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PROMOTING EXCELLENCE IN WOMEN'S HEALTHCARE in GEORGIA

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2020 Fall Legislative Update

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GOGS Legislative Committee Co-Chair

The local, national, and international events of the past six months have been, in a word, unimaginable. Since my last "Legislative Update" (February 2020), we have been confronted by a global pandemic that has politicized science and public health and metamorphosed every aspect of our daily lives. We have also seen national indignation over police brutality and overdue public discourse regarding systemic racism and the prioritization of diversity, inclusion, and equity. While these times are certainly unprecedented — and often disheartening — our advocacy efforts have become more critical than ever. Atlanta lost a great man when John Lewis passed away in July, but his voice lives on and words like these push us forward: "Do not get lost in a sea of despair. Be hopeful, be optimistic. Our struggle is not the struggle of a day, a week, a month, or a year, it is the struggle of a lifetime. Never, ever be afraid to make some noise and get in good trouble, necessary trouble."

Our GOGS Legislative Committee may not be getting in precisely the good and necessary trouble to which Lewis was referring, but we have certainly been hard at work on the legislative advocacy front. When we have been lobbying for our 2020 health policy priorities, we have been, in our own way, advocating to improve the health and livelihood of Georgia physicians, women and infants — despite a debilitating virus, in the face of institutional injustice, and regardless of race, ethnicity, or socioeconomic status.

GOGS' primary focus during the Georgia General Assembly 2020 Session was to continue the fight to improve our state's maternal mortality/morbidity rates and disparities. Georgia's 2019 House Study Committee on Maternal Mortality (which included GOGS Advisory Board Members) recommended postpartum Medicaid extension as a vital strategy, and GOGS' main "ask" during this year's Georgia Patient Centered Physicians Coalition "Day at the Capitol" was means to support this measure. To that end, I am thrilled to report that House Bill 1114 passed both chambers (despite the intervening COVID-related months-long recess) and was approved for $19 million in funding (despite an overall 10% cut to the state budget due to COVID). This (now) law extends comprehensive Medicaid coverage for low-income Georgia mothers to six months postpartum and provides for lactational support services. While a one-year Medicaid extension is certainly the ultimate goal – to facilitate ongoing monitoring, diagnosis, and management of potentially fatal postpartum issues like mental illness, addiction crisis, hypertension, and cardiovascular disease – the magnitude of this victory in the current state of affairs simply cannot be overstated.

Notably, another almost $2 million of the slashed FY 2021 budget was also allocated to increase Medicaid reimbursement rates for selected E&M codes. Both the Medicaid postpartum extension and outpatient rate raise will help ob/gyns across Georgia keep their doors open during the COVID pandemic (especially in rural areas, where the payor mix is dominated by Medicaid, and maternal mortality rates and health disparities are often magnified).

In other good news from the Georgia capitol, none of the bills involving licensure of certified professional midwives ("lay midwives") came to a vote on the chamber floor. This success was due at least in part to testimony provided by GOGS Legislative Committee members. As we emphasized at the committee hearings, our organization

Continued on page 3

Important Dates

Cancelled
GaPQC Learning Series 10/6

December 4, 2020
Virtual Coding Webinar

February 25, 2021
Legislative Day

May 12, 2021
Golf Tournament

August 19-22, 2021
GOGS Annual Educational Meeting

in this issue

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Legislative Update (*Continued from page 1*)

certainly has an interest in expanding access to obstetric services, particularly in our state's rural shortage areas. However, it is critical that any midwife seeking to provide maternity care to Georgia women meet minimum education and training standards, and CPMs traditionally do not.

Unfortunately, Georgia's first true attempt at tort reform legislation in 15 years (Senate Bill 415) failed to pass the Senate and cross over to the House. In partnership with the Medical Association of Georgia and our legislator allies at the capitol, our GOGS Legislative Committee will certainly attempt to reintroduce this critical issue next year. Georgia now ranks 6th on the list of "Top 10 Judicial Hellholes" and 41st in the U.S. Chamber of Commerce's Lawsuit Climate Survey. In an increasingly litigious society, it is critical we make an effort to control professional liability costs. Georgia is already struggling with a shortage of obstetricians, so we must do everything we can to make our state a more attractive place to practice. To that end, one last-minute bright spot this Session was the Assembly's passage and the Governor's approval of Senate Bill 359, which provides certain liability protections for Georgia healthcare providers (including a heightened standard of gross negligence) during the COVID pandemic.

Before retreating into quarantine in mid-March, GOGS members did have the opportunity to meet with state elected officials at the Georgia Patient Centered Physicians Coalition "Day at the Capitol" (March 5th) and with federal elected officials as part of the ACOG Congressional Leadership Conference in Washington, DC (March 10th). At the Georgia capitol, we lobbied for postpartum Medicaid extension, medical liability reform, and stringent midwifery licensure processes. At the U.S. Capitol, we advocated for increased NIH funding for women's health research and for postpartum Medicaid extension, as well. Furthermore, we asked our U.S. legislators to urge the Centers for Medicare and Medicaid Services (CMS) to correct an oversight in which they did not apply E&M payment increases to global maternity care codes (which was anticipated to lower payment rates overall for obstetric care). As a result, in early August CMS announced a proposal to increase the relative value of global obstetric care packages commensurate with increases for other types of office visits. ACOG is still working with a broad coalition of other medical societies to waive the Medicare budget neutrality requirements for 2021 and thereby stop any further payment cuts.

While we have not seen each another in-person since these pre-COVID advocacy events, our GOGS Legislative Committee continues to be in communication via Zoom calls and WhatsApp messaging. I am excited to announce that we recently reinvigorated the GOGS GynPAC Subcommittee, which has been strategizing a transparent process by which to evaluate and select state candidates deserving of PAC support. We are also developing processes by which we will hold elected officials accountable for their actions, or subsequently consider directing their funds to others. Furthermore, our Georgia Section recently submitted our inaugural application to the ACOG Ob-Gyn PAC Committee to request campaign contributions from this federal PAC to support our most-valued local women's health champions. We are optimistic these supplemental funds may be an asset to our political strategy for years to come.

Moving forward, while we anxiously await the November elections and the 2021 Georgia General Session, our GOGS Legislative Committee will continue to closely monitor COVID-related policies, with a focus on extending coverage and maximizing reimbursement for telehealth services. Please do not hesitate to contact me with suggestions for legislative priorities, advocacy strategies, or anything at all. Thank you, as always, for staying engaged in our efforts to improve the health and healthcare of the women of Georgia. Our committee is proud to serve you!

Top 7 Insurance and Legal Questions for Resuming Medical Practice During COVID-19

By: Todd Zeiter, *Vice President of Underwriting, The Doctors Company*

We've heard from physicians that they are concerned about the risks involved in reopening their practices and resuming elective procedures. In response to these concerns, the following are answers to the top questions from our members and doctors across the country:

Q: Am I covered for employee claims involving COVID-19?

A: If an employee of yours makes the claim that you failed to provide a safe work environment that claim would fall outside of your medical professional liability coverage.

Q: Am I covered if a patient alleges they contracted COVID-19 in my office?

A: If you are covered by The Doctors Company, the short answer is yes. The longer answer involves separating what the physician can't control from what they can. Perform daily reviews of any new CDC guidelines, train your staff, and maintain infection control standards — and document that you are doing those things.

Q: Can I continue my practice contrary to state recommendations?

A: We will rely on your professional judgment relative to your practice and your patients' best interests. We encourage you to follow all state mandates, laws, bulletins, and orders.

Q: If I cannot yet resume my usual level of patient interaction, can I adjust my coverage to reduce my premium?

A: The Doctors Company offers two types of coverage adjustment: reduction in time and/or reduction in the nature of procedures performed. Either or both would reduce premium.

Q: Am I covered if I provide services outside the scope of my specialty?

A: If you're being requested to provide services outside of the scope of your specialty your coverage with The Doctors Company will not be impacted. We will rely upon your professional judgment.

Q: Assuming elective surgeries or procedures are allowed, what special considerations apply during COVID-19?

A: The return to offering procedures will be a gradual process. Use your best judgment to determine whether you have the capability to safely perform the procedure. Additionally, no one knows what things will look like in a year or two, so documenting clinical reasoning based on conditions right now is critical.

Q: What if I have documented my best clinical judgment, but the insurer disagrees? Will I still be defended in case of a suit?

A: If you are a member of The Doctors Company, you can count on aggressive, effective defense of your claim. We do not cast doubt on our members' clinical judgment. However, we strongly recommend that you document your clinical reasoning in case of a suit.

The guidelines suggested here are not rules, do not constitute legal advice, and do not ensure a successful outcome. The ultimate decision regarding the appropriateness of any treatment must be made by each healthcare provider considering the circumstances of the individual situation and in accordance with the laws of the jurisdiction in which the care is rendered.

A Prematurity Collaborative Birth Equity Consensus Statement for Mothers and Babies

Fleda Mask Jackson[1], Kweli Rashied-Henry[2], Paula Braveman[3], Tyan Parker Dominguez[4], Diana Ramos[5], Noble Maseru[6], William Darity[7], Lisa Waddell[2], Donald Warne[8], Gina Legaz[2], Rahul Gupta[2], Arthur James[9],

ABSTRACT

Introduction

In 2016, March of Dimes (MOD) launched its Prematurity Collaborative to engage a broad cross section of national experts to address persistent and widening racial disparities in preterm birth by achieving equity and demonstrated improvements in preterm birth. African-American and Native American women continue to have disproportionate rates of preterm birth and maternal death. As part of the Collaborative, MOD created the Health Equity Workgroup whose task was the creation of a scientific consensus statement articulating core values and a call to action to achieve equity in preterm birth utilizing health equity and social determinants of health frameworks.

Methods

Health Equity Workgroup members engaged in-person and virtually to discuss key determinant contributors and resolutions for disparate maternal and birth outcomes. Workgroup members then drafted the Birth Equity Consensus Statement that contained value statements and a call to action. The birth equity consensus statement was presented at professional conferences to seek broader support. This article highlights the background and context towards arriving at the core values and call to action, which are the two major components of the consensus statement and presents the core values and call to action themselves.

Results

The result was the creation of a birth equity consensus statement that highlights risks and protections of social determinants based on the prevailing science, and identifies promising solutions for reducing preterm birth and eliminating racial disparities.

Conclusion

The birth equity consensus statement provides a mandate, guiding the work of March of Dimes and the broader MCH community, for equity-based research, practice, and policy advocacy at local, state, and federal levels.

Significance

This field report adds to the current knowledge base on racial and ethnic disparities in birth and maternal health outcomes. Research has documented the science behind eliminating health disparities. Scientists and practitioners should continue to explore in practice how the social determinants of birth and maternal health, which manifest historically and contemporarily, can be addressed.

Keywords

Birth equity · Health equity · Equity · Preterm birth · Social determinants · Social sciences · Maternal

Introduction

Building upon its past successes in eradicating polio, March of Dimes (MOD) shifted its focus in 2003 to prematurity, with the goal of decreasing the preterm birth rate by at least 15%. Between 2015 and 2017, the U.S. preterm birth rate increased from 9.6 to 9.8%. Preterm birth rates were 50% higher among non-Hispanic black/African-American women and 20% higher among American Indian/Alaska Native women compared to non-Hispanic white women (March of Dimes 2018). African-American and Native American women continue to have disproportionate rates of preterm birth and maternal death. (Note: In this statement the terms "black" and "African-American," and "American Indian/Alaskan Native" and "Native American" are used interchangeably.)

Maternal death rates have also increased and are 3 to 4 times higher for black women than white women (Building U.S. Capacity to Review and Prevent Maternal Deaths 2018). The United States is the only industrialized nation that has seen a rise in the maternal death rate, even as rates in other countries have declined. Recent figures reveal 700 women die each year from pregnancy-related complications (Building U.S. Capacity to Review and Prevent Maternal Deaths 2018).

Complex explanations exist for adverse birth and maternal outcomes; nonetheless, scientific evidence indicates that unequal health care, socio-economic and racial inequalities pose significant health risks to pregnant women and their babies (Solar and Irwin 2010; WHO 2017; Smedley et al. 2003). In 2016, March of Dimes launched its Prematurity Collaborative to engage a broad cross section of national experts to address persistent and widening racial disparities in preterm birth by achieving equity and demonstrated improvements in preterm birth. The Collaborative, co-chaired by MOD and the Centers for Disease Control and Prevention (CDC), consisted of several work groups: Access to Care, Policy, and Health Equity. In 2017, the Health Equity Workgroup was established to guide the work of all Collaborative members.

The Health Equity Workgroup expanded its focus to include the health of mothers, recognizing that strategies used to reduce premature birth also support and promote maternal health. This work was informed by scientific research; the Collaborative's guiding principles on equity; the World Health Organization's SDOH framework; and the United Nations human rights declaration (Glendon 2001; World Health Organization 2017).

As part of the Collaborative, March of Dimes created the Health Equity Workgroup whose task was the creation of a scientific consensus statement articulating core values and a call to action to achieve equity in preterm birth utilizing health equity and social determinants of health (SDOH) frameworks.

The objectives for the Health Equity Workgroup were to:

- Advance SDOH as the primary basis for disparities in maternal and birth outcomes;
- Articulate and advance core birth equity values to guide the work required to achieve the best possible maternal and birth outcomes for all mothers and babies;
- Create a call to action with equity-focused recommendations for work across and beyond the Collaborative, based upon the core values and the current science.

Continued on page 8

Rural Georgia's Champions for Maternal Heart Disease Awareness

By: Lauren Nunally, *MPH, BSN, RNC-OB*

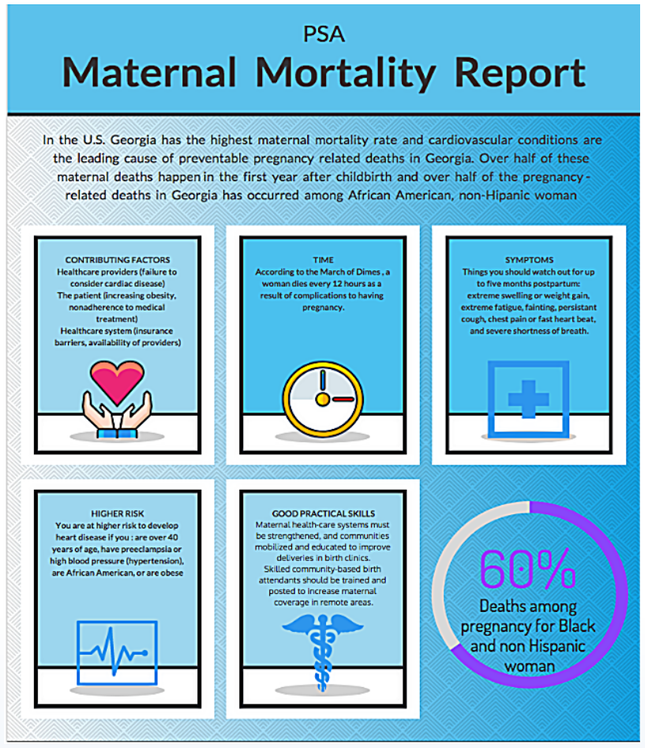
WomenHeart

WomenHeart is a national coalition founded in 1999 by three women who had suffered heart attacks in their 40s and found they had shared experiences such as delay in final diagnosis, feeling isolated, uninformed and depressed until meeting while being interviewed for a magazine article on women and heart attacks.

Sandy Wells RN and Alicia Roberts, who unfortunately has recently passed away, have been the coordinators of WomenHeart Hinesville. Sandy will continue in her role as Co-founder of the organization. The impressive development of this team of dynamic and determined women began when Alicia was diagnosed with cardiomyopathy and congestive heart failure soon after delivery of her daughter when she was just 26 years old. Alicia attended cardiac rehab for therapy, facilitated by her nurse, Sandy. For additional support with adjusting to the life changing medical condition, Alicia joined WomenHeart Savannah. Inspired by the program and developing a more positive outlook to her prognosis, Alicia decided to undergo training provided by the national organization and became an educator for WomenHeart.

WomenHeart Hinesville

The Hinesville chapter of WomenHeart, was founded in February, 2018. Their goal is to increase awareness and provide support to women who are at risk, currently have or have had heart disease. This is achieved through monthly support groups, through health services provide by WomenHeart at Work, regular walk schedules and other special events. WomenHeart Hinesville has partnered with Liberty Regional Medical Center (LRMC) to enhance its community outreach efforts and to serve as a referral source for local cardiac care and rehabilitation.



Liberty Regional is 1 of only 2 Critical Access Hospitals that still deliver babies. Through their own Perinatal Quality Collaborative Program, they have been participating with the GaPQC and reporting data since April 2018. The data reported contains measures related to Process, Structure and Outcome. Process Measures include provider education and protocol, risk assessment and quantified blood loss. Structure Measures include patient, family and staff support, debriefs, multidisciplinary case review, hemorrhage cart, unit policy and procedure, and EHR integration. The Outcome Measures reflect the goal of the program which is to decrease the overall rate of Maternal Mortality and Morbidity.

Dr. Seth Borquaye, OB/GYN, of Liberty Obstetrics and Gynecology, and Dr. Akinniran Abisogun, Cardiologist with SouthCoast Health, are consulting physician partners of the support group. Other partners include Resurrection Ink, Liberty County Chamber, Liberty County Minority Chamber, Liberty County School System, Liberty Regional Medical Center and the City of Hinesville.

Management of Cardiac Disease in Pregnancy and Postpartum

Every pregnant woman at LRMC that has chronic HTN, gestational HTN, or preeclampsia is referred for a complete cardiac workup. This information is used as a baseline for any future issues. Before being discharged home, the OB nurses make sure all postpartum mothers that have risk factors are provided with detailed discharge instructions that include a signs and symptoms flyer, infographic educational sheet, CVD risk factor educational sheet and how to recognize symptoms that warrant immediately contacting a healthcare provider or return to the hospital. Patients who are at risk for heart disease or those that may already have signs of heart disease are also referred to Dr. Abisogun for a cardiology follow up, with most women being seen within 3 weeks of delivery.

WomenHeart Banquet

The WomenHeart Banquet was held during national heart health week to educate the community about the pressing issue of heart disease. The Hinesville team came up with ways to involve the community by having a WomenHeart Health Infographic Challenge for the students as part of the Healthcare Pathways at Liberty College and Careers Academy. The 1st, 2nd and 3rd place winners were recognized at the February meeting of the Hinesville City Council. A PSA video was also developed for educating the community, where local survivors shared their experiences and humanized the issue of perinatal cardiac disease. This video and the infographic sheet are being used to educate postpartum mothers at LRMC.

Why We Fight Campaign

The health of the community has always been the primary drive for WomenHeart Hinesville and leading the charge to lower the maternal mortality rate in the state of Georgia is important for the community now and in the future. The "Why We Fight" Campaign brought together patients, the medical community, educators, businesses and community leaders to make a change. The primary focus is reeducating the public and even health care providers to consider heart disease as a potential cause for complications during pregnancy and postpartum. WomenHeart Hinesville's goal is to educate and inspire.

A major challenge the Hinesville team faces with the community they serve is behavior or lifestyle changes. While they acknowledge people need continued support and coaching, funding for these activities is difficult to come by.

Future goals

The WomenHeart Hinesville purposes to:

- Work with LRMC to educate medical staff about the risk of cardiovascular disease in women who have complications during pregnancy. This includes prioritizing education, training and access to medical resources for healthcare providers.
- Educate on the importance of life-style modification when risk factors are present.
- Perform research to determine the impact of lifestyle modification on heart disease in women who have complications during and/or after pregnancy.
- Community outreach to provide awareness of the risks and ways to prevent progression of the disease.
- Call upon city governments, education systems and businesses to partner with the medical community to educate the community about lifestyle modifications.

The remarkable work this multidisciplinary team performs in the corner of the state is no doubt a model of best practice that appears to be easily replicable in other locales. The impact of their outreach interventions may seem to be the tip of the iceberg; nevertheless, they continue with gusto and tenacity to raise awareness of cardiovascular disease in women, targeting not just those at risk, but all members of the community who have a loved one who could benefit from the knowledge gained.

Overview of Peripartum Cardiomyopathy:

Peripartum cardiomyopathy (PPCM) is defined as heart failure that may develop toward the end of pregnancy or in the months following delivery, where no other cause of heart failure is identified. The etiology remains ambiguous but symptoms can be mild or severe. Though prognosis has improved substantially over the past several years, women with peripartum cardiomyopathy are still at risk for adverse outcomes.

Preeclampsia and eclampsia are associated with PPCM and may have shared pathophysiology.

Stats in U.S. and GA

Peripartum cardiomyopathy occurs in 25–100 per 100,000 live births in the United States. According to the ACOG Practice Bulletin, #212; Pregnancy and Heart Disease, in the U.S., cardiovascular disease is currently the primary cause of death in pregnant women and women in the postpartum period, (4.23 deaths per 100,000 live births), equating to 26.5% of pregnancy-related deaths. MMR data from 2012-2015 revealed Cardiomyopathy accounted for over 25% of pregnancy related deaths. (DPH 2020)

Most women (50-80%) will make a full recovery with a normal or near-normal ejection fraction within the first 6 months after developing PPCM. These women have significantly lower mortality rates and better chances of improved cardiac function.

Of the women who continue to have reduced cardiac function, subsequent pregnancies are associated with a 25% mortality rate and ongoing decline in cardiac function. However, with increased recognition and understanding of heart failure management and improved treatment, PPCM mortality rates have decreased to as low as approximately 3% within 6 months postpartum.

Management

ACOG recommends patients with moderate and high-risk cardiovascular disease should be managed during pregnancy, delivery, and the postpartum period in medical centers with, at a minimum, a multidisciplinary team that includes obstetric providers, maternal–fetal medicine subspecialists, cardiologists, and an anesthesiologist.

References:
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WomenHeart https://www.womenheart.org/

Dedication

This article is dedicated to the memory of

Alicia Roberts

10/6/1983 - 2/23/2020.

Birth Equity Consensus Statement for Mothers and Babies (*Continued from page 5*)

This document presents the work of the Health Equity Workgroup that resulted in a birth equity consensus statement on the key drivers of prematurity and maternal mortality disparities to prompt transformation and advancements in research, policy, and advocacy.

Methods

The MOD Prematurity Collaborative Health Equity Work-group is comprised of approximately 300 individuals who represent a cross-section of partners committed to maternal and child health. Members were invited or requested to join. Quarterly meetings were facilitated in-person and virtually and offered insight into best practices for reducing racial and ethnic disparities in birth outcomes. The initial effort of the Workgroup was to produce a set of guiding principles and glossary to achieve equity in preterm birth. Workgroup members discussed key determinant contributors and resolutions for disparate maternal and birth outcomes and convened to write the birth equity consensus statement to reinforce inquiry and action by the social sciences based on the equity and SDOH perspectives. Workgroup members then drafted the Birth Equity Consensus Statement that contained value statements and a call to action. The birth equity consensus statement was presented at professional conferences to seek broader support. This article specifically highlights the background and context towards arriving at the core values and call to action, which are the two major components of the consensus statement and presents the core values and call to action themselves.

This work was conducted in accord with prevailing ethical principles and does not constitute human subjects research. The manuscript is not based upon clinical study or patient data.

In the review of the literature we identified the following core areas: health care access, psychosocial conditions and economic inequality that were of interest to the Health Equity Workgroup participants, which led to generating a consensus agreement process of the Collaborative. The following sections provide support for the consensus statement components.

Equity is a human right built upon the belief that all individuals are of equal worth and should be afforded respect, dignity, justice, and fairness. When applied to health, health equity means that all human beings must have every opportunity that is fair and just to achieve optimal health (Braveman et al. 2018). According to the CDC, health equity is when everyone has the opportunity to be as healthy as possible (CDC 2020). By extension, birth equity is "the assurance of the conditions of optimal births for all people with a willingness to address racial and social inequalities in a sustained effort." (National Birth Equity Collaborative 2019).

MOD's creation of a birth equity consensus statement emphasizing SDOH aligns with an expanding approach within the broader MCH community. This direction highlights SDOH as an explanation for racial disparities alongside medical and biological causes. While discourse persists about SDOH versus medical/biological explanations for racial and ethnic disparities, evidence points to SDOH playing a significant role in birth and maternal health outcomes (Solar and Irwin 2010).

While not explicitly applied to maternal and birth outcomes, the work of President and MOD founder, Theodore Roosevelt and First Lady Eleanor Roosevelt, director of the United Nations Human Rights agenda, foretold the significance of equity and SDOH. The Prematurity Collaborative's creation of a birth equity consensus document draws, in part, upon past MOD initiatives, the social reform legislative agenda of President Roosevelt and the human rights agenda led by Eleanor Roosevelt.

Through MOD early support for development and dissemination of a polio vaccine for all children, polio declined drastically to almost virtual elimination. The initial work of MOD, however, was not without controversy. Black civil rights leaders, journalists, sororities, and health professionals challenged the organization's early acquiescence to segregation and discrimination, which limited access to polio care and resources for blacks especially in the Deep South (Mawdsky 2010). Their efforts led MOD to hire Charles Bynum, in 1944, to champion the inclusion of African-Americans in all aspects of the national polio eradication campaign and treatment centers during the height of the epidemic (Mawdsky 2010). The work of the Prematurity Collaborative builds upon the premise of equality advanced by President Roosevelt and the First Lady to uphold equity and its requirement for specific resources to address the key drivers of disparities for black and Native American women.

Health Care Access

In 2016, the U.S. spent nearly twice as much on health care as 10 other high-income countries (Papanicolas et al. 2018), yet its infant and maternal mortality outcomes were among the worst. The reasons for poorer overall U.S. health outcomes are multifaceted; however, subpar health care is a key factor (Howell et al. 2016). Less accessible health care due to affordability and availability within communities of poor women and women of color who are at the highest risk impedes improved maternal health and pregnancy outcomes (Prather et al. 2018).

Besides access, unequal treatment in the health care system, stemming from implicit or explicit bias is a significant health risk for pregnant women and their babies (Smedley et al. 2003). Institutionalized racism in health care has a long history of denying women of color the best possible pregnancy and maternal care. These injustices can be traced back to the beginnings of modern gynecological practices. For example, in the 1800s as scientific racism emerged, enslaved black women were brutally experimented upon without anesthetics to develop gynecological procedures (Roberts 1997). The long-held belief that blacks have a higher tolerance for pain continues to be a basis for denying black women equitable health care (Hoffman et al. 2016). Similarly, Native American women have a history of forced sterilization as part of reproductive health care received at Indian Health Services; and controversy continues around the testing of high dose hormonal contraceptives with Puerto Rican women (Lawrence 2000; Liao and Dollin 2012).

Recent investigations suggest that while interventions are available to inhibit premature birth and prevent adverse maternal outcomes, black women and other women of color have not had equal access to these treatments (Rowley and Hogan 2012). The marginalization of poor women and women of color by health care systems, along with the history of scientific misconduct in the care of African-American, Latina and Native American women, has created distrust. Continued skepticism and distrust are not unwarranted as sub-standard quality of care is often commonplace in health care systems that serve under-resourced communities.

Inequity in maternity care provides only a partial explanation for the rising rates and persistent disparities in preterm birth and maternal mortality. SDOH—the socio-environmental exposures connected to the places where individuals are born, grow, live, age, work and play — exert a major influence on health outcomes. Research connecting health outcomes to SDOH illustrates the significance of equitable policies on housing, education, and childcare (Din-Dzietham and Hertz-Picciotto 1998; Polednak 1996). While 60% of poor health can be attributed to factors outside of health care, when it comes to spending on social services, the U.S. ranks in the bottom 10 among developed countries (Freedman 2018).

Psychosocial Conditions

The significance of racial segregation in the context of increased rates of preterm birth has relevance for social policies. Well before public health and medical communities studied the ill health effects of racial inequities in segregated neighborhoods, the work of Kenneth and Mamie Clark foretold the current research connecting place-based inequalities to disparate physical and mental health outcomes (Clark and Clark 1950). Their work demonstrating the damaging effects of racism on the psychological growth and development of black children became the scientific basis for the passage of the most significant decision on racial equality in the twentieth century, Brown v. Board of Education in 1954.

Non-medical factors can help explain persistent disparities in birth outcomes. College-educated black women have worse birth outcomes than their white college-educated counterparts (Din-Dzietham and Hertz-Picciotto 1998). They also fare worse in comparison to white women who are less educated, unemployed, and uninsured. Studies exploring a solely genetic explanation for consistent racially disparate birth outcomes remain unproven, inconclusive, and unproductive towards dispelling false narratives of the origins of race as a biologic construct (David and Collins 2007).

Intersectionality refers to the convergence of multiple identities and forms of discrimination (Jackson et al. 2001). When appropriated within a birth equity context, it reveals how racism and sexism simultaneously produce emotional and physiological responses that can lead to poor birth outcomes (Nuru-Jeter et al. 2009). Evidence shows a significant association between lower birthweight and racial discrimination experienced by black women (Dominguez et al. 2008). Research also shows the link between stress resulting from gendered racism and antenatal depression that places both mother and infant in jeopardy (Jackson et al. 2012).

The risk for poor birth outcomes as a consequence of SDOH begins long before pregnancy and childbirth. The accumulation of environmental exposures, starting in utero, may determine differential risks and protection for health outcomes across the life course (Shonkoff et al. 2012). In the case of pregnancy and inequity, studies suggest that repeated stress that accumulates over time triggers responses leading to early birth (Jackson et al. 2012). The "weathering" over time, from constant assaults from inequity places a woman at risk of an adverse pregnancy outcome (Geronimus 1992), conferring risk upon her infant for compromised health throughout the life course (Barker 2012). The study of epigenetics builds on these associations by exploring gene expression based on environmental changes and considers the multi-generational impact of these biological changes (NASEM 2019). Further examination in this growing area is needed.

Economic Inequality

Economic inequality in the U.S. is "a product of historical and present-day forms of racism: labor, housing and other policies and practices…" (Kraus et al. 2017). Despite racial progress, racially based economic inequality contributes to poor health, including poor birth outcomes. While poverty certainly has an adverse impact on pregnancy, surprisingly poorer birth outcomes among well-educated black women may be linked to stress from incongruence between class expectations and racial economic inequalities, including a significant wealth gap (David and Collins 2007).

Compared to $1 earned in this country by a white male, Latina women earn 54 cents, African-American women earn 63 cents, and white women earn 78 cents (Kraus et al. 2017). African-American families earn just $57.30 for every $100 in white households (Kraus et al. 2017). Data also show the considerable wealth gap between black and white families, where black families hold on to less than 7 cents for every $1 a white family possesses (AAUW 2019). Even when a white family is near poverty, it has $18,000 in median wealth; whereas, a black family near poverty has a median wealth of near $0 (Kraus et al. 2017; AAUW 2019).

Further exploration of how the wealth gap contributes to poorer birth outcomes for well-educated women is needed. Unemployment, low wages, incarceration, and social policies affecting black fatherhood also present major impediments to a family's economic stability. As skillfully articulated in a policy brief (Paul et al. 2018), we must build up the transformational vision of President Roosevelt to take bold action for families, mothers, fathers, and children by providing decent and significant employment for all Americans (FDR Presidential Library and Museum 2019).

The following section includes the actual result of these findings, which led to the consensus statement that highlights risks and protections of SDOH based on the prevailing science and identifies promising solutions for reducing preterm birth and eliminating racial disparities.

Results: Collaborative Core Belief Statements on Birth Equity

Health equity requires addressing equity not only in health care but in all human-made and modifiable determinants of health (DeSisto et al. 2018). Justice and fairness, as the foundations of equity, demand rectifying historic and current injustices. Injustices may occur among marginalized or excluded groups of people based on their multiple and intersectional identities and/or other characteristics closely linked with social exclusion, marginalization, and social disadvantage. Therefore,

1. We believe that health is a human right and, we expect health with quality, accessible and affordable health care for everyone that is supported by equitable conditions across all sectors representing SDOH (education, transportation, housing, etc.).
2. We believe that ALL mothers and babies, regardless of race, ethnicity, culture, language and national origin; poverty and socioeconomic status; gender identity and sexual orientation; disability; and region and place (urban and rural) must have every opportunity for optimal maternal and birth outcomes.
3. We embrace birth equity as a directive for confronting inaccessible and inadequate prenatal and maternal health care, while challenging the

Continued on page 10

Birth Equity Consensus Statement for Mothers and Babies (*Continued from page 5*)

inequalities in the distribution of power, income, wealth and other related factors (housing, employment, transportation) that contribute to persistent, unfair conditions expectant mothers impacted by negative birth outcomes endure.

4. We believe that undoing historical and contemporary patterns of racial and gender discrimination is imperative for disrupting implicit and explicit bias, miseducation and exclusionary customs and practices that can have dire health consequences for expectant mothers and babies that permeate systems of care; practice and treatment; education and research; public policies; communications; and access to funding and resources.
5. We respect the authoritative knowledge and assets among affected women, families and communities and regard their intersectional perspectives as paramount for the conceptualization and conduct of equity-driven research and its translation into maternal, paternal and child health education, practices and policies that are just and fair.
6. We believe that pursuit of explanations for racially disparate birth and maternal outcomes must employ social science disciplines and methods to best examine social and economic disadvantages as well as community and population assets for maternal mental and physical health.
7. We believe that scientific examination of the biological, clinical, social and environmental contributors to prematurity and maternal mortality must be inclusive of an equity framework in order to accelerate and translate reproductive health research and medical breakthroughs into innovative and accessible health care practices and policies that are equitable and beneficial for ALL expectant mothers and their infants.
8. We believe that the experience, expertise and leadership of researchers, practitioners and policymakers from historically underrepresented communities should be prioritized for birth equity solutions, including the provision of commensurate funding levels to advance equity for moms and babies.

Call to Action and Conclusion

March of Dimes must exhibit the same collective will and dedicate needed resources that were instrumental for ending the polio epidemic to achieve birth equity. Following approaches to expand social determinant pathways for research, policy, and practice to promote health equity and thereby eliminating racial disparities in maternal and birth outcomes, we recommend:

- Expanding the scope of research, including birth and maternal outcomes surveillance, to include the fundamental determinant drivers of population health.
- Advancing equity informed approaches for research and evaluation that are mindful of and responsive to the impact of inequity on every aspect (biologic, physiologic, genetic, sociological, economic, and psychological) of the lives and well-being of impacted women and children.
- Engaging in health systems reform, including re-educating providers to better serve high risk populations.
- Working to undo beliefs, perceptions and practices associated with racism and discrimination to ensure that every woman at risk receives the care and support they need.
- Empowering communities through inclusion, education, social activism, and advocacy with full participation in cross sector efforts to confront and change social policies that are detrimental to mothers, fathers, babies, families and communities, recognizing that positive discernible changes in SDOH are essential for birth equity.

The birth equity consensus statement provides a mandate, guiding the work of March of Dimes and the broader MCH community, for equity-based research, practice, and policy advocacy at local, state and federal levels. March of Dimes' focus on SDOH supports the ongoing quest for birth equity for all mothers and babies.

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Compliance with Ethical Standards

Conflict of interest The authors declare that they have no conflict of interest.

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