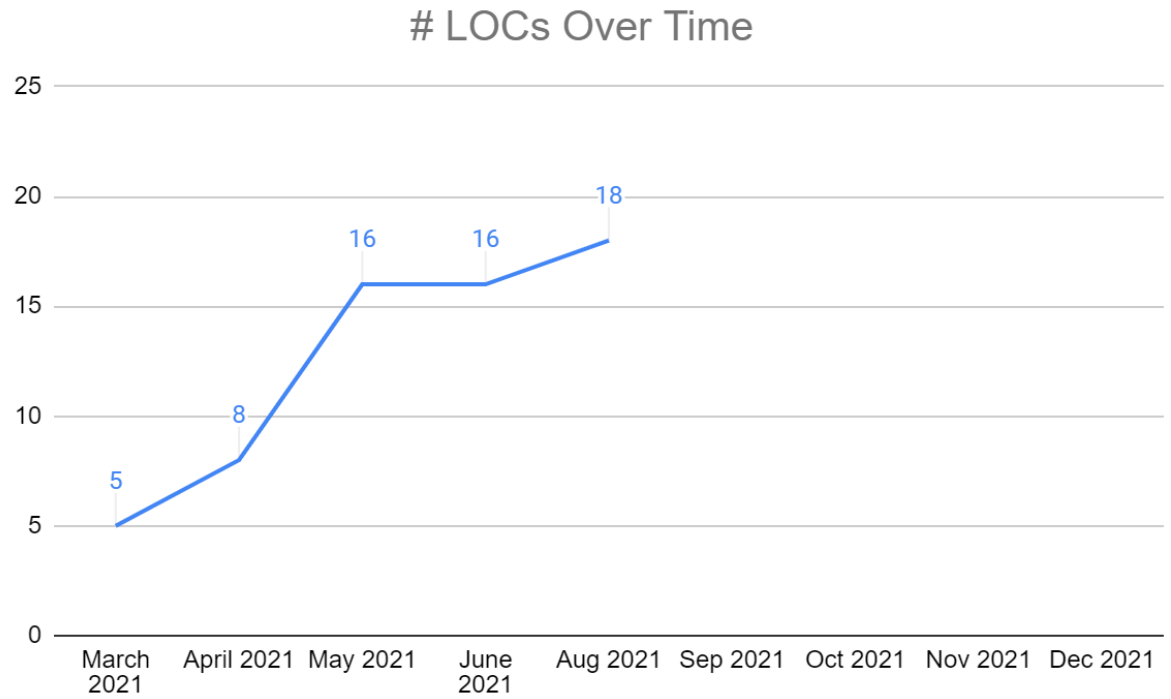
Implementation Data: Process Measures





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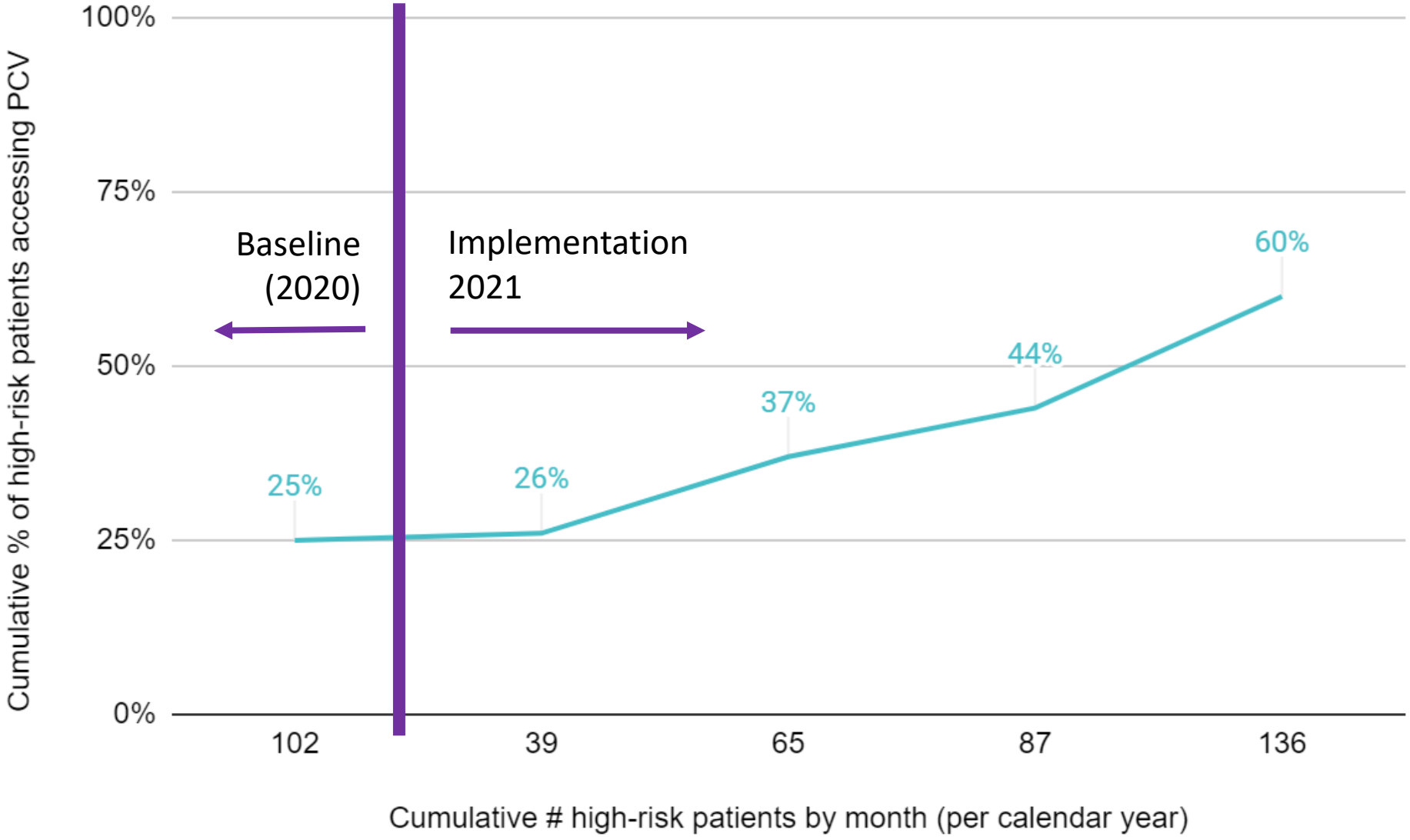
Implementation: High-Risk Patients Accessing Primary Care Visits (PCV)



Aim 2

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Aim 2: Community Engagement

Why Engage Community?

- Community-informed models of perinatal and reproductive health care aim to meet individual and community-identified needs of Black birthing people in a way that is collaborative, transparent, and reciprocal. (Julian, Z et al. 2020)
- Identify root causes of inequality, including structural racism, insurance access, access to and gaps in service provision, cultural differences between patients and providers
- Policies and programs are developed thoughtfully considering local needs and concerns

Community Engagement Continuum

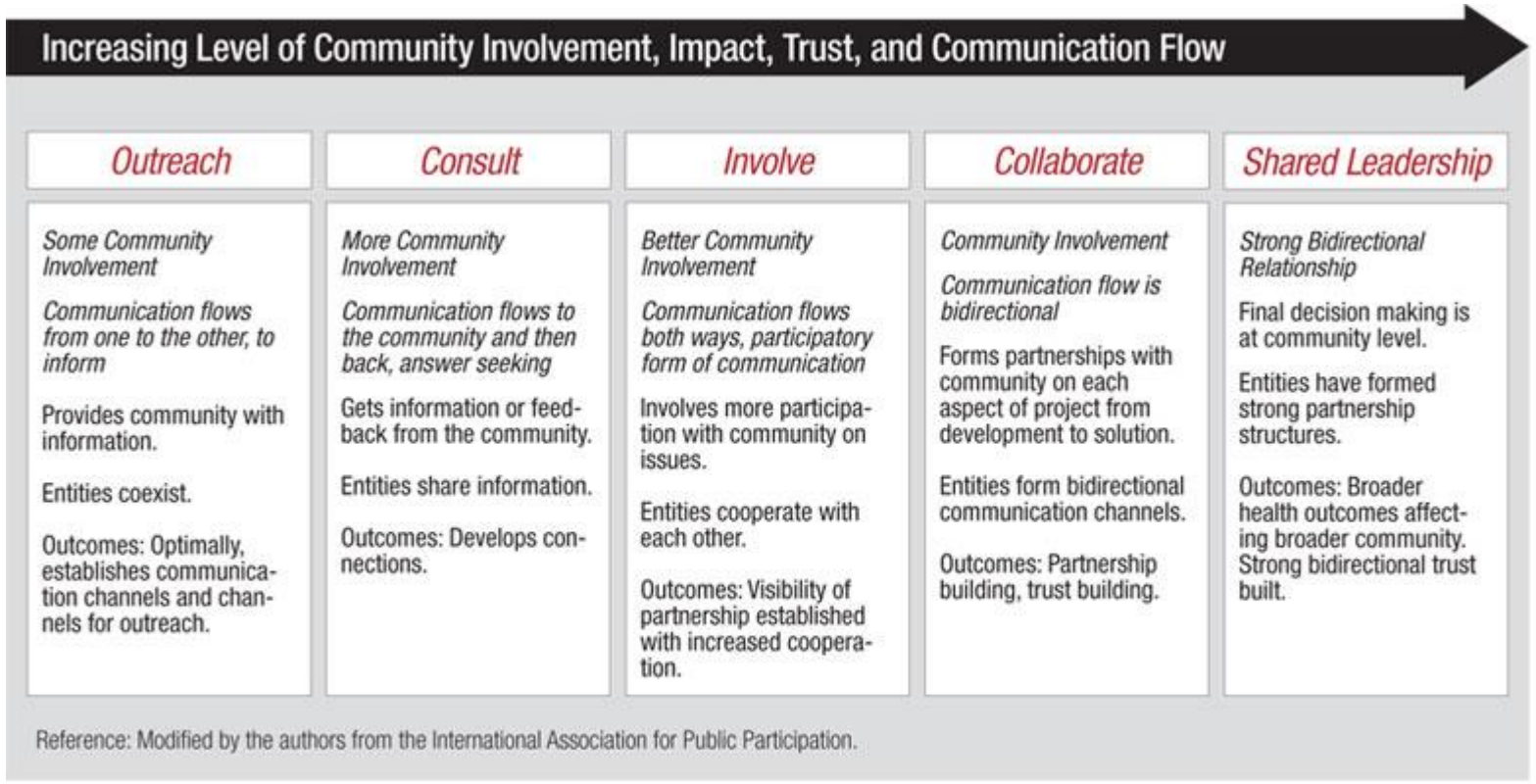

Figure 1.1. Community Engagement Continuum

Centers for Disease Control and Prevention. *Principles of Community Engagement (second edition)* Atlanta, GA. 2011. Retrieved from: https://www.atsdr.cdc.gov/communityengagement/pdf/PCE_Report_508_FINAL.pdf

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Aim 2: Community Engagement

GOAL: Work with community members and partners to develop and implement and community education campaign to promote maternal health and improve trustworthiness of healthcare systems.

PROCESS:

GUIDING PRINCIPLE: People with lived experience are essential partners in identifying barriers to care and transforming the healthcare system to better support pregnant and postpartum people.

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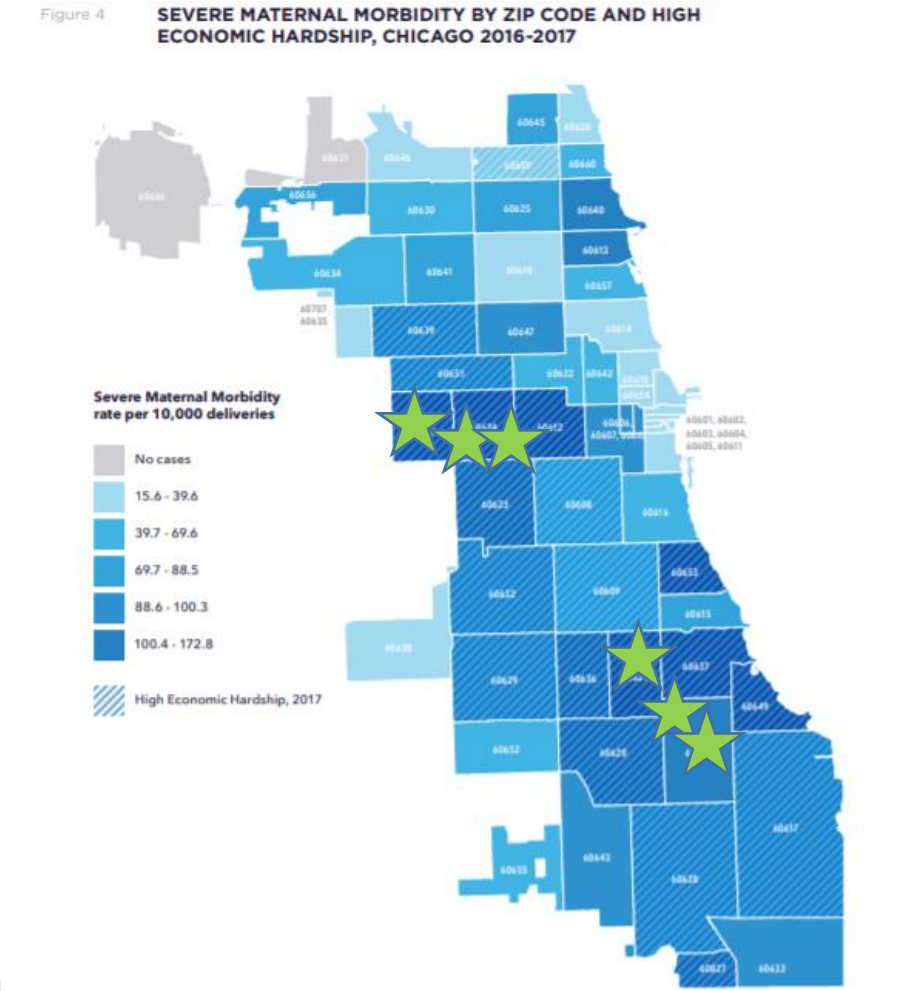
Needs Assessment

- Identified Chicago community areas with the highest pre-term birth and morbidity and mortality rates (Austin, Chatham, Greater Grand Crossing, East and West Garfield Park, and Englewood)

- Completed community mapping to identify local businesses, homeless shelters and other community services to engage in health education conversations and trainings



Needs Assessment

- Recognized need to build capacity of social service providers to be part of the solution
- Established Family Advisory Council made up of five individuals from community areas who have experienced complications during pregnancy, labor and delivery or postpartum to advise on program design and implementation

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Survey Development

- Drew on expertise of Family Advisory Council to develop culturally responsive surveys and focus group questions aimed at understanding:
  - *Where community members receive health information*
  - *Barriers and Facilitators to Care*
  - *Understanding of maternal mortality and morbidity*
- Results will inform policy priorities, health education campaign and other stakeholders

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Social Service Provider Curriculum

- Developed Train the Trainor curriculum to
  - ***Build*** awareness of maternal mortality and morbidity and associated disparities
  - ***Activate*** social service providers and community-based organizations as part of the solution
  - ***Learn*** from social service providers about how to improve the system for women.

Preliminary results (18 surveyed)

56% of providers stated that they knew someone who encountered a major illness from outcomes of labor and delivery

78% felt not prepared or slightly prepared to discuss pregnancy/post-partum health with families they serve

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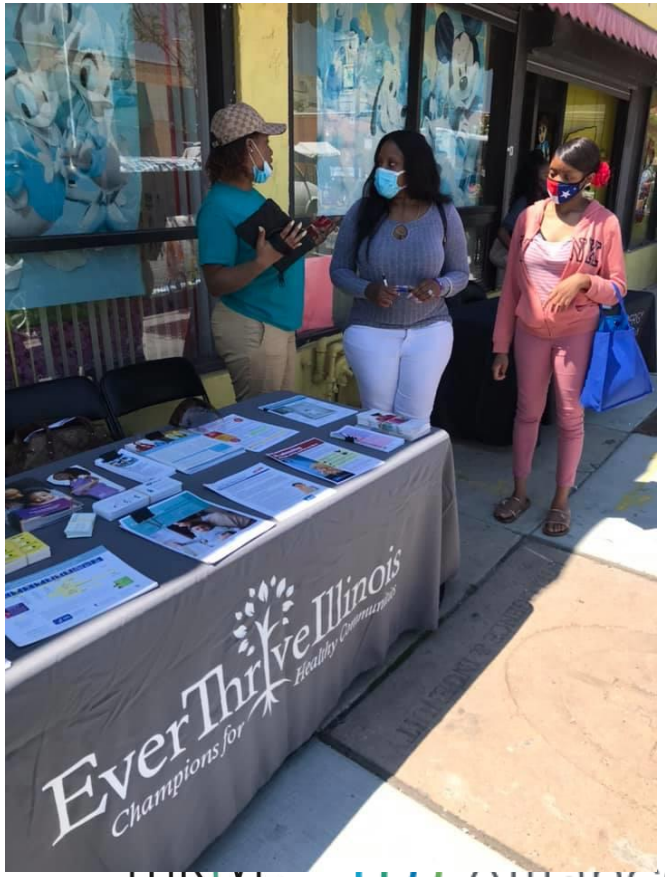
Community Engagement Results

- Outreach to health fairs, community events, back to school events, and local businesses
- **330 completed surveys and one focus group** engaging pregnant and post partum people in East and West Garfield Park, Austin, Englewood, Greater Grand Crossing, and Chatham
- Trained **89 social service providers**. Participants include home visitors, parent coaches, case managers, doulas, community health specialists, lactation consultants, and nurse interns



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Community Engagement Results

Emerging themes

- Need for increased community support and self care
- Continuous stress
- Difficulty navigating insurance for mental health services and need to increase mental health provider capacity
- Being ignored by clinicians and family when reporting something is wrong
- Need to return to work is a barrier to postpartum visits
- Cultural and language differences between patients and providers

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Aim 3

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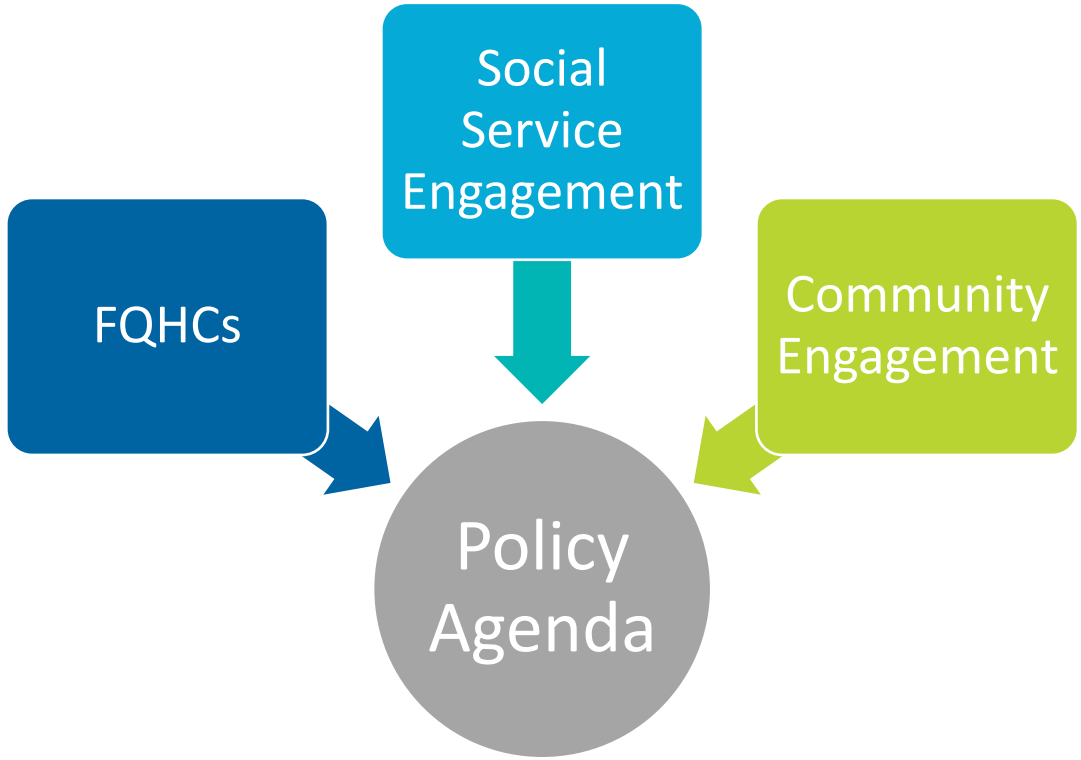
Community-Informed Policy Agenda

Community, clinician and social service provider, and Steering Committee engagement presents an opportunity to develop a community-informed and responsive policy agenda addressing structural barriers to healthy pregnant and postpartum people and their families



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Advocacy Impact

- Secured Blood Pressure Kits

  Secured guidance form IL Medicaid and Association of Medicaid Managed care plans to ensure smooth and timely requests during the pandemic

- Black Caucus Health Bill

  Expanded IL Medicaid program to cover doula and home visiting services

- SB967 Maternal Mortality Omnibus

  Unbundled payment structures for LARCs in all insurance plans, expanded case management services for folks with low incomes or at high risk for pregnancy, expanded emergency treatment access

Advocacy Impact

- HB3308 Telehealth Bill

  Telehealth reimbursement extended in private insurance plans with provider parity until late January 2028

- SB2017

  Expands Medicaid Coverage for People over 55 years old who are undocumented under 138% of the federal poverty line

- Approval of the 1115 Waiver Expanding Postpartum Medicaid Coverage

  Shifted postpartum coverage from 60 days to twelve months

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