SEMPQIC
Coalition Meeting

September 10, 2019
Welcome

Vernice Anthony, BSN, MPH, VDA Health Connect
Plans for 2020

× **Goal:** Create a coordinated, equitable and sustainable network for perinatal care based on best practices and evidence-based strategies that will result in improved birth outcomes for all babies in Region 10.

× **Objectives:**
  × Strengthen a southeast Michigan community-based perinatal system consistent with the recommendations included in the Mother Infant Health and Equity Improvement Plan
  × Create a coordinated network for delivery of home visiting services and other supports for high-risk babies and mothers, building on existing services and addressing the social determinants of health
HB@H in 2019 and Plans for 2020

Iris Taylor, Ph.D., VDA Health Connect
Initiative History

- Health Baby @ Home is a Quality Improvement initiative started in 2017 as a result of a Region 10 Gap Analysis focused on improving infant mortality.
- The intent of the project was to be an evidence-based approach that did not duplicate existing efforts but rather supported existing efforts in a meaningful way, while addressing SDOH or impact equity of care.
- The recommendations from the 2016 MDHHS Infant Mortality Reduction Plan served as the foundation for the quality project.
- And finally, the project efforts were to be measurable and sustainable over an extended period of time in terms of process, impact, and outcomes.
Project Objective

- Home visiting referral process for newly enrolled clients for prenatal care (hospital based clinic and a FQHC)
- Home visiting referral process for parents of infants admitted to either a hospital Neonatal Intensive Care Unit or Special Care Nursery
Project Service Area

- Hospital Based Prenatal Clinic
- Intensive Care Nursery
- Federal Qualified Health Clinic with Five Sites
  - The project involved two sites
Service Model

× Providers partnered with MIHP agencies to provide both direct referral and access to their client population for case finding efforts.
× A location near the service area was provided to allow on site enrollment assessment and coaching.
× A mechanism to support communication around referrals was established.
× MIHP agency was available scheduled clinic days.
× Referrals were encouraged for all discharges from the NICU.
× MIHP referral could occur in conjunction with a skilled nursing home referral.
PDSA Improvement Cycles

- Establish referral and feedback process with providers in the prenatal clinic.
- Case finding: MIHP available every clinic day to approach potential clients.
  - Management provided an area for onsite interviews and enrollment
PDSA Improvement Cycles

✗ Forty percent of available population who delivered in the hospital were not eligible for Medicaid, thus not eligible for MIHP services. The percent was consistent
  ➗ Efforts are in process with Great Start to identify an alternative solution to provide at least an home assessment

✗ Clients living in shelter were not able to access services of MIHP agency
  ➗ Improvement solution not developed
Concerns surrounding trust continued to be evident in the engagement process. Workshop conducted by Denise Evans for Provider staff and MIHP staff increased awareness and fostered skills regarding:
- Implicit Bias awareness
- Identifying personal bias and that effects your engagement
- Demonstrated methods of how one could modify approach
PDSA Improvement Cycles

- Improve engagement process
  - Workshop offered strategies regarding
    - Appearance
    - Elevator speech
    - Branding/marketing
Data Overview

- Consistently percentage of enrollment for the available population increased.
- Data trends for both MIHP Agencies increased from a baseline of less than 50% to consistently 63% to 77% of the available population being enrolled.
- There was also an increase in the number of individuals completing their care plans. MIHP agencies required an increased in staffing.
- The trending referrals for NICU discharges were inconsistent, however we continue to trend upward in number of referrals.
Data Overview

- There was an increased from baseline line of no referrals to averaging 33% to 48% of the available population being consistently enrolled from available population of the FQHC

- However, there was a significant difference between the site with complete staff engagement and the site with less staff engagement.
Draft Recommendations

- Replicate the model with other clinical partners with their identified MIHP agencies to provide an environment of referrals, case finding, and communication cycle.
- A coordinator be provided by DHHS to facilitate organizational negotiations and trouble shoot process.
- Technical support concerning implicit bias and engagement be a required component of the model.
- Develop a concept paper that documents the service model and past performance.
Plans for the rest of 2019 and 2020

- Exploring the potential to duplicate service model in Oakland County
- Exploring the potential to duplicate the service for a specific population of NAS babies in Macomb county
Q & A
Preliminary Results from the Biosocial Impact on Black Births (BIBB) Study: A Focus on Prenatal Care

Rhonda Dailey, MD
Assistant Professor,
Department of Family Medicine & Public Health Sciences
Scientific Director, Office of Community-Engaged Research (OCEnR)
Rhonda Dailey, MD

- Medical Degree from the University of Iowa College of Medicine, Iowa City, IA
- Undergraduate degree: Biology Pre-Medicine from Jackson State University, Jackson MS
- Formally Research Associate: DFMPHS, WSU
- Assistant Professor: Research in health disparities related to chronic diseases, health care quality, health information seeking; expertise in African American participant recruitment and retention
- Scientific Director: Office of Community Engaged Research
- Proud wife, mother of 2 college graduates
Background

- African American (AA) women have higher risks for
  - PTB and LBW compared to white women
  - PTB and LBW: leading cause of infant mortality among AA women—rates 2X higher than white women
  - Infant mortality (11.1 vs 5.06/1,000 births)
  - PTB (13.4% vs 8.8%)
  - LBW (13.4% vs 6.9%)
Background

- Inequity negatively affects the health and welfare of infants and their families (high child mortality, morbidity, and developmental delays)

- Prenatal care (PNC) regarded as a protective factor; but early initiation and utilization of care have failed to create equity in pregnancy outcomes such as PTB.
Prenatal Care

- Healthcare that a woman receives while pregnant. It not only provides women with important screening, testing, monitoring, education, and counseling, but it also includes treatment of complications and management of chronic diseases.

- Late prenatal care:
  - AA women are also more likely than white women to initiate prenatal care later (after the 1st trimester or > 13 weeks gestation).
  - Michigan: AA women are at nearly 2.5 X greater risk of late or no prenatal care compared to white women.
  - Education: < high school 8X greater risk vs college education.
Prenatal Care Utilization

- Underutilization of PNC associated with:
  - Healthcare mistrust and beliefs
  - Unsatisfactory clinical experience
  - Late recognition of pregnancy and prenatal care
  - Lack of knowledge about pregnancy
  - Lack of social support
  - Low information seeking and sharing

- Inadequate prenatal care (PNC)
  - Increased risk for: preterm births, LBW, still birth, neonatal and infant deaths
Prenatal Care Utilization

- Healthy People 2010: increase adequate care from 70.8 to 77.9%
- Quality of care may contribute to disparities
- Care may be affected by: patient values, attitudes, and preferences
- Successful: the push for increasing the number of PNC visit over the past 40 years
- Unsuccessful: Preterm birth and other adverse outcomes still persist for AA women
Interventions aimed to improve content or quality through: home visits, enhanced care, group care

+ outcomes: ↓PTB, ↓cesarean rates, ↑birth weight infants

Implementation of models are demanding and may not fit certain clinical settings

Measurement of Quality

- Relied on timing of initiation and total # of prenatal visits
- Based on satisfaction through focus groups, audit indicators, checklists, observations, exit interview and one-dimensional instruments

Satisfaction ≠ quality
Prenatal Care Quality

- Gap in direct measures of quality by the mother
- Quality of Prenatal Care Questionnaire
  - Nurse researchers: Developed, validated, and tested in Canada and later, Australia
  - No testing in U.S. populations, and with African American women
- Implications
  - Quality may impact outcomes beyond the impact of utilization alone
  - May contribute to our understanding of how to prevent adverse birth outcomes, potentially explain disparities, and possibly offer an avenue for intervention.
Prenatal Care Quality Determinants

- 3 Domains important for increasing utilization and quality of PNC
  - Psychological distress
  - Psychosocial resources
  - Health information seeking (behaviors and beliefs)
- May be important in utilization and quality and may be salient for AA women
- BIBB Study: We are examining the pathways among psychological distress, psychosocial resources, health information seeking, and prenatal care utilization and quality of birth outcomes among AA women
Biosocial Impact on Black Births (BIBB) Study

- Investigators:
  - PI: Carmen Giurgescu, PhD, RN
  - WSU PI: Dawn Misra, MHS, PhD
  - Co-I: Rhonda Dailey, MD, et al.
  - R01, prospective cohort, 5 years
  - Funding: NIMHD

- Facilities:
  - Detroit (St. John Hospital Ob/Gyn clinic)
  - Columbus, OH (Ohio State Univ Ob/Gyn clinic)

- Participants
  - AA pregnant women 18-44 years old, 8-29 weeks pregnant
  - Prospective study, 4 time points, blood and saliva collected
  - Goal: 1,500 women
  - Recruitment: 425+ women, 70 fathers
Hypothesis:

- ↑ social stressors → ↑ emotional stress → Δ cortisol
  levels → ↑↑ systemic inflammation → ↑ PTB risk

*Note: Each concept is measured 3 times during pregnancy (14-16, 22-24, and 30-32 weeks).

** Social stressors (disadvantaged neighborhoods, racial discrimination, stressful life events);
psychosocial resources (coping, social support); emotional stress (psychological distress, anxiety, depressive symptoms); salivary cortisol; inflammation (plasma cytokines, CRP).
Prior Results:
Social Stressors and Preterm Birth Study

- NINR R03 pilot of 114 pregnant AA women
  - Social stressors related to: emotional stress, systemic inflammation, and higher risk of PTB
  - Emotional stress mediated the effects of social stressors on PTB
  - Psychosocial resources in the 2nd trimester and changes in psychosocial resources between the 2nd and 3rd trimesters mediated the effects of disadvantaged neighborhoods on emotional stress
  - Women with lower anti-inflammatory interleukin (IL)-10 levels had higher risk of PTB
  - Subsample of 11 women: “bad” neighborhoods and resources (support) were linked to stress.
Prior Results: L.I.F.E. Study

(Life-course Influences on Fetal Environments study)

- NICHD R01 of 1140 pregnant AA women (2008-2011)
- 35% initiated PNC after 1st trimester; 60% fewer than 11 visits
- More likely to have < 12 years of education and to deliver preterm
- 65% began PNC in 1st trimester of pregnancy (≤ 13 6/7 weeks GA).
- Of the babies born: 16.4% were preterm, 12.7% had LBWs, and 11% were admitted to the NICU.
- Women who began prenatal care after the 1st trimester were more likely to have ≤12 years of education and LBW infants.
- Women who perceived that the FOB would be involved in the pregnancy were more likely to began prenatal care during the 1st trimester.
- Women who had only 1-10 prenatal visits were more likely to have ≤12 years of education (70.6%), premature babies (77.8%), babies admitted to the NICU (77.3%) and LBW infants (80.3%).
BIBB Study: Conceptual Framework

Figure 1: Conceptual Framework

Psychological distress
(Angst, depressive symptoms)
- Questions from BIBB Study

Psychosocial Resources
(Social support, coping)
- Questions from BIBB Study

Prenatal Care
(Quality + Utilization)
Quality: QPNCQ; PRAMS
Utilization: Total # of visits; timing of 1st visit; adequacy of PNC

Pregnancy Outcomes
- Gestational age at birth

Health Information Seeking
(Beliefs and behaviors)
- HINTS; HICS; PHSS

Aim 1
### BIBB Study: Variables and Instruments

<table>
<thead>
<tr>
<th>Concept/Variables</th>
<th>Measures</th>
</tr>
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<tbody>
<tr>
<td><strong>Psychological Distress</strong></td>
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<td>Psychological Distress</td>
<td>Revised Prenatal Distress Questionnaire</td>
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<tr>
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<td>Psychological General Well Being Index</td>
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<td>Pregnancy-related Anxiety</td>
<td>Pregnancy-related Anxiety Scale</td>
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<tr>
<td>Depressive Symptoms</td>
<td>Center for Epidemiological Studies Depression (CESD) scale</td>
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<td><strong>Psychosocial Resources</strong></td>
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<tr>
<td>Coping Strategies</td>
<td>Revised Prenatal Coping Inventory</td>
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<td>Social Support</td>
<td>MOS Social Support Survey</td>
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<td><strong>Prenatal Care Utilization</strong></td>
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<td>Prenatal Care visits</td>
<td>Medical Records abstraction</td>
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<tr>
<td><strong>Pregnancy Outcomes</strong></td>
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<td>Gestational Age at Birth</td>
<td>Medical Records abstraction</td>
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## Variables and Instruments

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<th>Concept/Variables</th>
<th>Measures</th>
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<tr>
<td><strong>Health Information Seeking</strong></td>
<td>Health Information National Trends Survey (HINTS)</td>
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<td>Beliefs, behaviors</td>
<td>Pregnancy Health Information Seeking Scale (PHISS)</td>
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<td></td>
<td>Health Information Competence Scale (HICS)</td>
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<tr>
<td><strong>Prenatal Care Quality and Utilization</strong></td>
<td>Quality of Prenatal Care Questionnaire (QPCQ)</td>
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<tr>
<td>Quality of prenatal care visits (postpartum)</td>
<td>Pregnancy Risk Assessment Monitoring System (PRAMS)</td>
</tr>
<tr>
<td>Physician Interactions</td>
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Quality of Prenatal Care Questionnaire (QPCQ)

Heaman et al. BMC Pregnancy and Childbirth 2014, 14:188
http://www.biomedcentral.com/1471-2393/14/188

RESEARCH ARTICLE

Quality of prenatal care questionnaire: instrument development and testing

Maureen I Heaman1†, Wendy A Sword2†, Noori Akhtar-Danesh3, Amanda Bradford3, Suzanne Tough4, Patricia A Janssen5, David C Young6, Dawn A Kingston7, Eileen K Hutton8 and Michael E Helewa9

Abstract

**Background:** Utilization indices exist to measure quantity of prenatal care, but currently there is no published instrument to assess quality of prenatal care. The purpose of this study was to develop and test a new instrument, the Quality of Prenatal Care Questionnaire (QPCQ).

**Methods:** Data for this instrument development study were collected in five Canadian cities. Items for the QPCQ were generated through interviews with 40 pregnant women and 40 health care providers and a review of prenatal care guidelines, followed by assessment of content validity and rating of importance of items. The preliminary 100-item QPCQ was administered to 422 postpartum women to conduct item reduction using exploratory factor analysis. The final 46-item version of the QPCQ was then administered to another 422 postpartum women to establish its construct validity, and internal consistency and test-retest reliability.

**Results:** Exploratory factor analysis reduced the QPCQ to 46 items, factored into 6 subscales, which subsequently were validated by confirmatory factor analysis. Construct validity was also demonstrated using a hypothesis testing approach; there was a significant positive association between women’s ratings of the quality of prenatal care and their
Quality of Prenatal Care Questionnaire (QPCQ)

- Developed by Heaman and colleagues, 2014 article; Canadian nurses
- Consists of 46 items (5 point Likert scale) with 6 factors:
  - Factor 1: Information Sharing
  - Factor 2: Anticipatory Guidance
  - Factor 3: Sufficient time
  - Factor 4: Approachability
  - Factor 5: Availability
  - Factor 6: Support and Respect
- Each item is scored: 46-230 range; a higher total or factor mean item score indicates higher quality of prenatal care.
- Administered within 8 weeks postpartum
## BIBB Study Demographics

### Variables N = 113

<table>
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<tr>
<th>Age, mean (SD)</th>
<th>N (%)</th>
<th>Education</th>
<th>N (%)</th>
<th>Current Family Finances</th>
<th>N (%)</th>
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<tr>
<td>Range</td>
<td>113</td>
<td>27.1 (5.2)</td>
<td></td>
<td>Very poor, not enough to get by</td>
<td>113</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Barely enough to get by</td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td>Have enough to get by, but no extras</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Have more than enough to get by</td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td>Well to do</td>
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### Sex of child at birth

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<thead>
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<th>Female</th>
<th>Male</th>
<th>N (%)</th>
<th>N (%)</th>
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<tr>
<td></td>
<td>50</td>
<td>(44.2)</td>
<td>63</td>
</tr>
<tr>
<td></td>
<td>(55.8)</td>
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### Location

<table>
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<th>Location</th>
<th>N (%)</th>
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<tr>
<td>Michigan</td>
<td>71</td>
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<tr>
<td>Ohio</td>
<td>42</td>
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### Household Income/year

<table>
<thead>
<tr>
<th>N (%)</th>
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# BIBB Study Demographics

<table>
<thead>
<tr>
<th>Variables N = 113</th>
<th>N (%)</th>
<th>Variables N = 113</th>
<th>N (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Marital Status</strong></td>
<td></td>
<td><strong>Reason Not Working/Laid Off</strong></td>
<td></td>
</tr>
<tr>
<td>Married</td>
<td>12 (11.0)</td>
<td>Unemployed</td>
<td>32 (57.1)</td>
</tr>
<tr>
<td>Living with partner</td>
<td>35 (32.1)</td>
<td>Homemaker</td>
<td>16 (28.6)</td>
</tr>
<tr>
<td>Divorced</td>
<td>3 (2.8)</td>
<td>Full-time student</td>
<td>1 (1.8)</td>
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<tr>
<td>Separated</td>
<td>2 (1.8)</td>
<td>Medical Reasons (leave, bed rest)</td>
<td>4 (7.1)</td>
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<tr>
<td>Never married</td>
<td>57 (50.4)</td>
<td>Looking for work</td>
<td>3 (5.4)</td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Hours work/week</strong></td>
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<tr>
<td></td>
<td></td>
<td>10-20</td>
<td>6 (11.1)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>20-30</td>
<td>12 (22.2)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>30-40</td>
<td>24 (44.4)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>&gt; 40</td>
<td>12 (22.2)</td>
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<tr>
<td></td>
<td></td>
<td><strong>Insurance</strong></td>
<td></td>
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<td></td>
<td></td>
<td>Private/employee</td>
<td>7 (6.4)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Private</td>
<td>3 (2.7)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Medicaid</td>
<td>72 (65.5)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Medicare</td>
<td>11 (10.0)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Medicare + Medicaid</td>
<td>8 (7.3)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Don’t know, unsure, other</td>
<td>9 (8.2)</td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Married to/ or living with FOB</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Yes</td>
<td>39 (83.0)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>No</td>
<td>8 (17.0)</td>
</tr>
<tr>
<td><strong>Work Status</strong></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Working</td>
<td>54 (49.1)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Temporarily laid off</td>
<td>6 (5.5)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Not working</td>
<td>50 (44.2)</td>
<td></td>
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</tbody>
</table>
Demographics: Sources of Income and Services utilized

- Food Stamps (EBT/SNAP): 66.4%
- WIC: 46.9%
- Substance Abuse counseling: 17.7%
- SSI: 16.8%
- Medicaid: 13.3%
- Welfare: 4.4%
- Utility assistance: 1.8%
Health Problems Before Pregnancy

- Asthma, or other lung problems (N=32): 28.3%
- HTN or elevated BP (N=14): 12.4%
- Diabetes or high blood sugar (N=10): 8.8%
- Thyroid problems (N=6): 5.3%
- Heart problems (N=2): 1.8%
- Kidney problems (N=2): 1.8%
- Other conditions (N=10): 8.8%
Knowledge

**PRAMS**: When sure of pregnancy?

- 5-8 weeks: 43.5%
- 1-4 weeks: 20.4%
- 9-12 weeks: 11.1%
- 13-16 weeks: 0.9%
- 17-20 weeks: 1.9%
- > 20 weeks: 3.7%
- Don't know: 18.5%

*PRAMS = Pregnancy Risk Monitoring System*
Information Seeking

HINTS*: How much do you trust information about pregnancy topics from...

*HINTS = Health Information National Trends Survey
HINTS: On a typical weekday or weekend, how many hours do you….

Typical Weekday
- Watching TV: 3.4
- Listen to Radio: 2.7
- Internet (personal reasons): 5.6

Typical Weekend
- Watching TV: 4
- Listen to Radio: 3.3
- Internet (personal reasons): 5.2
HINTS: How much do you trust information about pregnancy topics from…

- Doctors: 72.1%
- Family or friends: 47.1%
- Govt health agencies (CDC, etc): 36.8%
- Health orgs/groups (The Bump, etc.): 29.4%
- Charitable orgs: 31.8%
- Religious orgs/leaders: 31.8%

Options: Not at all, A little, Some, A lot

Source: Wayne State University, School of Medicine
Information Seeking

PHISS*: How often in the past month did you look for pregnancy related information from...

*PHISS: Pregnancy Health Information Seeking Scale
**Information Seeking**

**HIC: How much do you agree or disagree with the following statements...**

<table>
<thead>
<tr>
<th>Statement</th>
<th>Disagree very much, disagree</th>
<th>Neither disagree or agree</th>
<th>Agree, Agree very much</th>
</tr>
</thead>
<tbody>
<tr>
<td>I know exactly what I want to learn</td>
<td>4.5</td>
<td>27.3</td>
<td>68.2</td>
</tr>
<tr>
<td>I can figure out where info</td>
<td>1.5</td>
<td>12.1</td>
<td>57.6</td>
</tr>
<tr>
<td>Health info difficult to obtain</td>
<td>15.2</td>
<td>18.2</td>
<td>66.7</td>
</tr>
<tr>
<td>Satisfied with how learn</td>
<td>1.5</td>
<td>18.2</td>
<td>80.3</td>
</tr>
<tr>
<td>In control of how and what</td>
<td>1.5</td>
<td>18.2</td>
<td>80.3</td>
</tr>
</tbody>
</table>

*HIC: Health Information Competence Scale*
## Prenatal Care

**PRAMS**: During any of your PNC visits, did a doctor, nurse, or other healthcare worker talk to you about …

<table>
<thead>
<tr>
<th>Topic</th>
<th>Yes Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>How smoking could affect my baby</td>
<td>76.8</td>
</tr>
<tr>
<td>Breastfeeding my baby</td>
<td>94.6</td>
</tr>
<tr>
<td>How drinking alcohol could affect my baby</td>
<td>72.3</td>
</tr>
<tr>
<td>Using a seatbelt during my pregnancy</td>
<td>73.2</td>
</tr>
<tr>
<td>Medicines that are safe to take</td>
<td>95.5</td>
</tr>
<tr>
<td>How illegal drugs could affect my baby</td>
<td>75.9</td>
</tr>
<tr>
<td>Doing screening tests (birth defects)</td>
<td>90.2</td>
</tr>
<tr>
<td>Signs and Symptoms of preterm labor</td>
<td>85.7</td>
</tr>
<tr>
<td>What do do if depressed during or after pregnancy</td>
<td>83.9</td>
</tr>
<tr>
<td>Physical abuse to women by men</td>
<td>68.8</td>
</tr>
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Prenatal Care

Mothers Who Experienced Barriers to Receiving Prenatal Care as Early as Desired, by Maternal Age, 2009–2010*

<table>
<thead>
<tr>
<th>Age Group</th>
<th>BIBB Study</th>
<th>Total</th>
<th>19 Years or Younger</th>
<th>20-24 Years</th>
<th>25-29 Years</th>
<th>30-34 Years</th>
<th>35 Years or Older</th>
</tr>
</thead>
</table>
| Source: Centers for Disease Control and Prevention, Pregnancy Risk Assessment Monitoring System, 2009-2010. Analysis conducted by the Division of Reproductive Health, National Center for Chronic Disease Prevention and Health Promotion, Centers for Disease Control and Prevention.
Barriers to Receiving Prenatal Care at All or as Early as Desired Among Women Who Reported Delayed Care 2009-2010 vs BIBB study (2018-2019)

- Needed childcare for other children: 8.1% (BIBB Study) vs 7.9% (U.S. Mothers)
- Could not take time off work or school: 13.2% (BIBB Study) vs 9.8% (U.S. Mothers)
- Didn’t want anyone to know about: 13.9% (BIBB Study) vs 23.7% (U.S. Mothers)
- Lacked transportation to clinic or doctors: 12.5% (BIBB Study) vs 13.9% (U.S. Mothers)
- Mother was too busy: 21.9% (BIBB Study) vs 19.7% (U.S. Mothers)
- Doctor or health plan did not start as: 25% (BIBB Study) vs 24.1% (U.S. Mothers)
- Didn’t have a Medicaid card: 21.1% (BIBB Study) vs 36.4% (U.S. Mothers)
- Didn’t know she was pregnant: 23.7% (BIBB Study) vs 37.1% (U.S. Mothers)
- Couldn’t get appointment when desired: 65.6% (BIBB Study) vs 37.8% (U.S. Mothers)
- Lacked money or insurance for visits: 21.9% (BIBB Study) vs 38.7% (U.S. Mothers)

Source: Centers for Disease Control and Prevention, Pregnancy Risk Assessment Monitoring System, 2009-2010. Analysis conducted by the Division of Reproductive Health, National Center for Chronic Disease Prevention and Health Promotion, Centers for Disease Control and Prevention.
Quality of Prenatal Care Questionnaire (QPCQ)

- Developed by Heaman and colleagues, 2014 article; Canadian nurses
- Consists of 46 items (5 point Likert scale) with 6 factors:
  - Factor 1: Information Sharing
  - Factor 2: Anticipatory Guidance
  - Factor 3: Sufficient time
  - Factor 4: Approachability
  - Factor 5: Availability
  - Factor 6: Support and Respect
- Each item is scored: 46-230 range; a higher total or factor mean item score indicates higher quality of prenatal care.
- Administered within 8 weeks postpartum
Quality of Prenatal Care Questionnaire (QPCQ)

This questionnaire asks about the prenatal care you received from a physician, midwife, or other health care providers during your pregnancy. You might have seen more than one health care provider for your care but please think of the prenatal care you received overall when completing this questionnaire. Please read each statement carefully and indicate how much you agree or disagree with it by circling the appropriate number.

<table>
<thead>
<tr>
<th>Statement</th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Neither Agree nor Disagree</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. I had as much time with my prenatal care provider(s) as I needed</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>2. My prenatal care provider(s) gave me options for my birth experience</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>3. I was given adequate information about prenatal tests and procedures</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>4. I was given enough information to meet my needs about breastfeeding</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>5. My prenatal care provider(s) respected me</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>6. I was always given honest answers to my questions</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>7. My prenatal care provider(s) respected my knowledge and experience</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>8. My prenatal care provider(s) was rushed</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>
## Prenatal care  QPCQ Results: reliability, means

<table>
<thead>
<tr>
<th>Factors</th>
<th>Items</th>
<th>N</th>
<th>Mean Item Score (SD)</th>
<th>Total Score Range</th>
<th>Mean Total Score (SD)</th>
<th>Corrected Item-Total Correlation</th>
<th>Cronbach’s alpha if Item Deleted</th>
</tr>
</thead>
<tbody>
<tr>
<td>1: Information Sharing</td>
<td>9</td>
<td>109</td>
<td>4.24 (0.70)</td>
<td>9-45</td>
<td>38.14 (6.3)</td>
<td>0.95</td>
<td>0.89</td>
</tr>
<tr>
<td>2: Anticipatory Guidance</td>
<td>11</td>
<td>108</td>
<td>3.99 (0.77)</td>
<td>11-55</td>
<td>43.89 (8.5)</td>
<td>0.85</td>
<td>0.91</td>
</tr>
<tr>
<td>3: Sufficient Time</td>
<td>5</td>
<td>109</td>
<td>4.16 (0.72)</td>
<td>5-25</td>
<td>20.76 (3.6)</td>
<td>0.89</td>
<td>0.91</td>
</tr>
<tr>
<td>4: Approachability</td>
<td>4</td>
<td>107</td>
<td>3.97 (0.74)</td>
<td>4-20</td>
<td>15.85 (3.0)</td>
<td>0.53</td>
<td>0.94</td>
</tr>
<tr>
<td>5: Availability</td>
<td>5</td>
<td>109</td>
<td>4.19 (0.76)</td>
<td>5-25</td>
<td>20.94 (3.8)</td>
<td>0.92</td>
<td>0.91</td>
</tr>
<tr>
<td>6: Support and Respect</td>
<td>12</td>
<td>108</td>
<td>4.22 (0.74)</td>
<td>12-60</td>
<td>50.60 (8.9)</td>
<td>0.96</td>
<td>0.89</td>
</tr>
<tr>
<td><strong>Total QPCQ Score</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>191.84 (29.70)</td>
<td>0.92</td>
</tr>
</tbody>
</table>

**Prenatal care QPCQ Results:**
- **Sum of the 46 items:**
  - Total QPCQ Score: 191.84 (29.70)
  - Cronbach’s alpha if Item Deleted: 0.92
THANK YOU!!

Questions?

Contact: Rhonda Dailey, MD
rdailey@med.wayne.edu
Office: 313-577-6860
References


- Centers for Disease Control and Prevention, Pregnancy Risk Assessment Monitoring System, 2009-2010. Analysis conducted by the Division of Reproductive Health, National Center for Chronic Disease Prevention and Health Promotion, Centers for Disease Control and Prevention.

- Centers for Disease Control and Prevention, National Center for Health Statistics. 2011 Natality Public Use File. Analysis conducted by the Maternal and Child Health Bureau

References (cont’d)

- Vital Records and Health Statistics Section, Geocoded Michigan Birth Certificate Registries; Division for Vital Records and Health Statistics, Michigan Department of Community Health
Interactive Session on Implicit Bias

Vernice Anthony, BSN, MPH, VDA Health Connect
Alethia Carr, RD, MBA, VDA Health Connect
Objective: Apply health equity and the social determinants of health lens to all quality improvement projects implemented in FY2020

Activity: Support SEMPQIC members in drafting plans to create and implement written policies and procedures to address health equity and address the social determinants of health at their respective organizations. The goal is to have all members have policies and procedures implemented.

Measurement:
- Number of organizations with implemented written policies and procedures to address health equity and social determinants of health.
- Number of SEMPQIC member organizations
- Number of SEMPQIC agenda with an equity, implicit bias, social determinants of health learning opportunity
MIHEIP Primary Priorities

- Health Equity
- Healthy Girls, Women and Mothers
- Optimal Birth Spacing and Intended Pregnancy
- Full Term, Health Weight Babies
- Infants Safely Sleeping
- Mental, Emotional and Behavioral Well-Being
MIHEIP Primary Priorities: Implementation Methods

- Implement data-driven interventions based on data stratified by race, ethnicity, and geography
- Address systemic inequities
- Ensure inclusive decision-making
- Continued stakeholder engagement and feedback
- Assessing and connecting local assets and resources
“Efforts to reduce maternal and infant mortality and improve health outcomes cannot only focus on clinical interventions. They must address the underlying causes of maternal and infant mortality and acknowledge the underlying drivers of inequity, including poverty, racism, and discrimination.

Women and infants are at the center of Michigan families enjoying vibrant lives. Shaping their experiences are culture and history that are illustrative of beauty, intellect, ingenuity, and resilience. The numbers tell part of the story that clearly show the impact that systemic inequity is having on many Michigan families. Disparities in health outcomes for African American, Native American and Latino families are the result of systemic inequities.”
MIHEIP Health Equity Priorities: Action Steps

- Perform an initial assessment of organizational activities and health equity work that is underway in many sectors and systems (e.g. unconscious bias training, system assessments).
- Establish and support internal initiatives that specifically address social determinants of health and equity.
- Identify ways to streamline and simplify processes for families seeking MDHHS services.
- Assess lessons learned from projects such as the Kellogg Foundation funded Practices to Reduce Infant Mortality through Equity (PRIME) and a current Michigan Public Health Institute (MPHI) project, Achieving Birth Equity through Systems Transformation (ABEST).
MIHEIP Health Equity Priorities for Partners

**Partners May:**
- Implement data-driven interventions to ensure that populations that have been marginalized have access to services and resources needed.
- Model innovative strategies to address social determinants of health like transportation, housing and access to food to help families gain access to resources needed.
- Assess unconscious bias in providers who serve families and implement strategies to address it.
- Assess and improve how non-traditional health institutions (i.e. housing, environment, education) utilize a health and equity lens in policies and procedures.
SEMPQIC Goal

- Create a coordinated ... network for perinatal care ... that will result in improved birth outcomes for all babies born in southeast Michigan and narrow the disparity between black and white births...

Objective

- Build on existing services and address SDOH ... (to improve health equity)
Implementation Steps

× Meeting agendas include a topic related to Health Equity
× Agenda topics are designed to stimulate consideration and action in perinatal agencies

Our June meeting asked what next steps are needed to move Health Equity forward to support improved infant survival in Region 10.

Today, we want to share some ideas for next steps to implement health equity efforts as recommendations to the response of our members.
Membership Response

- Small agencies should work together, collaborating through MIHP on QI
- **Recommended Resource:** SEMPQIC
Membership Response

- Keep **equity** in the forefront
- Make yourself available and be intentional
- Collect demographic data and data by race – evaluate progress

**Recommended Resource:**
- *National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care*

[https://thinkculturalhealth.hhs.gov/](https://thinkculturalhealth.hhs.gov/)
Membership Response

- What is the accountability for action?
- Have your workforce represent who is served
- A deliberate system must be in place

Recommended Resources:
- Agency Assessment: **BARHII Tool**
- Annie E. Casey Foundation (AECF): *Race Matters: How to Talk About Race; Race Equity and Inclusion Guide; Embracing Equity: 7 Steps to Advance and Embed Race Equity and Inclusion Within Your Organization*

www.barhii.org
www.AECF-racemattershowtotalkaboutrace-2006.pdf
www.aecf.org/search/?q=Embracing+equity+7+steps
Membership Response

- Important to get leadership buy-in. How?
- Have a Community Plunge
- Check your own unconscious bias

Recommended Resources:
- Harvard Implicit Bias Website: [https://implicit.Harvard.edu](https://implicit.Harvard.edu)
- ASTHO – Health in All Policies: Strategies to Promote Innovative Leadership: [www.astho.org](http://www.astho.org)
- Health People 2020: [www.healthypeople.gov](http://www.healthypeople.gov)
- NACCHO – Roots of Health inequity: [www.rootsofhealthinequity.org](http://www.rootsofhealthinequity.org)
- Michigan PRIME: [www.prime.mihealth.org](http://www.prime.mihealth.org)
- National Prevention Strategy: [www.hhs.gov](http://www.hhs.gov)
- California Newsreel films on race and equity: [www.newsreel.org](http://www.newsreel.org)
- Podcasts by Dr. Camara Jones; Dr. David Williams
Healthy People 2020 SDOH

SDOH

- Economic Stability
- Neighborhood and Built Environment
- Health and Health Care
- Education
- Social and Community Context
NACCHO: Roots of Health Equity

- Web-based course for the Public Health workforce.
- www.rootsofhealthinequity.org
W.K. Kellogg Foundation funded project designed to integrate health equity in state administered programs in the areas of Maternal and Child Health

Is starting up again with equity workshops and learning labs targeting MCH programs. SEMPQIC Members will be invited to participate in FY 2020

www.prime.mihealth.org
California Newsreel – Health Equity Films

- *UnNatural Causes: Is Inequity Making Us Sick?*
- *Race: The Power of an Illusion*
- *The Raising of American: Early Childhood and the Future of Our Nation*
- [www.newsreel.org](http://www.newsreel.org)
Podcasts

- Dr. Camara Jones: Allegories on Race and Racism
  - TEDxEmory
  - https://www.youtube.com/watch?v=GNhcY6fTyBM

- Dr. David Williams: How Racism Makes us Sick
  - Ted Talk
  - https://www.ted.com/talks/david_r_williams_how_racism_makes_us_sick
Charge to Membership

Take 20 mins to…

- Discuss: what is possible in your agency?
  OR
- Discuss: what is possible in your unit in your control?
  OR
- Discuss: what can YOU do?

- Identify someone in your group to take notes and report out.

- How Microgressions Are Like Mosquito Bites – YouTube Video
Mother Infant Health and Equity Improvement Plan: Update and Town Halls

Kenyetta Jackson, MPH, MDHHS

Improvement Plan: https://www.michigan.gov/infantmortality/0,5312,7-306-88846---.00.html
Town Hall Registration: https://www.surveymonkey.com/r/2019-MIHEIP-TownHalls
Six Priority Areas

- Health Equity
- Healthy Girls, Women & Mothers
- Optimal Birth Spacing & Intended Pregnancies
- Full Term, Healthy Weight Babies
- Infants Safely Sleeping
- Mental, Emotional & Behavioral Well-Being
## Town Hall Meetings

<table>
<thead>
<tr>
<th>Region 10 County</th>
<th>Date/Time</th>
<th>Location</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oakland County</td>
<td>Sept 19; 6-8 pm</td>
<td>Franco Auditorium Saint Joseph Mercy Oakland 44405 Woodward Ave Pontiac, MI 48341</td>
</tr>
<tr>
<td>Macomb County</td>
<td>Sept 24; 6-8 pm</td>
<td>Room 103A/B Macomb Intermediate School District (MISD), 44001 Garfield Road, Clinton Township, MI, 48038</td>
</tr>
<tr>
<td>Wayne County</td>
<td>Sept 26; 5-7 pm</td>
<td>CAT Building Focus: Hope 1400 Oakman Blvd, Detroit, MI 48238</td>
</tr>
</tbody>
</table>
Health Equity and Social Justice Learning Labs

- Building on PRIME
- September 12th & 25th
- Future sessions
Other MDHHS Updates

Leadership and Bureau Updates

Continued Health Equity Efforts
∞Within MDHHS
∞With MCH Partners
Call to Action
What you can do

01
Sign up for the MIHEIP newsletter

02
Connect with your RPQC

03
November 14, 2019
Attend a MIHEC Meeting
Ann Arbor, Michigan
MOTHER INFANT HEALTH & EQUITY IMPROVEMENT PLAN

TOGETHER, SAVING LIVES
Thank You!

Kenyetta Jackson
Health Equity Consultant
SEMPQIC Consultant
JacksonK29@michigan.gov
Announcements
Safe Sleep Sabbath

- September is Safe Sleep Awareness Month
- Partnership between GDAHC, Henry Ford Health System, Great Start Collaborative Wayne and Detroit Health Department to target the faith community in southeast Michigan to advocate for safe sleep protocols among their congregation
- Messaging to be shared via social media and bulletins during the week of September 23
- Copies of messaging available (printed or by contacting Devon Parrott)
## Safe Sleep Sabbath Sample Messaging

<table>
<thead>
<tr>
<th>Date</th>
<th>Facebook</th>
<th>Twitter</th>
<th>Instagram</th>
<th>Bulletin</th>
</tr>
</thead>
<tbody>
<tr>
<td>Monday, September 23, 2019</td>
<td>Every 3 days, a baby dies in Michigan when sleeping in an unsafe place or position. 356 babies died due to unsafe sleep environments in Wayne County with 254 babies dying in Detroit. <strong>These deaths are preventable.</strong> Learn more at <a href="http://bit.ly/2kwEuHm">http://bit.ly/2kwEuHm</a></td>
<td>Every 3 days a Michigan baby dies when sleeping in an unsafe place or position. Learn more at <a href="http://bit.ly/2kwEuHm">http://bit.ly/2kwEuHm</a> #SafeSleepDetroit #SafeSleepWayneCounty</td>
<td>Every 3 days a Michigan baby dies when sleeping in an unsafe place or position. #SafeSleepDetroit #SafeSleepWayneCounty</td>
<td>Every 3 days, a baby dies in Michigan when sleeping in an unsafe place or position. 356 babies died due to unsafe sleep environments in Wayne County with 254 babies dying in Detroit. <strong>These deaths are preventable.</strong> Learn more at <a href="http://bit.ly/2kwEuHm">http://bit.ly/2kwEuHm</a></td>
</tr>
</tbody>
</table>
Thank you for attending!

Next meeting: January 21, 2020

www.gdahc.org/SEMPQIC