



## REPORT

# Human-Centered Solutions to Improve Reproductive and Maternal Health Outcomes in Washington, D.C.

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This report shines a light on unmet reproductive and maternal health needs of low-income women living in the District of Columbia, and provides policymakers and providers with a Roadmap for Action containing a clear set of 12 actionable and costed initiatives that can be pursued to improve the health and well-being of women and their families.

## About the D.C. Women's Health Improvement Project

The *D.C. Women's Health Improvement Project* is championed by the D.C. Primary Care Association and led by two Fellows. The project seeks to design human-centered policies and programmatic solutions to improve reproductive and maternal health outcomes in Washington, D.C.

## Acknowledgements

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# Executive Summary

## DC has one of the highest maternal mortality rates in the country

The U.S. has the worst maternal health outcomes in the developed world. Currently, the nation's capital is facing one of the highest maternal mortality rates in the country. DC's maternal death rate stands at 36 deaths per 100,000 live births.<sup>1</sup> Only four states have worse maternal death rates, and DC's rate is more than 50 percent higher than the national average.<sup>2</sup>

### **Death rates are even higher among women of color.**

While DC has one of the highest maternal death rates in the country, white patients in the District have the lowest maternal mortality in the U.S.<sup>3</sup>, indicating deep racial and ethnic divides. Nationwide, black women are over three times more likely to die from pregnancy-related causes than white women.<sup>4</sup>

### **Racism leads to racial differences in maternal health outcomes.**

Maternal health disparity transcends economics and education—black women of any income or educational level are more likely to suffer negative birth outcomes than low-income white women.<sup>5</sup> Such data point to implicit bias in our medical system that results in suboptimal care for black women when they are most in need of quality care. Black women are further impacted by the physical toll the daily experience of racism inflicts on their health.<sup>6</sup>

### **Hospital closures hit women with high-risk pregnancies in low-income neighborhoods the hardest.**

In DC, the recent closures of the maternity wards in the two hospitals on the east side of the city have only added to the urgency of addressing this issue. Women in Wards 7 and 8 are predominately black

and have a higher prevalence of risk factors that make pregnancy more complicated, such as high blood pressure and diabetes. The closures of the hospitals' maternity wards in these neighborhoods revealed the unmet needs of low-income women on the east side of the city to access quality reproductive and maternal health care.

### **Rates of newborn deaths, unintended pregnancy, and sexually transmitted diseases also remain high.**

Infant mortality rates remain high as well at 7.1 per 1,000 live births in 2016, well above the national average of 5.9 per 1,000 births.<sup>7</sup>

Related to the persistently high maternal and infant mortality rates in the District are unmet reproductive health needs, indicated by the high rates of unintended pregnancy and sexually transmitted infections including HIV and Chlamydia.<sup>8</sup>

### **Pregnancy intention is influenced by a complex mix of personal, cultural, economic, and social factors.**

In DC, 62 percent of pregnancies are reported unintended, compared with 45 percent nationwide.<sup>9</sup> The term "unintended" can be problematic because it implies that pregnancy intention is a binary choice and ignores that many women experience intention on a spectrum, influenced by a complex mix of personal, cultural, economic, and social factors<sup>10</sup>. In addition, provider-centric goals that support intention may not be meaningful or realistic for all women.

## Using Human-Centered Design to Develop Solutions

This report brings together the perspectives of low-income women of color on Medicaid, service providers, and local health experts to inform solutions to combat this growing health crisis in the District. Applying IDEO's Human-Centered Design (HCD) approach, the District of Columbia Primary Care Association (DCPCA) undertook a five-month project to deeply understand the reproductive and maternal health challenges facing women in DC. Led by two Fellows, the project put women and those closely involved in their healthcare, from

providers to insurers, at the center, involving them in each stage from problem-identification to solution design and development.

## What Women & Health Care Providers Told Us

Challenges across the continuum of care exist. Several key findings from the report are highlighted below:

- Contraceptive use is intermittent, and providers are challenged to reach women before pregnancy.
- Comprehensive sexual health education and youth friendly health services are not universal or consistently available.
- Late entry into prenatal care remains a challenge, but Centering represents a promising practice.
- Perceived quality and reputation matters and drives decisions on where women go for care. Respectful and culturally aware care is needed.
- Awareness of quality services was identified as the leading barrier.
- Postpartum care is lacking and is ripe with opportunity for improvement.
- Transportation is a burden for women with high-risk pregnancies. Medicaid transportation was poorly regarded.
- Other challenges exacerbate poor health care. Homelessness is number one.

## A Roadmap for Action

The 12 recommendations below were co-created with the women and providers interviewed, and present a roadmap for action that can be pursued to improve the health and well-being of women and their families. These 12 recommendations emerged from our interviews and are consistent with best practices that have been implemented in other states and localities. We focused on the most actionable solutions that can be pursued immediately at relatively low cost.

The solutions fall into two categories. The first category focuses on opportunities for scale-up and increased investment in existing evidence-based interventions to increase reach and improve outcomes. The second category puts forth ideas for

new solutions that should be pilot tested for their potential to address an unmet need.

## Our Top 3 Recommendations

1. Expand Centering Pregnancy and invest in personnel to ensure coordinated, quality care.
2. Invest in a Women’s Health Improvement Collaborative and Innovation Lab.
3. Create and test a respectful care toolkit and training for providers.

**Table 1. Solutions for Action**

Scale-up Existing Interventions	
1.	Invest in personnel to ensure coordinated, quality care across a women's reproductive life <ol style="list-style-type: none"> <li>a. Expand centering pregnancy model</li> <li>b. Utilize postpartum coordinators</li> <li>c. Coordinate mom and baby check-ups</li> </ol>
2.	Expand telehealth for pregnant women at community health centers, with a focus on high-risk patients
3.	Ensure providers are aware of separate payment for postpartum LARCs and access to devices is easy
4.	Expand access to Lyft and Uber through Medicaid Managed Care Organizations
5.	Invest in affordable housing
6.	Better utilize school-based health centers
Develop and Pilot Test New Innovations	
7.	Invest in the Women’s Health Improvement Collaborative and Innovation Lab
8.	Ensure women are aware of quality reproductive health services available <ol style="list-style-type: none"> <li>a. Develop and pilot test a commercial pack</li> <li>b. Develop and pilot test a women’s wellness pack</li> <li>c. Develop and pilot test a social media campaign</li> </ol>
9.	Ensure women can easily connect with quality reproductive health services. <ol style="list-style-type: none"> <li>a. Create and launch a personalized text service</li> </ol>

b. Use pregnancy tests as an opportunity to link women with healthcare services
10. Develop a lean data survey for providers to ensure quick feedback
11. Create and test a respectful care toolkit and training
12. Develop and pilot postpartum centering or group care model

## Putting Young Women and Mothers at the Center of Care

Deep engagement with women and families impacted by continued inequity in reproductive, prenatal, and postpartum care is greatly needed. Such an approach can help ensure effectiveness, improve efficiencies, and drive sustainable improvements. All of the solutions proposed in this report can be tackled using a human-centered design to ensure that they best meet the needs of women and health care providers.



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# Background

## D.C. has one of the highest maternal mortality rates in the country.

DC has one of the highest maternal mortality rates in the U.S., which has the highest maternal death rate of any developed country. According to a 2016 analysis of Centers for Disease Control and Prevention data in the journal of *Obstetrics & Gynecology*, from 2005 to 2014, an average of approximately 39 women per 100,000 live births died in DC from causes related to pregnancies.<sup>11</sup> This is more than twice the national average of 17 deaths per 100,000 live births. According to America's Health Ranking's 2018 analysis of CDC data, DC's maternal mortality rate still remains high at 36 per 100,000, with only four states with worse rates.<sup>12</sup> Compared to other major cities, such as New York (23 deaths per 100,000 births)<sup>13</sup> or Los Angeles (15 per 100,000 births), DC's maternal death rate is still high.<sup>14</sup>

## Death rates are even higher among women of color.

While DC has one of the highest maternal death rates in the country, white patients in the District have the lowest maternal mortality in the U.S., indicating deep racial and ethnic divides.<sup>15</sup> Nationwide black women are more than three times more likely to die from pregnancy-related causes than white women.<sup>16</sup>

## Racism leads to differences in maternal health outcomes

Maternal health disparity transcends economics and education—black women of any income or educational level are more likely to suffer negative birth outcomes than low-income white women. Such data point to implicit bias in our medical system that results in suboptimal care for black women when they are most in need of quality care. Black women are further impacted by the physical toll the daily experience of racism inflicts on their health.

## Hospital closures hit women with high-risk pregnancies in low-income neighborhoods the hardest.

In DC, the recent closures of the maternity wards in the two hospitals on the east side of the city have only added to the urgency of addressing this issue. Women in Wards 7 and 8 are predominately black and have a higher prevalence of risk factors that make pregnancy more complicated, such as high blood pressure and diabetes. The closures of the hospital maternity wards amplify the unmet needs of low-income women on the east side of the city to access quality reproductive and maternal health care.

## Rates of newborn deaths, unintended pregnancy, and sexually transmitted diseases also remain high.

Infant mortality rates remain high as well at 7.1 per 1,000 live births in 2016, well above the national average of 5.9 per 1,000 births.<sup>17</sup>

Related to the persistently high maternal and infant mortality rates in the District are unmet reproductive health needs, indicated by the high rates of unintended pregnancy and sexually transmitted infections including HIV and Chlamydia.<sup>18</sup>

## Pregnancy intention is influenced by a complex mix of personal, cultural, economic, and social factors.

In DC, 62 percent of pregnancies are unintended, compared with 45 percent nationwide.<sup>19</sup> The term “unintended” can be problematic because it implies that pregnancy intention is a binary choice and ignores that many women experience intention on a spectrum, influenced by a complex mix of personal, cultural, economic and social factors<sup>20</sup>. In addition, provider-centric goals that support intention may not be meaningful or realistic for all women.

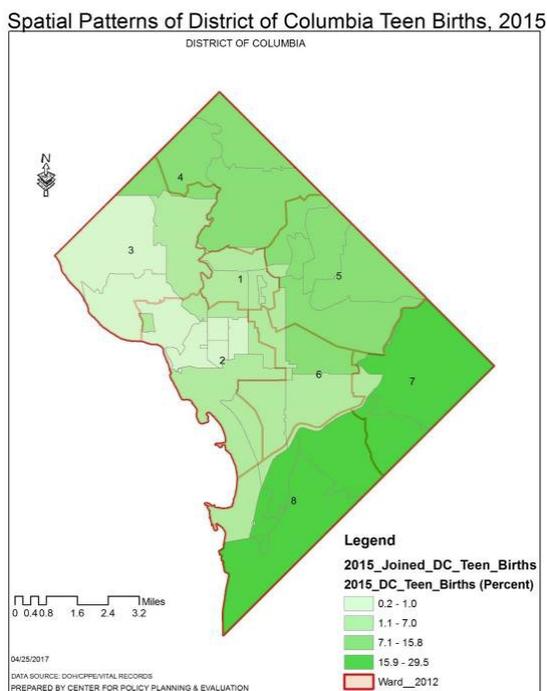
Lack of intention or planning is often linked to late entry into prenatal care and to poor birth outcomes. The label “unplanned” or “unintended” pregnancy can be used to blame women for bad outcomes, disregarding the reality that pervasive discrimination, patriarchy, and oppression are powerful forces that often shape reproductive choices and that individual women cannot resolve on their own.<sup>21</sup> For some women, a pregnancy that

“just happens” may be more acceptable than active planning when society deems their pregnancies as ill-advised. The health care system must take into account the structural challenges many women of color face as we look to design a system that empowers women to choose whether and when to have children.

**Teen pregnancy rates have improved, but the rates in the lowest income wards are significantly higher than those of higher income areas.**

DC also has one of the highest rates of teen pregnancy in the country.<sup>22</sup> And the general statistics shield the severe divides when data are disaggregated by socioeconomic status and race. As the map below indicates, teen births in the lowest income wards are significantly higher than those of higher-income wards.<sup>23</sup>

**Graph 1. Teen pregnancy disproportionately impacts low-income wards<sup>24</sup>**



**The DC Maternal Morality Review Committee is a critical step in the right direction.**

More data are needed to identify the key drivers of poor maternal health outcomes in the District, and

the new DC Maternal Mortality Review Committee will go a long way toward collecting this data and uncovering causes of maternal death. Still, the existing data reveal several factors clearly contributing to poor health outcomes for women and children.

**Late or no entry into care is a significant issue.**

According to the 2018 DC Perinatal Health and Infant Mortality Report, approximately half of black women (49%) and more than 1 in 3 Hispanic women (35%) are not getting into prenatal care until their 2<sup>nd</sup> or 3<sup>rd</sup> trimester or not receiving any care at all. As the report notes, “Delayed prenatal care is associated with poorer health outcomes for both mothers and infants, including preterm birth, low birthweight birth and infant mortality.”<sup>25</sup>

**Less than half of women on Medicaid are receiving the recommended number of prenatal visits.**

According to the Centers for Medicare & Medicaid Services (CMS) Medicaid/CHIP Child Core Set, only 36 percent of women in DC on Medicaid and CHIP received at least 81 percent of the expected number of prenatal visits.<sup>26</sup>

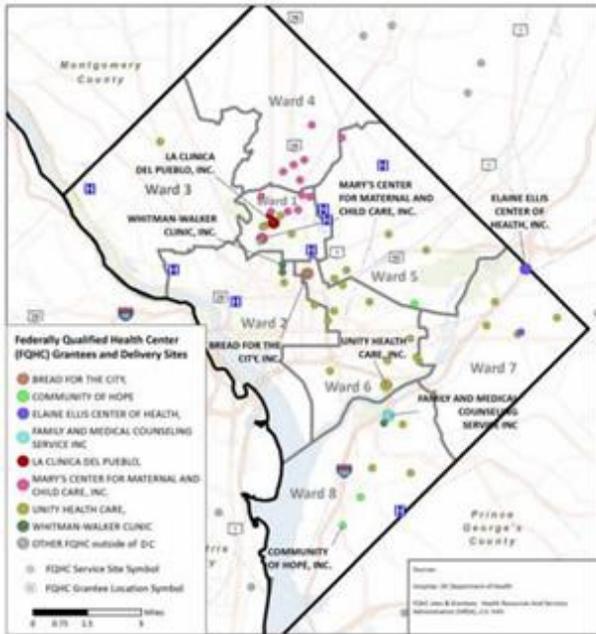
**Fewer than half of women on Medicaid or CHIP are receiving their postpartum visit in the recommended window after giving birth.**

According to the CMS Medicaid data from the Adult Core Set, only 49 percent of women in DC on Medicaid, CHIP, or dual eligible had a postpartum care visit between 21 and 56 days after birth.<sup>27</sup>

**Neither lack of available prenatal care providers nor lack of insurance coverage, appear to be the problem.**

A variety of complex factors contribute to late entry into prenatal care, but based on the findings in the *2017 DC Health Systems Plan*, a lack of available prenatal care providers does not appear to contribute.<sup>28</sup> DC has invested more than \$70 million in building primary care capacity throughout the city, including ambulatory facilities offering prenatal care services in Wards 7 and 8.

**Graph 2. Federally Qualified Health Center Grantees and Service Delivery Sites, 2015<sup>29</sup>**



Further, a lack of insurance coverage does not appear to be a significant issue, with DC achieving insurance coverage of 93 percent of adults and 96 percent of children.

According to the *2017 DC Health Systems Plan*, “there is strong evidence to suggest that absolute capacity is not the leading factor influencing access and engagement in primary care,” rather, “some of the leading barriers ... relate to the cost of care itself or other costs related to accessing care (e.g. transportation, child-care, lost wages), linguistic and cultural barriers, lack of appointments in the evenings or on weekends, perceptions of quality, and administrative barriers related to insurance coverage.”<sup>30</sup>

# Approach

Recognizing the need to engage with the community in order to better understand the drivers behind poor health outcomes for women in the District, the DC Primary Care Association, together with Fellows Robyn Russell and Carolyn Rodehau, undertook a five-month project to apply IDEO’s Human-Centered Design (HCD) to the reproductive and maternal health challenges facing women in DC.

## Using Human-Centered Design to Develop Solutions

We used a design and management framework that develops solutions to problems, which puts the end user at the center of every step in the process. This approach to HCD involves three phases:



- **Phase I – Inspiration:** Carry out deep dive interviews to deeply understanding the needs of the people you are designing for.
- **Phase II – Ideation:** Generate tons of ideas and prototype them quickly, sharing them with the end user, to collect immediate real-world feedback.
- **Phase III – Iteration:** Continue adapting your solutions to suit the needs of the people you are severing in order to land on solutions that are effective and sustainable.

## Uncovering the challenges with in-depth interviews

The fellows completed a first round of Phase 1, conducting 29 in-depth interviews with key maternal and reproductive health providers and experts in DC, as well as low-income women who receive care through this health system.

The researchers interviewed 16 providers or experts in the reproductive and maternal health space from

a variety of providers in the District and with a variety of credentials ranging from community health workers, to midwives and OBGYNs.

The researchers also conducted 13 in-depth interviews with women in DC, visiting them in their homes and meeting their children and partners in order to fully understand the challenges and opportunities facing low-income women in DC. Women were interviewed from a variety of wards, including 8, 7, 5, 4, and 1. All women interviewed are on Medicaid. All women interviewed identified as black or Hispanic. The ages of the women interviewed ranged from 18 to 38. The ages of first pregnancy for the women interviewed ranged from 16 to 30.

**Table 2. List of Interviewees**

Providers & Experts (16)
Director of Midwifery, Community of Hope
Prenatal Services Program Manager, Community of Hope
Senior Staff, Mary's Center
Director of OBGYN, Unity Health Care
Director, Mamatoto Village
OBGYN Specialist, Medstar Washington Hospital Center
Section Director Midwifery, Medstar Washington Hospital Center
Director, Midwifery Services, George Washington
OBGYN, George Washington
Senior OBGYN, Howard
Executive Director, Young Women's Project
School-Based Health Provider, Georgetown
Reproductive Health Coordinator, Children's National Health System
Nurse Practitioner, Children's National Health Systems

Co-Medical Director, Healthy Generations, Children's National Health Systems
Senior Staff, AmeriHealth, MCO
Senior Staff, Health and Wellness, DC Public Schools
Senior Staff, Health Wellness, DC Office of the State Superintendent of Education
<b>Women (13)</b>
Black mother of three, Ward 8
Black mother of five, Ward 8
Black mother, first pregnancy, Ward 8
Black mother of one, Ward 7
Black mother of three, Ward 7
Black mother of two, Ward 5
Black mother of two, Ward 5
Hispanic mother of one, Ward 4
Hispanic mother of one, Ward 4
Hispanic mother of four, Ward 4
Black mother of two, Ward 1
Hispanic mother of four, Ward 1
Black mother of one, Ward 8

## Envisioning potential solutions and getting feedback

This initial phase of interviews uncovered a rich array of texture and insight into the on-the-ground challenges faced by low-income women in DC attempting to access care. In addition to identifying problems, the interviewers also asked the women, providers, and experts interviewed about possible solutions. The interviewees proposed a number of innovative solutions to address several of the barriers to quality reproductive and maternal health care.

Outlined below are our key findings, coupled with potential solutions. The solutions fall into two categories: One category comprises recommendations around scaling or fully funding existing interventions that are proven and currently being implemented to produce greater impact. The second category comprises new solutions that address a currently unmet need.

## Bringing solutions to life in partnership with the community

This report summarizes Phase 1 [Inspiration through interviews] and Phase 2 [Ideation of potential solutions]; however, to fully capture the benefits of human-centered design, this process of speaking with the women using the health care system, developing solutions, testing solutions, and adapting them to meet needs must continue.

## Limitations

This research offers a rich qualitative look at the experiences of women, providers, and health experts in the District. However, we recognize that this is not a representative sample size and that respondents who participated may be more active in their care when compared to women who did not participate.

Additional interviews, both qualitative and quantitative will need to be conducted to flesh out a more comprehensive strategy. Still, these interviews give us a good window into the lives of women in DC and align with currently available data.

Lastly, this work is not intended to duplicate the Maternal Mortality Review Committee; rather, this is intended to serve as a supplement to this important research and begin a discussion with providers, NGOs, and policymakers around interventions outside the hospital aimed at preventing emergencies before they occur.

# Objective

Our objective is to shine a light on unmet reproductive and maternal health needs of low-income women living in the District of Columbia, and to provide policymakers and providers with a Roadmap for Action containing a clear set of 12 actionable and costed initiatives that can be pursued to improve the health and well-being of women and their families.

# Key Findings

The key findings below have been grouped into five categories: pre-pregnancy, prenatal, labor and delivery, postpartum, and cross-cutting. Using the human-centered design approach, we put the voices and feedback from the women interviewed at the center, using direct quotes to illustrate the current challenges and opportunities within DC’s reproductive and maternal health system. We also weave in the voices of providers who offer additional insights into areas of strength and weakness in the health system.

While there are 31 findings, the topline takeaways should leave us feeling hopeful. The good news is that unlike other areas of the country, DC has the infrastructure, providers, and insurance coverage to ensure every woman gets what she needs. The weaknesses appear to be that quality and trust need to be improved in order to drive more demand and that women need to be made aware of and easily connected with quality providers already operating in their communities.

**Table 3. Key Findings**

Pre-Pregnancy
1. Most women do not report planning their pregnancies.
2. Contraception is not hard to access; the barriers are misconceptions, nervousness, distrust, and side effects.
3. Many women’s first interaction with the health care system is once they are pregnant.
4. Many women chose their contraception based on recommendations from their social circles.

5. Most of the interviewees had not received comprehensive sexuality education; but all interviewed think more sex education is needed.
6. Although DC mandates comprehensive health education in its schools, the mandate is not universally or consistently implemented.
7. For young people in particular, they need not only information, they also need to know where to go and getting services must be easy.
Prenatal
1. Many women are not getting into care until 2nd or 3rd trimester
2. The challenge does not appear to be a lack of services, but that many women don’t know about <u>quality</u> services available.
3. Most women did not miss prenatal appointments, but those who did cited work and sickness.
4. Every woman who participated in Centering spoke very highly of it.
Labor & Delivery
1. Reputation matters and women make decisions on where to go based on reputations.
2. Quality matters and drives utilization decisions.
3. Many women were not familiar with or had not been offered midwives, doulas, natural birth options, support workers, or birthing centers as an option.
Postpartum
1. All women and most providers expressed a lack of postpartum care.
2. Most of the women reported some form of postpartum depression.
3. The women prioritized care for their children over care for themselves.
4. The women who received home visiting in the postpartum period liked it.
5. There are a number of barriers to postpartum contraception adoption.
Cross-Cutting
1. Awareness of <u>quality</u> services was identified as the leading barrier.
2. Word of mouth is very powerful.
3. Transportation is a challenge, but appears to be a greater barrier for those who are high-risk.
4. Small incentives are key and can be powerful.
5. Housing is a critical and urgent unmet need.
6. Nutrition is another major issue mentioned by all interviewees.
7. Child care was another major challenge.
8. Respectful and culturally aware care is key.
9. Electronic health records can be improved.
10. Communication can be improved.
11. Insurance can be improved.
12. Providers need more and better feedback on patient outcomes and satisfaction.

# Key Findings: Pre-Pregnancy

## 1. Most women reported not planning their pregnancies.

None of the women interviewed for the project reported planning their pregnancies. Statements from the women tell us several things and reveal the complex context in which women are making pregnancy decisions:

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*“I didn’t plan to have any of my daughters .... I didn’t find out I was pregnant for four months.”*

*36-year-old mother of three in Ward 7*

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### Unanticipated pregnancies result in later entry into care.

- A 23-year-old mother of two from Ward 5 who said, “they were both surprises,” didn’t get into prenatal care until she was 5 months along.
- A 25-year-old mother of two from Ward 5 who said, “neither one was planned,” also didn’t enter care until she was 5 months pregnant.
- One 27-year-old mother of four from Ward 1 said, “I was 21 weeks when I found out.”
- One woman came in for a physical and found out she was 11 weeks pregnant.
- One woman came in for birth control and found out she was almost 2 months pregnant.
- When asked why women are getting into care so late? One mother of one from Ward 7 who is also a family support worker said, “I always go back to information. A lot of women don’t know what signs to look for, so they don’t know they are pregnant.” “A

lot of women don’t even know how to count their fertility days ... how their bodies work.”

### Unplanned pregnancies are impacting women’s educational attainment and earnings ability.

- One 23-year-old mother of two from Ward 5 said, “They were both surprises .... I thought, how on earth am I going to do this? I was in school and working .... I was homeless.”
- One 32-year-old mother of one in Ward 7 said, “If I could go back, I would have been financially stable [before getting pregnant] .... A lot of us don’t have a plan when we get pregnant.”
- One 27-year-old mother of four from Ward 1 said, “I was going to graduate and all the sudden I was pregnant. I was in shock. I can’t put my daughter up for adoption, she’s my daughter.”

### Statements from providers also note a lack of pregnancy planning by many patients.

- “I’ve seen a number of patients who are ambivalent [about becoming pregnant].” – OBGYN, Director of Labor and Delivery
- “The majority of women who come into Community of Hope have not planned their pregnancy.” – Midwife

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*“I honestly didn’t want any [kids]. I’m young, kids weren’t on my mind .... I was focused on school work, trying to establish myself .... It was definitely a surprise. I cried.”*

*24-year-old woman from Ward 8 came in for birth control and found out she was pregnant*

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- Several providers, specifically those at community health centers, cited historic distrust of the medical community and misconceptions, spread via word of mouth, about contraception causing sterilization and severe side effects (pain, excessive bleeding).
- What's the biggest barrier to contraceptive use? "A lack of understanding and mistrust." – Community Health Worker
- "They are trying not to acknowledge it, and hoping it will go away." – OBGYN
- Providers may need a more nuanced understanding of intention in order to support women in their care. Women who are perceived as not actively planning their reproductive lives may not have been encouraged to express their range of feelings about pregnancy to caregivers.

## 2. Contraception is available. The barriers are misconceptions, nervousness, distrust, and side effects.

- "It's a hidden rule in our community – don't do birth control ....I feel like it's definitely taboo." – Mother of one, Ward 7, Family Support Worker
- "Racism ... people think birth control is like genocide ... and then religion .... We pass down things generation to generation." – Mother of one, Ward 7, Family Support Worker
- The 2018 Family Planning Community Needs Assessment found that contraceptives are generally available, finding, "Most clinics surveyed provide a wide range of contraceptive methods," including injectables, IUDs, and implants, and that methods are usually available on the same day as appointments.<sup>31</sup>
- The 2018 Needs Assessment also found that due to DC's high rate of insurance, "clinics encounter relatively few patients without health insurance coverage."<sup>32</sup>

## Misconceptions, distrust, and side effects were commonly cited as reasons for nonuse or discontinuation.

- "Pills, I don't trust it. You could miss it ....The shot every three months. I thought that was dumb." - 18-year-old mother of one, Ward 4
- "Depo bloats you. Pills, women forget. [Nuvaring] may be better." – 36-year-old, mother of three, Ward 7
- "I don't like birth control ... I would never .... I'm always missing my pill. Pills mess up my period ....They know, but they don't want to use it." – 30-year-old, mother of two, Ward 5
- "I used to do Depo, but I bled for three months, so I quit." She then used Nuvaring, and she liked that. – 38-year-mother of 5, Ward 8
- One 23-year-old, pregnant with her first child in Ward 8 said Depo seemed best. She stopped taking pills because a friend said they aren't good for you. She added that contraception is not hard to get.
- A 25-year-old mother of two from Ward 5 stopped taking Depo at 18. She got pregnant at 23. She thought she couldn't get pregnant: "I didn't think I could have kids."
- "I believed birth control was bad for you .... I thought the side effects were scary. I don't

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*"A lack of information is first and foremost .... Because of the lack of information, we don't know how to take it, then it doesn't work, then we think it doesn't work."*

*Mother of one, Ward 7, Family Support Worker*

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want a shot. I'm not disciplined enough to take pills." – Mother of one, Ward 7

### Feedback from providers also confirmed these barriers.

- “We have patients who see the pill as something to be used periodically. Same as with Depo. They only use it when they have a partner.” – Adolescent health provider.
- One adolescent provider shared that Depo is the most popular form of contraception. When asked why, she said, there is a “culture of wariness .... There is a general hesitancy to have a device placed in their bodies.”
- One adolescent health provider flagged that their patients using Depo can't schedule their next shot before they leave because they can't schedule three months out (only 4 weeks out). So the onus is on the patient to remember to follow-up and book her appointment in the window when she needs the shot, or someone from the provider has to follow up, but it's likely people fall through the cracks. This provider doesn't track who doesn't show up. This provider has a 30% no-show rate.

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*“I don't want an IUD because it's a hook and that makes me uncomfortable .... I want to have my period .... I never heard of a Nuvaring .... At my doctor's office, they only push two types of birth control: the Nexplanon and the IUD.”*

*23-year-old mother of one, Ward 1*

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- This finding that misconception, distrust, and side effects are common barriers is supported by a 2018 Family Planning Community Needs Assessment which found that “bad effects,” “weight gain,” “do not understand consequences of unprotected sex,” and “hard to remember” were among

the top barriers identified by the young women interviewed.<sup>33</sup>

### Most women interviewed were uncomfortable with LARCs.

- “They say that it doesn't work, it gets stuck up there .... I thought it would be weird to have something down there.” – 18-year-old, mother of one, Ward 4
- “I chose the pills .... Seems easier .... The other birth controls, it sounds like they hurt.” – 24-year-old mother of one, Ward 4
- “I've heard a lot of people have to get [implants] removed.” – 36-year-old, mother of three, Ward 7
- “Heard it causes heavy bleeding from girlfriend. Heard it can get stuck during sex.” “I don't want anything implanted in me.” – 30-year-old, mother of two.
- One 38-year-old mother of five from Ward 8 didn't want an implant because she was “leery of someone putting something under my skin.” She added: “My cousin had an implant and she gained a lot of weight.”
- Most contraception options seemed “scary.” – 23-year-old, pregnant with first child, Ward 8
- “They're not educated about it; that's the number one problem .... They don't know how to use [the different contraception methods]” - Hispanic mother of four, Ward 4, Family Support Worker
- The 2018 Family Planning Needs Assessment<sup>34</sup> also found 20 – 29-year-olds interviewed have more negative perception of IUDs and implants, with respect to IUDs being painful, pain during implant insertion, requiring a pap smear before IUD insertion, and IUD damaging the uterus.

### Three of the women interviewed have arm implants. None had IUDs. Feedback on the implant was mixed:

- One mother of one from Ward 4 chose the arm implant because, “I saw my sister had it.” She added: “The implant is 99 percent good; you

won't get pregnant. It's good for three years .... I think I would have used the [arm implant] if I had known about it."

- **Discontinuation is an issue:**
  - One mother had an arm implant for two months but is thinking of taking it out: "It's causing weight gain .... I thought I was having a period, but the bleeding hasn't stopped." – Hispanic, mother of four, Ward 4
  - "My choice was the arm implant because it lasts 5 years .... I had to take it out after a year because of bleeding .... I ended up getting pregnant the same year." – Mother of two, Ward 1.

**Challenges with contraception go deeper than simply not being aware of methods. Many women interviewed were not actively planning their reproductive lives.**

- "A lot of us don't have a plan when we get pregnant .... You're not taught to think of yourself .... I'm taught automatically to treat others before myself .... We need a confidence support group .... In our community, the black woman is taught to look out for everybody else and that will make them happy .... That's very common - They want to have children for their partner. It's generational." – Mother of one, Ward 7
- "Most of my patients had unplanned pregnancies .... 95 percent of the time it's not planned .... Instead of saying 'congrats', I say, 'How are you feeling?' ... Sometimes they say, 'I can't have this baby.' I give them options counseling. They're not educated about it; that's

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*One young Hispanic mom who became pregnant at 16 said, "I was not going to do anything after high school. I was not going to college .... My family never had money like that. No one went to college."*

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the number one problem." – Mother of four, Ward 4, Family Support Worker

- "Some people think it's natural – 'God wanted me to have this baby.'" - 36-year-old, mother of three, Ward 7.
- Two women who had been in foster care shared that they wanted to have children in order to have someone to love and be loved by. "I did want a baby ... because I felt like I needed someone to care for and someone to care for me," said one 21-year-old mother of one who had been in the foster care system.

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*"A lot of us don't have a plan when we get pregnant .... You're not taught to think of yourself .... I'm taught automatically to treat others before myself .... We need a confidence support group .... In our community, the black woman is taught to look out for everybody else and that will make them happy."*

*Mother of one, Ward 7*

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**Provider feedback supported this finding that many women are not actively planning their reproductive lives and highlighted challenges providers face in helping them to plan.**

- "If you live in an environment where people after high school have kids ... there's less of an expectation you will do something else .... It's harder to envision yourself doing something else. We are a product of our environment." – Reproductive Health Coordinator
- "They don't feel empowered to act .... There's this do-nothing phase where they hope it will go away." – Adolescent health provider.
- One provider said: "Teens can access care, but am I doing enough? ... Do I have enough time to

explore the reproductive life cycle with a patient?” She added that she feels they have to cram everything into a short visit and that the amount of time a provider can spend with a patient has decreased, while demands have increased.

- One provider pointed out that the reimbursement amount is the same no matter how much time they spend with their patients. “We’re gonna get the same amount whether we spend 10 minutes or 40 minutes with a patient,” she added.
- “Right now the focus is on prevention. We need to focus on what it is that you need as a sexual being ... talk about pleasure in sex, the emotional part. The goal is dignity.” - Midwife

### 3. Many women’s first interaction with the health care system is once they are pregnant.

- When asked why more women don’t use LARCs, one 38-year-old mother of five from Ward 8 explained that women aren’t using LARCs because they aren’t going to the doctor, so no one is telling them about LARCs. They don’t know about them until they get pregnant and into care.
- One 25-year-old mother of one from Ward 4 shared that she did not have a primary care doctor, and the last time she had been to the doctor before she became pregnant was when she was a teenager.
- One adolescent provider shared that teens access care at least once per year, usually to get their shots and health forms for school. She asked how they can do a better job of keeping them connected with care.
- The provider explained that adolescents come in a lot until age 12, then there is a bit of drop off until they come back at 16. There appears to be a gap in contact with the health system between ages 12 and 16, the prime time when teens need reproductive information and care.

### 4. Many women chose their contraception based on recommendations from their social circles.

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*The attitude of people on contraception is: “If you have it, I’ll take it .... If your friend has the knowledge, the others will get it.”*

*Hispanic mother of four, Ward 4*

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- One mother of one from Ward 4 chose the arm implant because, “I saw my sister had it.”
- “People ask me now if the implant works. I say yeah.” – Mother of one, Ward 4
- “No one in my social circle is using birth control .... The best indicator of which birth control you use is the birth control your friends use .... The more people who use it, the more people will use it.” – Reproductive Health Coordinator
- “Young people rely on word of mouth.” – Adolescent reproductive health provider

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*One provider who works in a school-based health center shared that a friend of a young woman secretly filmed her having an arm implant inserted. The young woman posted the video on her social media, with notes about how it didn’t hurt and was easy, and several of her friends came to the clinic asking for an implant as well.”*

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## 5. Most interviewees had not received comprehensive sexuality education; but all interviewed think more sex education is needed.

- “I was never talked to about sex or ... you do this, you get this disease.” – First time mom, Ward 8
- “They did talk about it. They didn’t talk about birth control.” –25-year-old mother of one, Ward 4
- “We need sex ed .... These young girls need support.” – Mother of three, Ward 8
- “They should have more sex ed.” Mother of two, Ward 6
- One mom has a teen daughter who attends Community of Hope’s teen night. The daughter likes it, and the mom likes that she is receiving sexuality education there, since “she’s not getting it in school.”
- No one talked to one mom about sex when she was young. She had her first baby at age 17.
- Another first-time teen mom in Ward 4 received some sexuality education in school and information on contraceptives, but said, “Sometimes people don’t think, or they don’t know about it.” When asked where she would have gone for birth control in high school, she said, “Only the doctor, but I didn’t want to go because my mom would have to go with me.” She didn’t know if there was a health center at her school. She suggested sex ed start in middle school because she knows two girls in her neighborhood in DC who are 12 and pregnant. One is her cousin, and one is a friend’s younger sister. She has twins in her family – one got pregnant at 12, the other got pregnant at 13.
- “I feel like we need a class ... it should be based in the community ... since nobody wants to teach it in schools .... I feel like the younger generation they are using the internet more.” – 30-year-old, mother of one, Ward 7

- “They [young people at her high school] didn’t know about birth control .... The only thing they know about is condoms” - 18-year-old mom of one, Ward 4

## 6. Although a comprehensive set of health guidelines for schools was passed, they are not being fully implemented.

- According to the DC Young Women’s Project, there are three health-only teachers in DC Public Schools and Charter schools - They need 32, in the elementary schools alone, at a cost of \$3.2 million to teach the full guidelines.

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*“First is improving knowledge, and then making is so easy to do that it’s almost hard not to do it.”*

*Reproductive Health Coordinator*

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- Officials from DCPS and the Office of the State Superintendent disagreed that there is a shortage of teachers, but did note they are seeking creative ways to allow for more classroom time to be spent on health education.
- There are a few groups currently coming into schools to provide some health education, such as Planned Parenthood, but they are reaching a small percentage of the young people.
- The Young Women’s Project is reaching 7,000 students with basic education, referrals, and access to condoms, but that is only a fraction of students and only a sliver of the information and services needed.
- Providers shared that school clinics are severely under-utilized and that many students do not know about them.
- There have been issues with confidentiality and insurance at clinics. Students are told

the services are confidential, but then a bill is sent to their home alerting their parents.

- An official from DCPS agreed school clinics could be better utilized, saying “about 50 percent of students are enrolled in SBHCs. We’d love to see more ... We need to work to improve awareness ... SBHCs need outreach staff and marketing.”

## 7. Young people, in particular, need health education and information on where to go. Accessing services must be easy and private.

- “There are plenty of places to go ... but is there knowledge about where you can go? Will it cost you something?” – Adolescent health provider
- “I would love to be able to give patients a number they could call or text to get an answer at 8 o’clock at night.” – Adolescent health provider
- “Several teachers said, ‘I didn’t know this [school-based health clinic] was here.’” – School-Based Health Provider
- The time it takes to make an appointment is key: “If you are on hold for 10 minutes, kids are not going to wait.” – School-Based Health Provider
- “If we ask - ‘where should you go if don’t want to be pregnant?’ - they need to know.” – Reproductive Health Coordinator
- “Why is it harder to get Plan B than an electric scooter?” – Reproductive Health Coordinator
- “The hardest part is the “It Factor,” making it cool ....The people making contraceptives are out of touch with the people using them.” – Reproductive Health Coordinator

## Meet Brittany



Brittany with her one-month-old daughter

Brittany, 23, lives with her two daughters, in an apartment provided through a two-year program run by the Salvation Army. She worked part-time as an aide in a senior home, paying 30 percent of her income toward rent, and is returning as soon as she can arrange care for her new baby.

Brittany became pregnant while participating in a Job Corps program to become a certified nursing assistant (CNA) in Pennsylvania. She had been using the contraceptive shot, but missed a shot while working in PA and found out five months later she was pregnant. She explained that the staff in the program told her she would need to go back to her primary provider in Maryland where she had been living with her aunt to get care, but because she could not afford the bus ticket back, she didn't make the trip and missed her contraceptive shot.

When Brittany learned she was pregnant she said, "I thought how on earth am I going to do this? I was in school and working." She had to drop out of her job training program because she couldn't finish her clinicals while pregnant. Although she was only a few months from finishing the program, she wasn't able to complete it and receive her certificate needed to work in DC.

Brittany felt her prenatal care and delivery services were good; however, she did share several instances of feeling unheard by providers. After her first delivery she noticed she was bleeding a lot and when she told her nurse "I'm still gushing a lot, is that normal," the nurse said it was. She was hemorrhaging, although they caught it early enough that she did not need a transfusion. Still, Brittany added that she had been telling the doctor about symptoms during the pregnancy such as blurry vision, feeling light headed, very swollen feet, and extreme sickness, but the doctor kept telling her "it's normal." It was only after arriving at the hospital that she learned she was at risk for preeclampsia.

After giving birth, Brittany opted for an arm implant contraceptive, but she had it removed after a year because of bleeding. She became pregnant the same year. After her second baby, Brittany opted for the contraceptive shot adding, "At my doctor's office, they only push two types of birth control: Nexplanon and the IUD."

For Brittany, factors outside the health care system pose some of the biggest challenges. Unable to live with her parents, who also experienced homelessness, Brittany has struggled to find an affordable place to live and generate enough income to support herself and her daughters.

"Some people think that when you're on benefits, they think you're lazy and don't want to work .... But I'm trying to work." The challenge for Brittany is that as a nursing aide in a senior home, she doesn't make enough to cover rent, and as soon as she reaches a certain threshold her other sources of assistance are cut off: "Once you start working, they cut off all your benefits ... It's really hard .... Taking away food stamps was an eye-opener. There were times when we didn't have anything but snacks. We didn't have meat, or vegetables ..." Brittany plans to start working again as soon as she can find child care, but added "when [benefits] are turned off, that worry comes back."

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## Key Findings: Prenatal Care

### 1. Many women are not getting into care until 2nd or 3rd trimester.

- As outlined in the previous section, none of the women interviewed reported planning their pregnancies, leading many of them to enter care after the first trimester.
- All providers interviewed believe that unintended pregnancy is a primary driver of late entry into care.
- The label “unplanned” or “unintended” pregnancy can be used to blame women for bad outcomes, disregarding the reality that pervasive discrimination, patriarchy, and oppression are powerful forces that shape the reproductive choices of women and the care they that individual women cannot resolve on their own. The health care system must take into account the structural challenges women of color face as we look to design a system that empowers women to choose whether and when to have children.

### 2. The challenge does not appear to be a lack of services, but that many women don't know about the *quality* services available.

- “Someone somewhere should tell us more about programs.” – Mother of two, Ward 5
- “I had no idea you could have a water birth in North East DC on Medicaid!” – Mother of five, Ward 8

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*“Most people aren't aware of services, because I wasn't.”*

*Woman on first pregnancy, Ward 8*

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- One woman found out about Community of Hope after she drove by and saw the sign.

- One Community of Hope provider shared that while she was flying an apartment building next to her clinic about a health fair, several residents said they were surprised to learn they could go to the clinic because “we thought it was for people with private insurance. They wouldn't give us such a nice, shiny building.”

### 3. Most women did not miss prenatal appointments, but those who did cited work and sickness.

- One mother of five from Ward 8 did not miss an appointment but said scheduling appointments around work was her biggest challenge.
  - She suggested later appointments and more flexibility, in case things come up.
- A first-time mother from Ward 8 said she missed centering a few times because of work, and her employer wouldn't let her take off.
- One mom had a broken foot while she was pregnant and so missed a few appointments because getting to the office was too difficult with her cast.

### 4. Every woman who participated in Centering spoke very highly of it.

- “[Centering] was the best part .... I learned a lot I didn't know in my first pregnancy .... It was nice to be with other women. To hear their stories and know they are going through what you are going through.” – Mother of two, Ward 5.
- One mother of five from Ward 8 said she loved Centering. She learned a lot, such as the different birthing techniques, the “yeses” and “nos” of hospital care, and what a doula is. She also liked that they provided food. “I can't express how happy I was,” she said.
- “I liked Centering. It was informative .... I did not know not to put cereal in the baby's bottle ... I went to the classes so I could get a crib.” – Mother of three, Ward 7

- One mother of four from Ward 4 didn't do Centering, but said, "I definitely would have taken it. I lost a lot of friends in high school. I was by myself."
- One mom of two living in Ward 1 had not heard of Centering but said "That would have been appealing ... talking with other women about what I'm going through .... It's nice to know what other people go through."
- A mother of one from Ward 7 did pregnancy classes at Mamatoto, but said of Centering, "I definitely think it's good – women supporting women is the best thing .... A lot of women need the support."
- A first-time mom from Ward 8 said she loves Centering. The baby's dad joins her; and he is supportive. She likes to hear from other women about their experiences, and she likes the midwife instructors.
  - She learned things she didn't know before like "how to breastfeed," not to put covers in the crib with the baby, and what to eat and not eat while pregnant. She likes seafood, but said she will have to wait until the baby is born to eat it.

**Provider feedback on prenatal care supported many of these findings.**

- "We want to do Centering, but with who? We need the personnel and funding. There aren't enough people." – OBGYN, Ward 1
- "We used to do Centering, but we ran out of funds." – OBGYN at Unity
- "There are not incentives for better outcomes." – OBGYN, Wards 5, 7, 8
- "Some come in before 12 weeks, but a large percentage come in long after 12 weeks .... Some are 36 or 38 weeks." – Community health worker
- "A lot of women from immigrant communities are coming in in their 2nd and 3rd trimesters, often because they don't speak English and don't prioritize their own health." – OBGYN at Unity

## Meet Stephanie



Stephanie with her belly cast which she made in Centering prenatal care. She posted this picture on social media and had several friends ask where she made it and how they could get one too. She referred them to Community of Hope.

Stephanie lives with her children in an apartment in Southeast DC with the help of a voucher she received after being on a housing waitlist for ten years. When asked what her greatest challenge was she responded quickly: “housing.”

During her last pregnancy, Stephanie participated in Centering Pregnancy, saying about the experience, “I can’t express how happy I was.” She explained that she learned a lot, including the “yeses and nos” of hospital care, what a doula was, and “they feed you.”

Stephanie found out about Centering from a friend after switching from a provider in Southeast DC that she described as “not professional” with “bad attitudes.”

During Centering, Stephanie learned about the Birthing Center in Northeast DC and decided to deliver there, saying, “I wish I had all my kids there!” She loved the Birthing Center because she liked the personalized attention from the midwives,

the comfortable surroundings, and the fact she was able to go home shortly after giving birth.

According to Stephanie, one of the biggest challenges for women in DC is that they don’t know about these quality services. “I had no idea you could do a water birth in Northeast DC on Medicaid,” she added.

Although Stephanie had a very positive prenatal and delivery experience, she shared that she wished she had more support in the postpartum period, saying, “After I had the baby, everything dropped.” Stephanie shared that she wished prenatal Centering continued after the baby was born so she could meet with the same group of moms she had grown to know before delivering.

When asked what message she would like to share with policymakers in DC, Stephanie responded: “Women’s health care is very important because we are the backbone of our community.”

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## Key Findings: Labor and Delivery

Please note the names of specific providers have been removed to avoid outsized focus on specific providers and maintain the emphasis on unmet needs throughout the entire community.

### 1. Reputation matters and women make decisions on where to go based on reputations.

- On one hospital, a mother of one from Ward 4 said, “I didn’t want to. I heard bad stuff ... I heard the nurses were not good.” She delivered at that hospital anyway because she was told that was the only provider her insurance would cover.
- “I just heard [hospital] is a bad hospital.” – Pregnant with first child, Ward 8.
- “I don’t like [hospital].... I don’t like any of the hospitals in my area .... I love [hospital].” – Mother of two, Ward 5

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*On a DC hospital: “I will not even go there ... That hospital is no good...” Why? “Because we’re in Southeast. They don’t care. They let my friend bleed to death.”*

*Mother of three, Ward 8*

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- “[Hospital] is alright. There are a lot of things you wouldn’t get at [hospital].” – Mother of three, Ward 8.
  - A senior staff member from an MCO said, “We need to make the health care experience better so members want to go.”

### 2. Quality matters and drives utilization decisions.

**Staff attitudes were the most important issue mentioned.**

- “It was awful ... I had her at [hospital].” Why? “I had a really mean nurse. She wouldn’t give me any pain meds .... I had a doctor come in and tell me to push ... It was my first baby and I didn’t know how to push ... he said ‘This little girl can’t push, we need to prep the room for a c-section.’” “I didn’t want to go back .... The rooms were dirty. The nurses were mean .... I didn’t want to go back for my 2nd daughter .... I had bad depression and wanted a more loving environment.” – Mother of four, Ward 4
- One first time mom from Ward 7 switched from [hospital] to Community of Hope at 33 weeks because she was so unhappy with the care at [hospital]: “I felt like she was trying to treat me like a business .... At [hospital] they are kind of pushy ... they don’t let you control your health. We’re supposed to work together. Not just you tell me what to do. They don’t expect the mothers to care.”
- One mom from Ward 7 said, “If I were to have another baby, I would go to the birthing center ... It was really magical.” She said she wants a provider to be “caring and nurturing .... focused on me and the baby” and to “explain what’s going on.”
- One mom from Ward 5 delivered at [hospital] and said, “That hospital is terrible. I hate that hospital .... I would not recommend it.” When asked why, she explained that she was trying to breast feed, and the milk wasn’t coming in. She was in a

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*“I didn’t want to go back .... The rooms were dirty. The nurses were mean .... I didn’t want to go back for my 2nd daughter .... I had bad depression and wanted a more loving environment.”*

*Mother of four, Ward 4*

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lot of pain. She didn't feel the hospital responded to her needs. "They weren't coming in ... I was in pain," she said.

- One mother of five from Ward 8 stopped going to [community health center] because she felt they were not professional: "Don't just hire someone from southeast, they need to be good, professional." She wants her provider to be clean, and she wants to be greeted in a kind, professional way. She felt many of the workers had "bad attitudes." "You don't want to go to the doctor for a 15-minute meeting where they push you through and don't even talk to you or listen to you," she said.

**None of the women interviewed reported serious health issues going into delivery. Few had complications; however, those who did reported not feeling listened to.**

- One mother of two in Ward 1 hemorrhaged after her second delivery and said, "I told my nurse, 'I'm still gushing a lot, is that normal?' She said it was, but then a lot of doctors came in." They caught it early, so she didn't need a blood transfusion. She didn't realize she was at risk for preeclampsia until she was in the hospital. She felt like she was telling her doctor things, but s/he wasn't listening. She had blurry vision, felt light headed, had very swollen feet. She got so sick in her 3rd trimester she couldn't keep water down, so when she got to the hospital she was very dehydrated. They kept telling her "It's normal."
- One mother of three from Ward 7 said her epidural didn't work and when she told them, they said it should be working. "I felt it when I was stitched up. They told me I shouldn't feel anything, but I did," she said.
- One mother of two from Ward 5 shared that she went to the hospital saying she was ready, but that they sent her home. She said that as soon as she arrived home she felt she needed to push, and so turned around to go back, and delivered ten minutes after arriving. She was then not able to get an

epidural, even though she wanted one. She felt they hadn't listened to her.

**3. Many women were not familiar with midwives, doulas, natural birth options, support workers, or birthing centers as an option. Yet, many of the women were interested in learning more and the ones who had used these services liked their care.**

- One mother of three from Ward 8 had a doula through Mamatoto Village who came to her house and said, "I'm gonna miss her when she leaves."
- "[Natural birth] seems like an amazing experience ... I don't want a c-section." – First time mom, Ward 8

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*"I don't think they know it's an option to have a midwife or a doula ... But they all love the idea of a doula once they hear about it."*

*Mother of one, Ward 7, family support worker*

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- "It's natural, no epidural.... I wanted to try a natural birth." – Mom, Ward 5
- One mother of eight had a midwife and a waterbirth at the birthing center, and said, "I wish I had had all my other kids there."
- "I did like [my friend's] experience [at the birthing center] having the baby and going home afterward, almost makes me want to have another baby." "Watching her midwives take care of her, I was like 'oh wow.' There were no midwives or doulas at [my health center]. There were doulas at the hospital. I like that because the doulas focus on you." "During the pregnancy it's all about the baby ... having someone focus on mom is good." – Mother of three, Ward 7.

## Meet Claribel



Claribel with her three daughters at their home in NW DC

Claribel, born and raised in DC, unexpectedly became pregnant at 16. She shared that she had never received sexual education in school, adding, “I didn’t know about contraception as an option.”

As a teen, Claribel faced numerous challenges and poor treatment. During her prenatal care she felt judged, explaining, “I saw one midwife who was mean. She told me ‘why would I get pregnant so young,’ and that it was a mistake, and I would struggle.”

Claribel also reported receiving poor care when she went to deliver, saying, “It was awful ... I had a really mean nurse. She wouldn’t give me any pain meds.” She also felt the doctor did not treat her with respect, explaining, “I had a doctor come in and tell me to push ... It was my first baby and I didn’t know how to push .... He said ‘This little girl can’t push, we need to prep the room for a c-section.’” Claribel’s mother was there and requested a new doctor. After a different doctor arrived, Claribel shared that she pushed and “I had the baby after 15 minutes of pushing.”

Her experience at the hospital colored her view of that provider and she chose not to return for care, saying, “I didn’t want to go back .... the rooms were dirty. The nurses were mean ... I didn’t want to go back for my second daughter. I had bad depression and wanted a more loving environment.”

Upon coming home from the hospital, Claribel’s experience did not improve much. “I had postpartum depression right away,”

she said. “She would cry, and I wouldn’t hear her.” Claribel’s postpartum depression eventually ended, but she said she wished she had had more support after giving birth.

Today Claribel is a family support worker, working with other women in DC to navigate the complex health and social services systems to access needed care.

One of the biggest challenges, according to Claribel, is that women “just don’t know [about services].” “I’ve had people say ‘wow, I wish I knew about this with my first child .... They usually don’t know what a midwife is or what a doula is,” she explained.

Claribel works closely with women and their families to provide a full range of support from joining them at doctor appointments and helping to watch the kids while the mother is receiving care, to accompanying women to parent-teacher conferences, to receiving late-night texts about gender-based violence.

For Claribel, the key is building trust. It’s only when providers develop trust with women that women will take advice and actively pursue the care they need. Claribel added that she is motivated to do the work she does because she wants to ensure women in DC receive better care than she did.

# Key Findings: Postpartum Care

## 1. All women and most providers expressed a lack of postpartum care.

- One provider shared their postpartum follow-up rate is only 50 percent.
- Several providers and women shared that the onus is on the women to schedule follow-up appointments.
- “They just let me go .... They didn’t even know if I had a ride.”-  
Mother of two, Ward 5  
*“After I had the baby, everything dropped.”*  
Mother of five, Ward 8
- “Being with a baby is hard. I don’t have family. When I went into labor it was just my boyfriend and his mom. Now I just feel all alone.” – Mother of three, Ward 8.
- “They could have better explained the importance of going to classes .... After my 1st daughter ... there was a lot I didn’t know .... Breastfeeding was so painful, so I didn’t breastfeed for as long. If I had had a better head going into it ...” – Mother of three, Ward 7.

## 2. Most of the women reported some form of postpartum depression.

- “After the second baby, I was really sad and depressed ... I guess it was just an adjustment from one child to two.” – Mother of two, Ward 5
- “They didn’t tell me what I would go through .... I was mentally ... I was having pain.” – Mother of two, Ward 5
- One mother of one in Ward 4 said she felt depressed after giving birth. She didn’t talk

to anyone but said, “I would have loved to go to a therapist, just to talk.”

- “I had postpartum depression right away .... She would cry and I wouldn’t hear her.” – Mother of four, Ward 4.
- “In our community, women are supposed to be strong ... so they don’t say anything .... People don’t want to talk about postpartum .... We only talk about the magic of it – not talking about the really hard parts, the challenges .... In our community, nobody talks about or deals with mental health. We’re passing down generational mental illness.” – Mother of one and family support worker, Ward 7

*“In our community, women are supposed to be strong ... so they don’t say anything .... People don’t want to talk about postpartum”*

*Mother of one, Ward 7, family support worker*

## 3. Women prioritize care for their children over care for themselves.

- Several women reported missing their six-week postpartum appointments; however, none of the women missed getting their children vaccinated.
- “I missed my two-week check-up. I forgot to make it .... They left me a voicemail, and I didn’t hear it. They normally text. They should send a text.” – Mother of two, Ward 1
- One mother of one from Ward 4 said she missed her six-week appointment because she didn’t have insurance. She went back for her annual wellness visit later, and she went in for her baby’s vaccinations. She now goes for her care and the baby’s care to Children’s Adam’s Morgan clinic.

- One provider flagged that one issue they see is that many moms take their kids to Children's, but Children's doesn't provide adult care. This provider is trying to see if they can better coordinate with Children's so they can treat the moms who come in.

#### 4. The women who received home visiting in the postpartum period liked it.

- "Mary's Center is great .... Leah gave me a lot of support." – Mother of two, Ward 5
- One mother of one from Ward 4 said she felt supported by two community health workers from Mary's Center: "I needed their help. I'm thankful." What did they help you with? "They would help with everything .... For Thanksgiving, they gave me Turkey and food," she said.
- One mother of four from Ward 1 said she likes home visiting because "It's more better, easier. Sometimes when my daughter's dad goes to work, I don't have anybody to talk to. It's good to have home visiting to check on me, my kids – to give me advice." Of her family support worker, she said, "She is one of the sweetest and nicest people I've met. She helps me with diapers when I don't have money."

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*"We are only providing care when women are pregnant, but they need primary care all the time. We need to keep them in care once they've had a baby."*

*Community health worker, Ward 8*

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#### **Supporting feedback from providers included:**

- "I don't always see them showing up at the six-week .... I definitely think we are lacking in getting people scheduled before they leave .... We used to have discharge

facilitators. Now we don't have the funds to support it." – OBGYN, Ward 1

- "There is very little postpartum care because the hospital is eating the cost." – OBGYN Wards 5, 7, 8
- "We've had a lot of problems getting women to come in for postpartum care." – OBGYN Wards 5, 7, 8
- "We finally found a way to fund two case managers to follow-up with women after they leave. Still, that's only two people covering thousands of people." – OBGYN

#### 5. There are a number of barriers to postpartum contraception adoption.

##### **There is confusion around reimbursement for postpartum LARCs.**

- Several providers shared that hospitals don't have an incentive to insert IUDs and implants because the cost of such methods is high and eats into their already small profit margin. Instead, women are encouraged to come back in six weeks, but many do not return.
- One woman had requested a tubal ligation, but she said there was a mix up – they let her eat and then she couldn't get the surgery. They told her to come back but she said, "No!" She left with a three-month shot of Depo. She had learned about tubal ligation in Centering.
- One mother of two in Ward 1 said that after she gave birth, the hospital asked her to come back in six weeks for a contraceptive, but that "I would have liked to have it when I left the hospital."
- One mother of four from Ward 4 said the hospital scheduled her postpartum visit farther than six weeks out, so she went to her primary care doctor instead, and that doctor offered her an arm implant instead.
- Several women reported not being offered postpartum contraception.

**Religious organizations are not proactively offering LARCs.**

- One mother of two in Ward 5 said, “[Hospital] told me they are a Catholic hospital and they don’t mention birth control unless you mention it.” After her 1st child they didn't discuss family planning, she left and got pregnant two months later. She was experiencing homelessness at the time, and is currently still living in transitional housing.
  - After her 2nd child, she asked for Depo and the hospital gave it to her. She went back after 6 weeks and got an arm implant.

## Key Findings: Cross-cutting Issues

### 1. Awareness of *quality* services was identified as the leading barrier.

- “I didn’t know anything about the system ... I was out here trying to fend for myself. It was rough .... When I got to Virginia Williams, they should have provided a list of providers and services.” - Mother of two, Ward 5
- One mother of two from Ward 1 said her biggest challenge was accessing information: “They send a big packet in the mail, but I don’t go through it.”
- “Most people aren’t aware of services, because I wasn’t.” – First pregnancy, Ward 8
- “Someone somewhere should tell us more about programs .... A lot of people don’t know about the free diapers and milk .... I hear a lot of ‘I didn’t know about that.’” – Mother of two, Ward 5
- One mother of five from Ward 8 said she had no idea you could do a water birth in NE DC on Medicaid. She heard about the Birth Center from a friend, but added that a lot of people don’t know about the services.
- Why are women getting into care so late? “I always go back to information. A lot of women don’t know what signs to look for, so they don’t know they are pregnant .... Living in DC, there are so many opportunities; so many clients don’t know about services .... They don’t even know they have the options. No one is telling them. The resources are there ... the initiative is not there. Or even feeling like they deserve something better for

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*“Offering services is good, but we have to know about them.”*

*Mother of three, Ward 7*

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themselves .... We need a confidence support group. It’s generational .... In our community, the black woman is taught to look out for everybody else ... and that will make them happy .... That’s very common - They want to have children for their partner .... Black women need to give themselves permission to put themselves first .... Knowledge, information, and access to services would help.” – Mother of one, Ward 7.

- One mother of one from Ward 4 did not know about Mary’s Center and the services they offer before they approached her in the hospital.
- One mother of four from Ward 4 who is also a family support worker said for her first pregnancy prior to getting referred, she had not heard about the prenatal care at George Washington. She said that one of the biggest issues is that “they just don’t know [about services].” She added that women don’t know about home visiting services. “I’ve had people say, ‘wow, I wish I knew about this with my first child.’ .... They usually don’t know what a midwife is or what a doula is,” she added.
- “The resources are available, but women don’t know about them or don’t want to use them.” – Community health worker, Ward 8

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*“Living in DC, there are so many opportunities; so many clients don’t know about services .... They don’t even know they have the options. No one is telling them. The resources are there ... the initiative is not there. Or even feeling like they deserve something better for themselves.”*

*Mother of one, Ward 7, Family Support Worker*

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- These findings match those found in the 2018 Family Planning Community Needs

Assessment, which found that more than 30 percent of women interviewed in Wards 5, 7, and 8 reported having “never” visited a provider for family planning services.<sup>35</sup>

## 2. Word of mouth is very powerful. When asked how they heard about a service provider, most women said a friend or family member.

- One mother of five from Ward 8 heard about a birthing center in Northeast and their ability to do water births from a friend.
- One mother of one from Ward 1 went to her provider on the recommendation of her aunt.
- One first time mom from Ward 8 heard about Community of Hope from her sister.

## 3. Transportation is a challenge, but appears to be a greater challenge for those who are high-risk.

- When asked why they missed an appointment, only one woman said transportation. She was living in the Howard Johnson Hotel on New York Avenue and wanted to receive care at Georgetown, and so commuted across town.
- When asked if transport was a major challenge, all women except one said no.
- However, when asked about Medicaid transport, most women had very negative feedback, with multiple stories of waiting 2 – 6 hours for a scheduled ride.
  - One mother of two in Ward 5 waited 3 hours for Medicaid transport. “They suck,” she said.
  - “They would make me late. They would be late .... One time I waited so long I finally took the bus home ... Now I take Lyft to appointments.” She pays out of pocket for the Lyfts. – Mother of two, Ward 1

- One mother of two from Ward 5 said the Medicaid van would be 20 minutes late picking her up. Then they would pick someone else up and drop him/her off, causing her to be late. “The driver was very rude ... very unprofessional,” she said.
- One mother of four who is also a family support worker with Mary’s Center said she had a patient who called the Medicaid van, and it never showed up and she missed her appointment. “I have participants all the time who ask ‘can you take me to that appointment?’” she said. She added that transportation is the most difficult in Southeast, but they are opening more clinics, and it’s becoming easier.
- For some high-risk patients who have to travel to a hospital, rather than a community health center, more frequently for tests during their pregnancy, the transportation burden is higher.

## 4. Small incentives are key and can be powerful.

- Women and providers all reported that gift cards, food, and baby gear were good incentives to encourage women to come in for care.
  - When asked if women would be motivated to attend an appointment by \$10 rather than \$20, most said yes.
  - The specific places suggested for gift cards include: Safeway, Giant, Walmart, CVS, Target, Chipotle, Subway, I-Hop, Fandango
  - Many of the women mentioned receiving gift cards for their children’s check-ups, but noted they don’t receive gift cards for their own care.

## 5. Housing is a critical and urgent unmet need.

**Every single one of the women interviewed had experienced homelessness or housing insecurity.**

- “I was on the list for 13 and a half years before I got housing .... They treated us like we're defendants; we are victims .... I used to stay at the Grey Hound station.” – Mother of three, Ward 8
- One mother of five from Ward 8 said she fought for ten years to get housing and finally got a voucher in 2015. She added that three-bedroom apartments are hard to find.
- One mother of two from Ward 5 said she has been homeless since age 16. Virginia Williams told her should could not get into housing until she was 7 months pregnant. “That part was difficult, being pregnant and homeless .... We were at the Days Inn when I was pregnant. The room smelled like antifreeze,” she said.
- One mother of two from Ward 5 experienced homelessness with her son. They lived in her car and then they lived in shelter for one year (DC General) before finally receiving a voucher.
- One mother of one in Ward 1 said she had been living with her mom in a one-bedroom apartment. She was living in the living room with her boyfriend and baby. She said a lot of “people were coming and going” and she was “worried about drugs.” She said there was a lot of “white stuff” in the kitchen, “it was scary, and I was really frightened” about being there with the baby. So she left. “My mother and father were struggling with substance abuse,” she said.
- One mother of one from Ward 7 said Edgewood sent her to Community of Hope’s housing assistance, but they turned her down. She was homeless for a time. She called the shelter hotline and they sent her to DC General. She got a new caseworker through DC General, applied for rapid rehousing, and got an apartment.
- One mother of three from Ward 7 said she lived in a shelter for 6 months: “My daughter was living in a shelter with me. It was a hard time .... I was having a rough

time in the shelter. I was getting depressed.”

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*“That part was difficult, being pregnant and homeless .... We were at the Days Inn when I was pregnant. The room smelled like antifreeze.”*

*Mother of two, Ward 5*

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- One mother of one from Ward 4 said her family was evicted from their apartment after her dad was not able to pay the rent. Her dad would not allow her mom to work. She lived with friends and family, moving back and forth between DC and Maryland during her pregnancy.
- One mother of four in Ward 4 who is a family support worker said her step dad kicked her out at 16 after learning she was pregnant. When asked if housing is an issue for the women she sees, she said, "Yes, for all of them."
- One 21-year-old mother of one experienced housing insecurity her whole life, saying, “I never knew my parents very well ... my mom was homeless, she died in February ... both had mental health issues. I was in foster care.” She then became homeless at age 19 in her 7<sup>th</sup> month of pregnancy. She went to Virginia Williams and they recommended she go to a shelter, which she did, saying, “I went to the shelter. I was not comfortable ... my sleep and stuff ...I was sleeping on a cot. I was twisting and turning, trying to get comfortable. I like to sleep on my side. I wish I had a comforter.”

**Lack of housing exacerbates nutritional challenges.**

- One mother of three from Ward 8 explained that nutrition is hard when living in a shelter because you can't bring your own

food, so it's hard to eat healthily while pregnant.

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*One mother of two from Ward 5 said she had low iron and would faint sometimes while pregnant. She felt it was in part because she was living in a hotel and she didn't have a kitchen and so couldn't cook. She said her diet during that time was not good.*

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#### **Feedback from providers:**

- “We see a fair share of patients in a shelter or transient. This might be why they aren't coming into care.” – OBGYN, Ward 1
- One OBGYN at Medstar Washington Hospital Center shared that she had one woman come in with a very small fetus. The doctor asked the woman what she was eating, and found out that she had not been eating because she was homeless and had been living on the street with her other son.

## 6. Nutrition is another major issue mentioned by all interviewees.

- Most of the women interviewed receive SNAP and WIC.
- One mother of three in Ward 8 buys in bulk and freezes her food so she can stretch the money farther.
- One mother of two in Ward 1 talked about the challenges she faced when she was cut off from food stamps after going back to work: “Once you start working, they cut off all your benefits ... it's really hard. Taking away food stamps was an eye-opener .... There were times when we didn't have anything but snacks ... we didn't have meat or vegetables.”
- Providers also identified nutrition as a major challenge and noted that many

women have diabetes and hypertension, which are exacerbated by poor diet. Getting women housed and into primary care and prenatal care where they can receive nutrition counseling and eat more healthily is key to improved maternal and child health outcomes.

- One MCO started a meal delivery service, providing nutritionally complete meals to members with high risk pregnancies, gestational diabetes, hypertension/preeclampsia, or food insecurities placing their pregnancy at risk. Members receive meals until 45 days postpartum. They deliver food for mom and kids 14 days at a time. They will also pay for a dietician to come to the woman's house and do a cabinet inventory.

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*“Taking away food stamps was an eye-opener .... There were times when we didn't have anything but snacks ... we didn't have meat or vegetables.”*

*Mother of two, Ward 1*

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## 7. Child care was another major challenge.

- Many women shared that the cost of child care is higher than what they could make working, so they will wait until their baby is 3 and in pre-school to work again.
- Many women also noted that child care at provider offices would be good.
- One mother of four from Ward 1 said she missed a doctor's appointment “because my kids' father was working, and I didn't have no body to care for the babies.”

## 8. Respectful and culturally aware care is key.

- When asked whether women ever felt discriminated against or treated poorly, they all said no. However, when asked if they ever had a bad experience, several stories that indicate culturally unaware or disrespectful care came to light.
- One mother of one from Ward 4 was trying to breastfeed after giving birth and the baby wasn't latching. She was also in a lot of pain, but she felt the hospital was not responding to her needs: "They weren't coming in ... I was in pain."

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*"We as black women, we need other women like us ... we've been through a lot ... shelters. Of the providers: "Where's the passion? Where's the love?"*

*Mother of three, Ward 8*

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- One mother from Ward 5 had a lot of questions and fears during pregnancy. She called the hotline, and would leave messages, but sometimes she would not receive a response, or she felt the person speaking to her was "rude."
- One mom from Ward 8 said she stopped going to a provider because they were not "professional." She said, "don't just hire someone from southeast, they need to be good, be professional." She wants to receive care in a place that is clean, and she wants to be greeted in a kind, professional way. She felt many workers there had "bad attitudes."
- One mother of five from Ward 8 said some people of color don't want to go to the doctor. They don't want to tell the doctor "I smoke weed," she said.

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*"I saw one midwife who was mean. She told me, 'Why would I get pregnant so young,' and that it was a mistake, and I would struggle."*

*Mother of four, Ward 4*

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- One mother of two from Ward 5 said in the hospital's mobile van, "they were kind of ... they would call my mom and tell her about stuff with my kids .... So I stopped going there."
- One mother of two in Ward 1 went to a hospital once for regular health check-up and had a bad experience. "I didn't like that hospital," she said. She asked for a female doctor and they gave her a male doctor. She felt very uncomfortable. She did not ever go back after that.
- "A lot of people they hire in Wards 7 and 8 are just doing it for the money." – Mother of one, Ward 7
- "Subconsciously, when white women talk to them about birth control, there is a fear of fertility control." – Mother of one, Ward 7, family support worker
- "I felt it when I was stitched up. They told me I shouldn't feel anything, but I did." – Mother of three, Ward 7
- When asked why women wait to get into care, one mother of three from Ward 7 said, "They may be afraid of being a stereotype. Be afraid of telling a doctor the baby's father isn't in the picture. Afraid of being judged."
- One mother of one from Ward 4 said when she came in to deliver they would not let her eat, so she spent a whole day without eating and was very hungry. She explained: "The baby came out hungry .... I breastfed her. It was hard; the milk wasn't coming in

.... The baby was hungry, they gave her milk, but it took too long .... Only one nurse was nice. I would go out in the hall and they would be talking ... it's like 'I need you in here.'"

- One mother of one from Ward 8 said of her epidural, "They said it wasn't supposed to hurt, but it really hurt – like someone stabbing me."
- These findings are supported by the 2018 Family Planning Community Needs Assessment, which found almost all of the provider and staff characteristics were reported as important factors to patients interviewed, including "staff talk to me about the side effects of birth control," "the staff listen to me," and "the staff respect me."<sup>36</sup>
- The 2018 Community Needs Assessment also found 19.94% of those surveyed reported that information received as part of a recent visit for family planning services was not useful.<sup>37</sup>

### Provider Feedback:

- One provider working in Wards 7 and 8 said, "Some trainees come in who haven't worked with people of color." She added: "Since I've been in Southeast for ten years, I haven't received an internal training on reproductive justice ... That would be helpful."

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*"Since I've been in Southeast for ten years, I haven't received an internal training on reproductive justice ... That would be helpful."*

*Provider in Wards 7 & 8*

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- When asked, "Do you feel you provide culturally aware care?" One provider answered: "I don't know the answer to that."

- "It's hard for us to know if it's an issue ... I wouldn't know." – OBGYN in Wards 5, 7, and 8

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*"I need help. I need the words to communicate properly. When I offer LARCs, I get shut down immediately. I don't know if it's a reproductive rights thing. Maybe it's because I'm white."*

OBGYN

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- One provider said, "Patients need to take responsibility for their health. Patients act helpless ... They think, 'My doctor should fix that.' But they need to take ownership. We can't go to their houses and make them act healthy."
- A few community-based providers had a deeper understanding of the cultural challenges faced by some patients. One midwife working in Wards 5, 7, and 8 shared that she heard stories from patients who felt discriminated against. For example, one woman of color was asked by a provider if her "baby daddy" would come to a visit, and the woman responded, "you mean my husband?"
- One midwife working in Wards 5, 7, and 8 shared that a provider might suggest a pregnant patient eat more kale or lentils, but that they should be asking who in the woman's house controls the grocery budget. Many women live in houses where someone else makes the food purchasing decisions. A better approach is asking the woman what she eats, and seeing how you can incorporate healthier options into her existing diet.
- Several providers identified low levels of literacy or English language skills as a challenge.

- “Many providers give out pamphlets, but a number of patients cannot read.” – Midwife
- “Working in the Hispanic community, a lot of people don’t read and write .... They are explained things too fast. They don’t understand .... I’ve had women who have Depo, they think they are pregnant because they aren’t getting a period. That’s a common side effect, but they didn’t understand ..... I get pamphlets with pictures ... and use color codes .... I do not make them feel bad.” – Hispanic mother of four, Ward 4, Family Support Worker

## 9. Electronic health records and health information exchange can be improved.

- Many providers shared that they don’t feed into CRISP, a health information exchange for the District’s hospitals and some primary care providers.
- One provider who uses CRISP described it as “clunky” and “unreliable.”
- One provider shared that older doctors aren’t using CRISP and rely on younger doctors to help them. She added that it needs to be easier to use.

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*“I use CRISP on a limited basis. A lot prenatal information is not in CRISP .... In an ideal world, we would be able to see ultrasounds, labs, and flow sheets.”*

### OBGYN

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- There is no easy way to view all the needed information for a pregnant patient (e.g. ultrasounds, labs, dates, flow sheet).
- One patient said the hospital was not sending her sonograms to her community health provider, so she had to wait each

time she came in for them to call and track down the images.

- When asked about EHR, one provider said, “There’s a lot of room for improvement.” The same provider added that there needs to be a way to share information with adolescents confidentially.
- “The hospital has a set of records and the office has a set, but they don’t talk to each other.” – OBGYN, Ward 5

## 10. Communication channels can be improved.

- When asked which form of communication they prefer, all women said text. Most providers are not using text.
- Some women said emails and phone calls are good too.
- Only one patient was using an app, but she said it was hard to understand, so she didn’t use it often.
- “We use a patient portal. It’s terrible. It’s embarrassing ... We need to use text more.” – OBGYN Ward 5

## 11. Insurance can be improved.

- Medstar Washington Hospital Center only accepts AmeriHealth, and is the only place Community of Hope midwives have privileges. This means that when midwives have patients from the other two MCOs (Amerigroup and Trusted) who have to deliver at Medstar, there is a break in their care, because the midwives can’t deliver the babies. This can lead to worse outcomes.
- Recertification of Medicaid is a challenge for some patients. Patients who move around a lot, including between DC, MD, and VA, have to recertify each time they move in or out of DC to ensure they still meet the requirements to receive benefits in DC. Often the notice is sent via letter, which never reaches the patient.
  - Some MCOs work to use email and text message to reach people about recertification.

- This could be expanded to ensure all patients are being texted and emailed about recertification. Recertification could also be flagged on the electronic health record, so the provider is aware and can help them recertify when they come into the office.

## 12. Providers need better and more frequent feedback on patient outcomes and satisfaction.

- While all the providers had some sort of general survey, none of them had surveys tailored for reproductive and maternity care, and none of them used the survey feedback to alter their services.
  - For example, when asked why their patients choose them for care, none of the providers had survey data from patients on why they were choosing that provider. Similarly, when asked why patients missed an appointment, none of the providers had any survey data on causes of no-show rates.
  - When asked if such data would be useful, all providers said “yes.”
- When asked what the greatest challenge facing them is, one adolescent health provider said, “Are the services we are providing and the way we reach teens working for the teens? .... We want to better assess what teens think ... what providers think. Are they comfortable? How are we doing?”
- When asked if they feel they are providing culturally appropriate care, several providers said they didn’t know.
- One provider was asked what percentage of the people she talks to about contraception actually adopt a method. The provider responded: “That’s a good question. I don’t know.”
- “We don’t track our outcomes. We don’t know what our disparities are.” – OBGYN

- “I don’t know the barriers to care [for my patients].” – OBGYN

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*When asked if she is providing culturally appropriate care one provider said, “I cannot answer. We have not asked how good a job we are doing .... It would be helpful to solicit that information from our patients.”*

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# A Roadmap for Action

The interviews conducted to date give us unique insights into the challenges, barriers, and unmet reproductive and maternal health needs of low-income women in the District. The 12 recommendations below, co-created with women and providers, present a roadmap for action that can be pursued to improve the health and well-being of women and their families.

In order to chart a clear and feasible path forward, we focused on the most actionable solutions that are most pressing and can be pursued immediately at relatively low cost. These solutions that emerged from our interviews are also consistent with best practices that have been implemented in other states and localities.

The solutions fall into two categories. The first category focuses on opportunities for scale-up and increased investment in existing evidence-based interventions to increase reach and improve outcomes. The second category puts forth new ideas that should be pilot tested for their potential to address an unmet need.

Finally, following this “Roadmap for Action” is an additional set of solutions that have been suggested by either providers or women we interviewed. These recommendations could be considered in the future.

## **Illustrative Cost Estimates**

*Please note the cost estimates below are illustrative and not finalized. They are meant to give policymakers and potential partners an idea of the scope of budget that would be needed to test and implement several of these solutions. As recommendations are adopted, updated budget numbers will be provided together with implementing partners.*

# Solutions to Scale-Up

## 1. Invest in personnel to ensure coordinated, quality care across a woman’s reproductive life.

A common theme throughout the interviews was a lack of coordinated, quality care. Pregnant women are entering care late or not at all, missing postpartum appointments, and dropping out of care after giving birth. In order to ensure women are aware of services and connecting with services before, during, and after pregnancy, strategic investments in care coordinators can pay significant dividends. Three specific recommendations aimed at improving quality and coordination of maternal care in DC are outlined below:

### a. Expand Centering Pregnancy model

- All women who participated in Centering reported high satisfaction. Specifically, they liked learning more about their pregnancy and being with other women, hearing from them, and knowing they weren’t alone.
- For many of the women in need of care, they do not have support systems, and Centering creates a support system and more hands-on care from midwives and other community health workers who can spend more time with the women than physicians.
- According to the 2018 DC Perinatal Health and Infant Mortality Report, approximately half of black women (49%) and more than 1 in 3 Hispanic women (35%) are not getting into prenatal care until their 2<sup>nd</sup> or 3<sup>rd</sup> trimester or not receiving care at all.
- Non-Hispanic black mothers are 2.3 times more likely than white mothers to receive delayed or no prenatal care.<sup>38</sup>
- Centering Pregnancy is an evidence-based approach to prenatal care that brings women at similar points in their

pregnancies together for a series of 10 prenatal visits, in a group setting, to learn about a variety of topics and build community.

- Centering Pregnancy decreases the rate of preterm<sup>39</sup> and low-weight babies, increases breastfeeding rates,<sup>40</sup> and leads to better pregnancy spacing.<sup>41</sup>
- Centering Pregnancy can also save resources by reducing costly neonatal intensive care unit (NICU) admissions. One study found a savings of more than 4:1 for every dollar invested in Centering Pregnancy that averted NICU costs.<sup>42</sup>
- All providers currently offering Centering said they liked providing the service, and those who are not offering it expressed an interest in being able to do so.
- Medicaid reimburses for Centering-- the cost barrier is the staff time needed to coordinate and facilitate Centering. All providers currently offering it had received a grant to cover the staff time, but all the grants are set to expire.

## Estimated Cost & Action Needed

Table. 4 Illustrative Budget Estimate

Activity	Details	Annual Cost	Four-Year Cost
Centering certification	6 FTEs & 4 facilities	\$15,100	\$42,400
Centering coordinator	6 FTEs at \$60,000	\$360,000	\$1,440,000
<b>Total</b>		<b>\$375,100</b>	<b>\$1,482,400</b>

- Centering Certification Cost Assumptions: Assumes \$850 per person for basic facilitation training and the need for two facilitators per group. Assumes cost for one implementation services plan (two one year payments of \$9,250) and three annual site licensing fees of \$250 per year.

- Centering Coordinator Cost Assumptions: Assumes \$50,000 salary plus 20% fringe benefits.
- According to the DC Perinatal Health and Infant Mortality Report, there are 5,255 women of color not entering care until their 2nd or 3rd trimester or receiving care at all; assuming Centering is a good fit for even half of these women, and if each coordinator can provide care to 200 women over the course of a year; 13 care coordinators would be needed. The estimate above projects the cost for 6 additional positions, which would be start toward better care coordination.
- These cost estimates would allow community health centers, all of whom have expressed interest in providing or expanding Centering, to compete for six new Centering programs with the ability to reach 1,200 women with prenatal services through Centering Pregnancy.
- Applying the return on investment seen in other Centering programs of 4 to 1, this investment could save close to \$1.5 million in one year alone.

**b. Utilize postpartum coordinators to follow-up with women and coordinate their care.**

- As the interviews with both women and providers reveal, there is a serious lack of postpartum care with some women not returning for their recommended postpartum check-up and many feeling that supportive health services they could use, such as mental health services, family planning, and breastfeeding support were not available.
- Providers all reported feeling care coordination in the postpartum phase is lacking and causes women who enter into care to drop out of the system, missing an opportunity to engage them, improve broader health, and prevent future poor maternal and infant health outcomes.
- 49 percent of women in DC on Medicaid, CHIP, or dual eligible had a postpartum care visit between 21 and 56 days after birth, according to Medicaid data from the Adult Core Set.<sup>43</sup>

- According to ACOG, a lack of postpartum care reduces the ability to manage chronic conditions and improve contraception use, which increases the risk of short interval pregnancy and preterm birth.<sup>44</sup>
- More than half of pregnancy-related maternal deaths occur after the birth of the infant,<sup>45</sup> indicating care in this postpartum period is vital to reducing maternal death.
- Providers also added that the lack of coordination stems from poor and disjointed reimbursement.
- Without concerted postpartum care coordination, the burden falls to women to reach out to secure needed services. This means many women end up without needed care. In a recent U.S. survey, one in four postpartum women did not have a phone number for a health care provider to contact for any health concerns.<sup>46</sup>
- These findings are supported by national data which finds as many as 40 percent of women do not attend a postpartum visit,<sup>47</sup> and attendance rates are lower among populations with limited resources.<sup>48</sup>
- Several providers have secured funds to hire postpartum coordinators who can follow up with women after giving birth to ensure the women are receiving the care they need. Those providers who do not have postpartum coordinators would like to hire coordinators but currently lack the resources.
- Postpartum coordinators move the burden from the women and the clinical care providers to a person dedicated to coordinating care for women and are recommended members of the Postpartum Care Team outlined in ACOG's 2018 Presidential Task Force on Redefining the Postpartum Visit.<sup>49</sup>

**Estimated Cost & Action Needed**

- In order to ensure women are receiving continuous, coordinated care from prenatal all the way through postpartum, Centering

coordinators could be employed to ensure women are receiving the care they need in the postpartum period and are being seen for their first postpartum visit in the first 3 weeks after birth, as recommended by ACOG.<sup>50</sup>

- The CMS Maternal & Infant Health Initiative outlined a series of strategies that employ some type of care coordinator or community health worker and saw significant increases in postpartum care utilization.<sup>51</sup> For example, a program in Pennsylvania paired high-risk, primarily black women with community-trained doulas and saw a 10 percent increase in PPC visit rate.
- To ensure women and their families are supported during pregnancy and continue to receive the care they need after giving birth – care such as breastfeeding support, mental health services, family planning services, and other wrap-around services to reduce poor health outcomes and costs – the District could explore increased investment in and cross-agency coordination of home visiting.
- ACOG lists at-home care providers as members of its recommended Postpartum Care Team and notes that “additional mechanisms for assessing women’s health needs after birth include home visits, phone support, text messages,” and other remote supports.<sup>52</sup>
- Home visiting programs have been shown to increase breastfeeding, reduce preterm and low birth weight babies, reduce depression, and improve nutrition, among other benefits, while also saving \$5.70 for every dollar invested.<sup>53</sup>
- An estimated 33 states also use Medicaid to cover some home visiting services, including through their MCO contracts.<sup>54</sup> Currently, no DC home visiting programs implementing evidence-based models receive Medicaid reimbursement for services.
- Nationally, states often provide significant local and private funds supplemented by Maternal, Infant, and Early Childhood Home Visiting (MIECHV); however, in DC MIECHV remains the largest source of home visiting funding.
- The District could conduct a feasibility study, as recommended by the Center for American Progress,<sup>55</sup> to assess which services could be

covered by Medicaid, the potential cost-savings, changes that could be made to the DC Medicaid State Plan, and additional funding sources needed.

- Additionally, DHCF could work with MCOs to increase the availability of at-home care in the postpartum period.

### **c. Standardize coordination of postpartum mother and baby check-ups**

- A consistent theme in the interviews was that mothers prioritize their children’s care over their own. While some women missed their postpartum check-up, none reported missing their appointments for their children.
- In order to take advantage of the fact that women appear to come in for their children’s care more than their own, providers should ensure care for moms is provided alongside care for babies.
- MCOs in other states, including New York are working to schedule postpartum care alongside new born visits,<sup>56</sup> and research shows there is support for colocation of postpartum services at Well-Baby visits due to convenience.<sup>57</sup>
- Providers should work to ensure that when mothers come in for their babies’ vaccinations, moms get check-ups as well.
- All providers interviewed agreed this is a good practice and some try to do it.

### **Estimated Cost & Action Needed**

- This recommendation requires no additional cost. The action needed is for providers to make a concerted effort to ensure that when moms schedule appointments for their babies, that providers are scheduling follow-up appointments for mothers as well, preferably at the same time, in order to improve coordination and increase postpartum care for mothers.
- Children’s Hospital may also want to consider partnering with maternal health providers in the community to ensure that when moms

come in for care for their children, the moms are referred for needed care as well.

- One challenge is that there are many more pediatricians than OBGYNs. Providers need to keep their schedules full.
- Engaging more family practice doctors may be beneficial, as they can provide care for both the mother and the baby.
- One way to reduce costs would be to host postpartum group care, and then have a pediatrician attend the meeting to see the babies while the moms are present.

## 2. Expand telehealth for pregnant patients at community health centers, with a focus on high-risk patients.

- The interviews and a mapping of providers revealed that for most women, there are a number of prenatal and reproductive health care providers in their wards, including Wards 7 and 8. The women with high-risk pregnancies, who need to see Maternal Fetal Medicine (MFM) doctors only located at hospitals on the west side of the city, are the segment facing challenges accessing this specialty prenatal care.
- One woman interviewed from Ward 8 who had weekly and biweekly check-ups at a hospital in NW shared that she was thinking of skipping her next appointment because it was too far to commute when she had just gone and thought they would tell her the same thing. She added that she would use telehealth if it was available.
- One solution would be to support community health centers, primarily located in Wards 7 and 8, to use telehealth consultations with MFMs at hospitals on the other side of the District, so the women don't have to commute. Preferably, the consultations would be with MFMs at the hospitals where the women plan to deliver.
  - Arkansas runs a telehealth program for high-risk obstetric patients, allowing video conferencing with MFMs, and over a nine-month period saw Medicaid deliveries of very low birthweight infants in hospitals without NICUs decrease from 13.1 percent to 7.0 percent and saw a small but statistically significant reduction in infant mortality.<sup>58</sup>
  - The Arkansas program also provides a 24-hour call center for provider access to specialty OBGYN consultations.
  - Virginia runs a similar program connecting specialists with high-risk obstetric patients via videoconference and saw a 39 percent reduction in NICU hospital days and a 62 percent reduction in patient appointment no-shows.<sup>59</sup>
- Community of Hope tried to use telehealth for certain high-risk consultations, but was not able to secure commitments from MFMs to be available for telehealth consultations. Specifically, Community of Hope had difficulty securing the volume of patients needed to offset the cost of a single provider's time, in part because they have a high rate of patients not coming for appointments.
- Unity also expressed interest in using telehealth consultations for high-risk pregnancies.
- Mary's Center has also been providing telehealth services for some patients through their home visiting program and is set to begin scheduling low-risk obstetric (OB) patients for telehealth.
  - Mary's Center will employ one of their nurse midwives, who is trained in telehealth, to pilot the use of telehealth for low-risk OB patients. Mary's Center purchased two portable dopplers for use in the field. Mary's Center has found home visitors using telehealth extremely beneficial because it allows patients to see physicians from their homes, while allowing the home visitor to develop a strong relationship with the patient that allows him/her to ensure the patient understands the medical advice, fills and picks up

prescriptions, and addresses other social determinants of health.

- Mary's Center receives reimbursement from Trusted and AmeriHealth MCOs for telehealth visits.
- AmeriHealth already reimburses for telehealth. There would be no need to change the contract or policy. Allowing providers to bill for telehealth would simply require a modifier on the claim, according to AmeriHealth.

### Estimated Cost & Action Needed

- MCOs should reimburse for telehealth consults for pregnant women in the District, with a focus on high-risk women.
- Maternal Fetal Medicine doctors need to agree to partner with community health centers to provide consultations for pregnant mothers.
  - One provider shared they have enough volume for eight high-risk patients for one or two half-day sessions with a MFM per month.
  - One other approach would be to model the program on the DC MAP pediatric psychiatry telehealth program which provides a hotline providers can call and receive a call back from a specialist within 30 minutes. The patient is not present, but this approach facilitates provider to provider consultations.
  - Some providers may want to join together to create a critical volume of patients in order to secure time with remote specialists.
  - The MFMs could be scheduled during Centering or group prenatal care sessions to ensure a higher volume of patients.
- If providers want to expand telehealth provision beyond their clinics to lower risk patients via home visits, they may need to purchase some equipment to enable maternal telehealth consults such as portable dopplers, internet "hot spots," high-definition laptop and point-of-care tests.

- Providers piloting and scaling telehealth, and specifically those providing services to pregnant women, should create a working group to share best practices and lessons learned.

### 3. Ensure providers are aware of separate payment for postpartum LARCs and access to commodities is easy.

- Several providers reported that the current reimbursement system disincentivizes postpartum LARC insertion. They reported that because LARCs are included in a "maternity care bundle" there is a disincentive to provide them.
- DHCF issued guidance in 2014 aimed at clarifying Medicaid coverage of LARCs, including separate payment for postpartum LARCs to ensure no disincentive.
- AmeriHealth already does this and several providers shared that the separate payment enables them to offer higher-cost LARCs in the postpartum period.
- DHCF, MCOs, and hospitals should ensure separate payments for postpartum LARCs are available and that providers are aware of this policy.
- Providers shared that in addition to the payment hurdle they also sometimes face challenges accessing LARCs in the hospital. One providers said, "It's not easy. I have to get my hands on a LARC."
- To streamline easy access to postpartum LARCs, AmeriHealth gives providers an expidose cabinet which provides a full range of contraceptives.
  - Delaware has implemented a similar program where providers order LARCs out of pocket through the hospital's inpatient pharmacy and stock the devices in an automated dispensing cabinet on labor and delivery floors. The hospital's pharmacy tracks devices removed from the cabinet and passes the information to the outpatient pharmacy that then submits a claim to Medicaid.<sup>60</sup>

NEMT has an agreement with Lyft to offer transportation in 31 states.<sup>62</sup>

### Estimated Cost & Action Needed

- This recommendation will not generate new costs for the District and in fact will likely reduce health care costs by increasing contraceptive use and therefore unintended pregnancies. DHCF could ensure language is included in all MCO contracts requiring separate payments for postpartum LARCs and that providers are aware of this policy.
- Amerihealth's expidose cabinet model providing quick and easy access to LARCs could be expanded to ensure all providers can easily secure LARCs in the postpartum phase.
  - Delaware's initiative to ensure all women have access to quality contraceptives is estimated to save \$16.2 million annually, and \$48.5 million over three years.<sup>61</sup>

## 4. Transportation: Expand access to Lyft and Uber through MCOs.

- While transportation was not identified as a leading barrier to care, poor transportation through Medicaid and the high cost of public transport were still identified as issues.
- All interviewees agreed increased access to Lyft and Uber would be good and preferred over the Medicaid van service due to their convenience and flexibility.
- Several interviewees added that Lyft and Uber should offer car seats.
- AmeriHealth currently offers Lyft as an option to all pregnant members. They offer Lyft to any member who needs a ride to an appointment in less than three days. For appointments more than three days out, they offer rides through Medical Transportation Management (MTM) Inc.
- Other states are adopting ridesharing. Circulation, a non-emergency medical transportation (NEMT) company, has an agreement with Uber to provide ridesharing in 25 states, and LogistiCare, another

### Estimated Cost & Action Needed

- Transportation is a covered benefit under Medicaid, therefore, MCOs need to ensure they cover the cost of ride-sharing transportation for reproductive health services, negotiate a rate with Lyft or Uber, and ensure their members are aware of the availability of those services.
- **Potential Private Sector Partners:** Uber and Lyft could be approached about offering discounted or free rides to pregnant women seeking care. There is a precedent for offering free rides as part of their corporate social responsibility efforts. Lyft offered free rides to anti-gun rallies and discounted rides to the Women's March. After recent reports of gender-based discrimination at Uber, the company may be open to partnering on a program aimed at helping women.

## 5. Invest in affordable housing; it's essential to maternal health.

- Homelessness and housing instability was identified as a significant challenge by every one of the women interviewed and all the providers.
- This is not surprising considering housing costs in the District have surpassed inflation by 50 percent and one in five DC households now pay more than half of their income towards rent.
- According to the 2017 DC Women's Needs Assessment Report by the Women's Task Force of the DC Interagency Council on Homelessness, 57 percent of women experiencing homeless who were surveyed have been diagnosed with ambulatory, hearing, vision, cognitive disability, or a chronic medical condition.<sup>63</sup> Only approximately half of survey participants (52 percent) had had a Pap smear or mammogram within the past year.
- The interviews make clear a lack of stable, quality housing is impeding women's ability

to focus on themselves, plan their families, and get into care once they are pregnant. A lack of housing is also driving stress and poor nutrition, which exacerbate maternal and infant health risk factors such as diabetes and hypertension.

- While funding for housing is separate from health care spending, if the District wants to reduce maternal mortality and poor health outcomes for women and children, it will invest in affordable housing.

### **Estimated Cost & Action Needed**

- Representatives from the affordable housing community, specifically members from the Interagency Council on Homelessness Medicaid Work Groups, should be invited to key reproductive and maternal health meetings, such as those of the women's health collaborative; and members from the women's health community should attend key housing meetings in order to support coordination.
- The Coalition for Nonprofit Housing and Economic Development (CNHED) has recommended substantial investment in a continuum of affordable housing, calling for increased funding for a spectrum of affordable housing programs, including the Housing Production Trust Fund, and full implementation of the DC Interagency Council on Homelessness Strategic Plan.<sup>64</sup>
- In particular, full funding for Permanent Support Housing (PSH), which matches housing subsidies with wrap-around case management; and Targeted Affordable Housing (TAH), a similar program but for those who require less intensive services; would be of particular assistance to low-income women who are pregnant or at risk of becoming pregnant.
- In addition to increasing funding for housing programs, the District should ensure the State Medicaid Plan covers as many of the housing-related services and activities provided in PSH as possible for Medicaid enrollees.
- The District should also build the capacity of PSH providers to bill for Medicaid.

- Many residents of supportive housing are also covered by Medicaid. Historically, assistance securing housing, transportation services, assistance obtaining and maintaining Medicaid, and other wellness programs for individuals in supportive housing have often been paid for through housing funds. Enabling Medicaid to cover some of the services provided by staff embedded in supportive housing programs could provide additional needed resources for housing and streamline funding.<sup>65</sup>

## **6. Better utilize school-based health centers.**

- DC has one of the highest rates of teen pregnancy in the country,<sup>66</sup> high rates of sexually transmitted infections such as Chlamydia, and a much higher rate of unintended pregnancy – 62 percent – than the national average of 45 percent.
- The 2018 Family Planning Community Needs Assessment also found that 42 percent of 15-19-year-olds interviewed report having never been to a provider for family planning services, significantly higher than other age groups, and indicating a need to reach adolescents with information and services.<sup>67</sup>
- Several adolescent health providers, and an official from DCPS, interviewed shared that School-Based Health Centers (SBHC) are currently significantly under-utilized.

### **Estimated Cost & Action Needed**

- One approach to better leverage the existing SBHC infrastructure in order to ensure young people have access to reproductive health information and services they need to plan their pregnancies and reduce adverse outcomes would be for the District to provide targeted, outcomes-based grants to each SBHC to ensure resources needed to focus on provision of sexual and reproductive health services.
- These funds could be tied to outcome indicators such as the percentage increase in the number of students adopting a contraceptive method,

the percentage decline in pregnancies, and percentage increase in STI tests and treatment.

- The School-Based Health Alliance provides technical assistance to SBHCs and could assist with indicators.<sup>68</sup>
- The additional funds could be used to develop and launch a campaign to advertise school-based health clinics to students, teachers, and parents to increase student awareness of and thereby use of currently underutilized school-based health clinics.
- SBHC could also improve linkages with community-based health centers to ensure young people get seamlessly connected with care.
- As one SBHC provider shared, “I think that the needs are not being met. Our funds have been stagnant since 2010 ... demands are increasing.”
- Another funding option would be to request that those SBHCs being run by hospitals be paid for through the hospital’s community benefit funds.
  - Several SBHCs in Ohio are funded in this way and hospitals have benefited by improving community relations, enabling referrals for other services, and increasing name recognition and patient trust.<sup>69</sup>
- Another funding option would be to allow young people, parents, and members of the community to access SBHC to increase billable visits.
  - Several providers interviewed stressed their desire to be able to provide care to people outside the schools in order to generate a more reliable stream of revenue.
  - A DCPS official noted most SBHCs could be retrofitted to allow outside patients to utilize the centers. This official added, “We support community health provision.” Security would need to be provided.
  - Interact for Health, a foundation in Ohio that has funded more than 40 SBHCs has found that allowing SBHCs to serve the broader community can be done in a safe effective way that not only increases

revenue and makes SBHCs more viable, but also improves the quality of care for students and their families.<sup>70</sup>

Table. 5 Illustrative Budget Estimate

Activity	Cost per SBHC	# of SBHC	Annual Cost	Four-Year Cost
Sexual and Reproductive Health Improvement Grant	\$20,000	7	\$140,000	\$560,000

## Solutions to Develop & Pilot Test

### 7. Invest in a Women's Health Improvement Collaborative and Innovation Lab.

- A message from all providers interviewed is that providers in DC want to improve, they want to innovate, and they want to coordinate. Everyone interviewed suggested the creation of some sort of women's health coordinating platform to gather, share ideas, and coordinate.
- The Washington Area Women's Foundation (WAWF), along with Mary's Center, Mamatoto Village, and DC Action for Children has begun convening a group of interested providers and community organizations to discuss challenges and opportunities in the women's health space.
- DC Health has launched a maternal health Collective Impact Initiative, which could also be considered to consolidate several groups working on maternal health.
- In order to keep the collaborative focused and impactful, it could be time-bound, and have a clear set of milestones and deliverables in order to push for action. For instance, the collaborative could meet for 3 years with the goal to launch one new innovation every 6 months and report out on progress yearly.
- The collaborative could house an innovation lab to continue the human-centered design process started with this report in order to develop and test innovative new solutions that could serve as models for the rest of the country.
- A working group within this broader collaborative could be created with women from the community to ensure all solutions are rooted in what is most impactful in women's lives. Several of the women interviewed for this project indicated that they want to continue to be involved and help develop solutions.
- This would be different from the "Maternal Mortality Review Board" recently created with legislation, as this group would focus on more holistic, community-based care.
- The Midwest Health Initiative (MHI) is a regional healthcare improvement collaborative that brings physicians, hospital representatives, health plan representatives, employers, and consumers together for quarterly meetings to share health improvement priorities and establish strategies for achieving common goals. This organization established the Healthier Babies initiative, which aligned nearly 50 partners to create a community policy statement on the risks of inductions and caesarean sections before 39 weeks of pregnancy. Through this initiative, the organization also created a working group of obstetrics nurse managers to develop a policies and procedures manual, distributed thousands of March of Dimes materials to mothers-to-be, and conducted public reporting of hospitals' early delivery rates.<sup>71</sup>
- In New York, Public Health Solutions organizes Community Collaborations that engage social service organizations, businesses, healthcare professionals, and community members to build healthier communities. One of these collaborations is the Maternal and Infant Community Health Collaborative<sup>72</sup>. The risk of delivering a low birth weight baby is reduced by half for mothers involved in partner programs of this collaborative, and the children of these mothers have a 67% reduction in behavioral and intellectual problems and are 2.7 times more likely to be enrolled in a gifted program at school.<sup>73</sup>
- Outlined below are six potential innovations, co-created with the women interviewed for this report and providers, that could be developed, prototyped, and potentially scaled through the innovation lab embedded in the collaborative.

## Estimated Cost & Action Needed

- Resources should be allocated to cover personnel to ensure a staff member is able to dedicate time to convening, coordinating, and spurring action by such a collaborative. Another staff member could lead the innovation lab.
- Some resources could also be used to help convene a community group to ensure feedback from the community continues to be a core component. These costs would be small and could include food, a transportation subsidy, and perhaps a gift card or small stipend.
- The budget below is based on an estimate by the coalition described above comprising WAWF, Mary’s Center, Mamatoto Village, and DC Action.
- While this represents an investment in the reproductive and maternal health of women in DC, it is designed to generate savings.
  - For example, New York City found the economic burden of severe maternal morbidity (SMM) was high, costing on average \$15,714 compared to \$9,357 for deliveries without SMM. From 2008 to 2012, SMM cost NYC an extra \$17 million per year.<sup>74</sup> Avoiding even a fraction of this SMM through the interventions outlined below could save resources and lives.
  - Similarly, Delaware’s initiative to ensure all women have access to quality contraceptives is estimated to save \$16.2 million annually, and \$48.5 million over three years.<sup>75</sup>
- **Potential Funding Partners:**
  - Private sector partners such as Merck for Mothers, Pfizer, Bayer, Johnson & Johnson, AMAG, and technology companies should be approached about investing in this innovative approach.
  - Other partners such as the March of Dimes, William and Flora Hewlett Foundation, Silicon Valley Foundation, Robert Wood Johnson Foundation and others may also want to invest in this collaborative and

innovation lab that could be a model for others.

Table. 6 Illustrative Budget Estimate

Activity	Details	Annual Cost	Three-Year Cost
Personnel	Two staff + benefits	\$180,000	
Travel	Mileage + parking	\$434	
Supplies	Office, events, childcare	\$2,160	
Comms/ Marketing	Website, marketing and material development	\$35,000	
Innovation Lab	See broken out costs below	\$55,000	
Fringe @ 15%		\$24,990	
<b>Total</b>		<b>\$313,483</b>	<b>\$940,449</b>

## 8. Ensure women are aware of the quality reproductive health services available.

- An important finding from the interviews was that women often did not know about the range of quality reproductive health services available in their own communities. While most women knew about a health provider, when asked if they knew where to go before becoming pregnant for contraception and other services, or if they knew about certain support services such as family support workers, midwives, and doulas, many shared that they had been unaware of such services.
- Together with the women interviewed, the researchers developed the potential solutions below.
- These innovations could be prototyped, tested, and potentially scaled through the innovation lab housed at the Women’s Health Improvement Collaborative.

- Evidence-based public health communication has been shown to affect health behavior in areas ranging from tobacco use, to AIDS, to highway safety and more.<sup>76</sup>
- A systematic review article of 54 studies conducted around the world on mass media interventions for HIV prevention concluded that these campaigns result in increases in condom use, transmission knowledge, and prevention knowledge.<sup>77</sup>
- A review article published in the medical journal *The Lancet* concluded that the spread of reproductive health and family planning information through mass media results in increased contraceptive use.<sup>78</sup>

**a. Create and test a commercial to play at key locations where women go, such as Social Service offices.**

- All women interviewed noted they have been to and usually visit multiple times per year the Economic Security Administration (ESA) center to apply for benefits, yet none has ever been connected through the center with health services. One woman said, “I could have gone in there six months pregnant and walked out without them telling me about [the clinic] right down the street.”
- Many women shared that they often wait for hours for their numbers to be called and in that wait time could be provided messages about reproductive health care in the District.
- Most agreed a commercial played on the screens at the ESA centers would be a good way to reach women.
  - They felt a commercial would be good because it grabs your attention, and many people don’t like to read pamphlets.
  - Some also mentioned illiteracy as an issue a commercial would help overcome.
- The women suggested that such a commercial could also be played at other

places they frequent such as hair salons, the unemployment office, WIC locations, and on social media such as Instagram.

- Some women suggested having a person at the ESA center to speak with people one-on-one as well.

**Estimated Cost & Action Needed**

- As part of the Human-Centered Design (HCD) process, the researchers created a rough prototype of the commercial, available in Appendix A.
- Using HCD this commercial can be rapidly prototyped, tested, and iterated until an impactful product is ready for launch.
- The cost would be low, including \$10,000 to produce, film and edit a commercial; \$1,500 to run three focus groups; \$3,500 to test the commercial at several government sites such as ESA offices, unemployment offices, and WIC locations and collect feedback from viewers and workers.
- The expenditures would primary go toward small incentive payments for participants to provide feedback and potentially a small contract to assist with collection and processing of feedback.
- The commercial could also be rolled out on social media channels for no additional cost.

Table. 7 Illustrative Budget Estimate

Activity	Cost
Film & edit commercial	\$10,000
Test Focus Groups (3)	\$1,500
Test at Sites & Collect Feedback	\$3,500
<b>Total</b>	<b>\$15,000</b>

**b. Create and test a Women’s Wellness Pack that would include free gifts and easy-to-consume health information.**

- Many women shared that they often don't read brochures or packets of information they receive in the mail or pick up at service provider locations.
- In order to capture the attention of women and reframe reproductive health services as something fun and positive, the researchers suggested creating a pack that could include fun freebies such as a lip gloss, a pad, condoms, a snack bar, and three or four easy-to-consume cards highlighting women's health services – different cards for different women's needs – with testimonials on the back.
- Personal referrals or word-of-mouth were the most common ways women determined where to seek services. Personal testimonies from women in DC about positive experiences they've had with health providers could serve as a powerful incentive to get care.



“I made an appointment on my phone, came in on Saturday, got the birth control I wanted – for free – and was out in under an hour. Now I can focus on making a living.” - Ward 7 Resident

### Pregnant or planning to be? We've got you covered!

Text "Woman Power" to 202-123-4567 today to get personalized support.

- Takes 5 minutes.
- Connects you directly with a provider close by.
- \$20 gift card with first appointment.
- Most women in DC are in care in their first trimester.

### Estimated Cost & Action Needed

- As part of the Human-Centered Design process, the researchers created a rough prototype of the Women's Wellness Pack, available in Appendix B.
- Using HCD, a wellness pack could be created, tested, and iterated until an impactful product is ready for launch.
- Different wellness packs could be created to target different populations: Adolescents, Hispanic women, Black women.
- The wellness packs could be distributed at key touch points such as schools, Social Service centers, WIC locations, libraries, and hair salons.
- With a small grant of \$10,000, wellness packs could be pilot tested.
- **Potential Private Sector Partners:** Such wellness packs could be funded by a private sector partner investing in women's health such as Merck for Mothers, Bayer, Johnson & Johnson, or Durex. They could provide their products in the packs.

Table. 8 Illustrative Budget Estimate

Activity	Cost
Produce Women’s Wellness Pack Prototype (500)	\$2,000
Test Focus Groups (5)	\$2,500
Test at Sites & Collect Feedback	\$5,500
<b>Total</b>	<b>\$10,000</b>

**c. Develop and test a grassroots social media campaign.**

- The majority of the women interviewed suggested advertising services on social media, specifically Instagram. When asked who they follow, they all said their friends.
- Because we know the best indicator of which birth control someone will use is the one her friends are using, one idea is to ask young people who have adopted various contraceptive methods, to share those methods on social media, with a specific # and to include in the comments section where they got it, or a link to a microsite or text service where women can go to be connected with a provider near them.



- One provider who works in a school-based health center shared that a friend of a young woman secretly filmed her having an arm implant inserted. The young woman posted the

video on her social media, with notes about how it didn't hurt and was easy, and several of her friends came to the clinic asking for an implant too.

**Estimated Cost & Action Needed**

- As part of the Human-Centered Design process, the researchers created a rough prototype of the social media campaign, available in Appendix C.
- Using HCD, with a small grant of \$10,000, a social media campaign could be rapidly developed, tested, and iterated until an impactful product is ready for launch.
  - Developing a social media tool kit is low-cost.
  - Local organizations such as the Young Women’s Project would be critical partners to recruit young women to use the social media tools.

Table. 9 Illustrative Budget Estimate

Activity	Cost
Produce Social Media Toolkit Prototype	\$1,000
Test Focus Groups (5)	\$2,500
Collect Feedback & Data	\$6,500
<b>Total</b>	<b>\$10,000</b>

**9. Ensure women can easily connect with quality reproductive health services.**

**a. Create and launch a personalized text service.**

- Many of the women and providers stressed that information is not enough. Once women have the information about quality services in the District they need to be easily connected.
- Brainstorming with the women revealed that a personalized text service would be a low-cost, high-impact way

to connect women with care and engage them on a personal level.

- All the women interviewed have smart phones and all said they preferred to be communicated with via text.
- A text service, rather than an app or a website (like ones that exist, such as [www.auntbertha.com](http://www.auntbertha.com)) requires fewer steps to initiate interaction. Rather than going to a website or downloading and app, all the women would have to do is text a code to a number and after a few simple questions (what are you looking for, what's your address, what's your insurance) be connected with the provider nearest them, given an incentive gift card for booking an appointment, and followed up with to ensure they made their appointment.
- Many of the women shared that they want to feel they are connecting with a real person, and a text service could provide the personal interaction in a way an app or website could not.
- Such a text service could be advertised in the commercial, in the women's wellness pack, and other places recommended by the women such as buses and social media.



### Estimated Cost & Action Needed

- As part of the Human-Centered Design process, the researchers created a rough prototype of the text service, available in Appendix D.
- Using HCD, with a small grant of \$20,000, a text service prototype could be developed, tested, and iterated until an impactful product is ready for launch.
- **Potential Private Sector Partners:**
  - DC's Inclusive Innovation Incubator (In3) could be a partner in helping to develop and test the text service.
  - Tech companies such as Apple or Facebook could be approached about supporting the text service.

Table. 10 Illustrative Budget Estimate

Activity	Cost
Text Service Prototype	\$8,000
Content Management System	\$6,500
QA & Testing	\$2,000

Initial Three-Month Maintenance (10 hours/month)	\$3,000
Annual Hosting	\$327
<b>Total</b>	<b>\$19,827</b>

**b. Leverage pregnancy tests to get women into care.**

- Several providers noted that pregnancy tests are a critical marker in a women’s pregnancy journey and could be made more readily available and used to link women with care.
- Several providers suggested creating better linkages between Emergency Rooms where women sometimes receive pregnancy testing and prenatal care.
- One provider said, “In an ideal world, they would get a print out from the ER with their due date from the ultrasound, get scheduled for their first visit and be instructed to go to the lab at that site a day or two before so that their prenatal panel is completed before they come in.”
- One local health expert suggested attaching the text number suggested above to pregnancy test. For example, pregnancy tests could be included in the Women’s Wellness Packs and the personalized text service number could be attached with a sticker to the pregnancy test. The number could also be attached via sticker to pregnancy tests in school-based health centers. Finally, CVS may be interested in partnering to place an advertisement for the sticker with the number in the section where pregnancy tests are sold.



**Estimated Cost & Action Needed**

- Emergency Rooms should develop a protocol to ensure women coming in for a pregnancy test are always connected with a care provider who can give prenatal care,

contraceptive services, abortion counseling, and other needed care.

- Pregnancy tests should be made easily available at school-based health centers and include a number young women can call or text with any follow-up questions and to get connected with services.
- **Potential Private Sector Partners:** CVS should be approached about allowing DC to include a text number or other information in the section where pregnancy tests are sold to encourage women to connect with care.

**10. Develop lean data survey for providers to ensure quick feedback.**

- While all the providers had some sort of general survey, none had surveys tailored for reproductive and maternity care, and none of them used the survey feedback to alter their services.
- For example, many of the providers said they did not know why their patients missed appointments, and many did not know if their patients feel the care they were providing was culturally aware.
- All providers expressed an interest in implementing some sort of basic survey to collect more real-time feedback from their patients in order to alter the way they deliver care.
- This lack of rapid, actionable feedback is not unique to DC providers. While many providers across the US have worked to collect patient-reported outcome measures (PROMS), most have not adopted simpler approaches used in other industries such as the Net Promoter Score, which simply asks customers if they would recommend a product or service to a friend.<sup>79</sup>
- Geisinger Health System, which offers a satisfaction guarantee, pointed out that “Recent strong evidence ([here](#) and [here](#)) suggests that improved

patient satisfaction is in fact correlated with better health outcomes and quality.”<sup>80</sup>

- Lean data collection, currently being perfected and shared in a publicly available Field Guide by Acumen<sup>81</sup>, could be used by providers in DC to quickly gather usable data to help improve the services they provide.
- Lean data requires a short survey to patients (no more than 10 questions) at a point of interaction with the patients, such as check-in, or via phone or email.
- A few key questions could include:
  - If you have ever missed a doctor’s appointment, why?
  - What is your favorite part about our office? Staff, Building, Location, Hours of Operation, Ability to Schedule Appointments, Quality of Health Care, other. Please explain.
  - What’s your least favorite part?
  - Where can we improve? Staff, Building, Location, Hours of Operation, Ability to Schedule Appointments, Quality of Health Care, other. Please explain.
  - How should we communicate with you? Circle: Text, Call, Email, Mail
  - Please check here if you would like to be a community consultant and continue to help us improve our care.
- Even a sample of 300 patients would give providers significant insight.



**Estimated Cost & Action Needed**

- With a targeted grant of \$50,000 a lean data survey could be developed, tested, and iterated, in partnership with DC providers.
- Such a survey could significantly advance additional actions by providers to improve quality, draw in customers, and ultimately improve outcomes.

Table. 11 Illustrative Budget Estimate

Activity	Cost
Develop Lean Data Surveys	\$12,500

Test Survey w/Select Providers (3x200 patients)	\$20,000
Back checks and survey tweaks	\$7,500
Analyze Feedback & Develop Next Steps	\$10,000
<b>Total</b>	<b>\$50,000</b>

**11. Create and test a respectful care toolkit and training**

- As the interviews underscored, reputation and quality matter and drive health care utilization decisions. A number of women reported poor care at certain providers and decided not to seek care there. A number of women also received care they liked at some providers. In each case, the women told people in their social circles, and many women interviewed shared that they make provider decisions based on word-of-mouth from friends and family.
- Providers similarly shared that they were often unsure if the care they were providing was culturally aware and noted that they would welcome additional training and guidance.
- Quality and respectful care are often seen as extra or icing on the cake. But without respectful, culturally aware care, people will not come for services, so these elements are not extra but essential. A provider can have the best services in the world, but if no one will come because she doesn’t trust that provider, then the services are useless.
- Further, research shows that black women with higher incomes and more education still suffer similarly high rates of maternal mortality, indicating bias, conscious or unconscious, is playing a role in care delivery.
- 32 percent of black women feel they’ve been discriminated against in physicians’ offices.<sup>82</sup>
- Providers from the Mayo Clinic, to Kaiser Permanente, to Vanderbilt University

Medical Center are urging doctors to recognize their bias so they can combat it.



**Estimated Cost & Action Needed**

- One idea suggested by the Director of Midwifery at Community of Hope is to create a respectful care toolkit with guidance on how best to work with patients from specific communities.
  - A number of providers thought this was a good idea and suggested they would use it if there was a training.
  - Sectors from policing to Starbucks are adopting implicit bias training, but it is just beginning in the field of health care.
- DC should support the development and testing of a respectful maternity care toolkit coupled with training on the toolkit to give DC providers the tools they need to effectively communicate with their patients.
- DC’s respectful care toolkit and training could become a model for the rest of the country.
  - Ebony Marcelle, Director of Midwifery at Community of Hope and Christina Fleming of the National Birth Equity Collaborative have begun creating a toolkit and could help lead the effort.

Table. 12 Illustrative Budget Estimate

Activity	Cost
Develop Respectful Care Toolkit and Training	\$30,000
Test and Refine Respectful Care Toolkit and Training	\$20,000
Roll Out Respectful Care Toolkit and Training	\$50,000
<b>Total</b>	<b>\$100,000</b>

**12. Develop and pilot centering or group meetings into postpartum period.**

- As the interviews illustrated, the period after a woman has a baby is often overlooked, leading to poor health outcomes for moms and babies, as well as a missed opportunity to keep women in care and improve health going forward.
- 40 percent of women do not attend a postpartum visit,<sup>83</sup> and only 49 percent of women in DC on Medicaid, CHIP, or dual eligible had a postpartum care visit between 21 and 56 days after birth, according to Medicaid data from the Adult Core Set.<sup>84</sup>
- Trust and strong personal relationships were some of the factors identified by providers as critical to care. Once trust has been established in prenatal care or through Centering, providers can continue those relationships through into the postpartum phase.
- Community of Hope is piloting “Ladies Night”, or a continuation of prenatal Centering, allowing women who have formed relationships with each other and providers while pregnant to come in after delivery with their babies for additional education on nutrition, breastfeeding, mental health, and other topics.
- Many of the women interviewed liked this idea.
  - One woman stressed the events should be fun rather than only educational.
  - One provider suggested offering a professional photographer to take family photos.



### Estimated Cost & Action Needed

- In order to increase the number of low-income women of color coming in for postpartum care and for other forms of needed care, DC could invest in the development and testing of postpartum Centering or group care.
- Keeping women in care once they have given birth can reduce poor maternal and infant health outcomes as well as improve other areas of health such as diabetes, hypertension, mental health, and substance misuse.
- To date, an evidenced-based postpartum group care curriculum does not exist, but DC is well-positioned to develop one and become a model for the rest of the country.

Table. 13 Illustrative Budget Estimate

Activity	Cost
Develop postpartum group care model	\$20,000
Test and refine postpartum group care model	\$25,000
<b>Total</b>	<b>\$45,000</b>

## Additional Potential Solutions for Consideration

Outlined below are several additional solutions suggested by the providers and women interviewed that could be considered for additional action.

- **Create maternal health snapshot in CRISP.**

- As the interviews revealed, many providers are not feeding into CRISP, the DC electronic health information portal, and those that are cannot easily see the items needed for maternity care.
- Policy changes could be made to enable all providers to feed into CRISP and allow CRISP to generate a maternal health snapshot that includes ultrasounds, labs, dates, and flowsheet.

- **Expand Teen Night or other youth-friendly health education models.**

- Community of Hope is currently piloting a teen night offering free food, gift cards, games, and other incentives to encourage young people to come to health centers and learn more about their bodies and the services offered. Mary's Center offers a similar teen program.
- A pool of competitive, outcomes-based grants could be provided to further develop and test the ability of adolescent-based programs through health centers to reach young people and improve their reproductive health outcomes.

- **Hire more teachers and add instruction time on health education in schools.**

- As the interviews highlighted, many women and girls are not receiving comprehensive sexual education in schools, which is contributing to the high rates of STIs and unintended pregnancies, which in turn are contributing to poor maternal and infant health outcomes.
- Although DC Council passed a comprehensive set of health guidelines for

schools they are not being fully implemented.

- According to the DC Young Women's Project, there are currently three "health-only" teachers in DC Public and Charter schools, but they need 32, in elementary schools alone, at a cost of \$3.2 million to teach the full health guidelines adopted by the Council.
- In order to teach the health guidelines for schools adopted by the Council in 2016, DC could hire additional teachers to teach the curriculum in elementary schools and add additional instruction time for health in high schools.
- A systematic review article published by the *Journal of Adolescent Health* found that two thirds of the 83 sex education programs that were studied resulted in a significant increase in contraceptive usage, a significant delay in sexual activity, or both<sup>85</sup>. One of the key distinctions that differentiated successful and unsuccessful programs was the selection, training, and support of the educators leading the programs.

- **Expand the use of health promoters in schools.**

- Several organizations such as Planned Parenthood and the Young Women's Project are running programs placing health promoters in schools.
- These programs could be expanded to reach all students in DCPS and given more tools to connect students with youth-friendly services.
- In a study on the Teen Prevention Education Program (Teen PEP) in North Carolina, 800 high school students were asked to evaluate their experience after participating in the program. 70% evaluated the program as extremely helpful in learning where to obtain birth control, 73% said the program was extremely helpful in learning when it is necessary to see a doctor, and 70% said the program increased how much they cared about graduating from high school<sup>86</sup>.

- **Expand the use of texting for patient education.**

- One provider currently operates a text service for adolescent patients, where patients can text questions and the provider will text back with PDFs containing information or offer to call the person. The provider must first receive permission to communicate via text.
- This provider has found it to be an extremely useful and highly utilized service.
- Questions for further discussion:
  - Could there be a central line for text questions?
  - Can only a provider communicate with his/her patients?
  - What legal permissions are needed?
  - The suicide hotline and Whitman Walker hotline could serve as models.
- A systematic review article of eleven studies on social media and text message use in sex education reported that the use of these platforms increased adolescent knowledge regarding the prevention of STIs. The studies also showed the potential for the use of these platforms to increase the rate STI screenings, decrease risky sexual behaviors, and reduce STI transmission<sup>87</sup>.

- **Expand use of Reproductive Health Coordinators**

- Children's National has three years of funding from DOH to pilot the use of a reproductive health coordinator.
- Having a person dedicated to following up with teens after their appointments moves the onus from the providers, who often don't have time, and from the teens. So far, Children's has found the coordinator to be very useful. They are collecting data on impact.
- The Reproductive Health Coordinator is also using data to help drive decisions. For example, if they see an uptick in

unintended pregnancies after Spring Break, they can do more outreach before.

- This pilot could be scaled if found to be effective in improving adolescent health outcomes.

- **Standardize STI testing**

- One provider found that if a doctor asks, "Are you sexually active," the patient may say "no." But then the same patient will test positive for an STI. The patient may have misunderstood the question and thought it meant, "Are you having sex now?" The patient may also have been embarrassed. But the positive STI test will open the door to a discussion around contraception.

- **Expand access to midwives and doulas**

- As the interviews revealed, most women who interacted with doulas and midwives reported having a positive experience.
- The interviews also indicated a desire for more personal support and attention from providers, which midwives and doulas are well positioned to provide.
- In the UK, midwives deliver half of all babies; and in Sweden, Norway, and France midwives oversee the majority of births. In contrast, only approximately 10 percent of births in the U.S. are overseen by midwives.
- A recent five-year study looked at the ability of midwives to operate in states across the U.S. and found that states where midwives are integrated into health systems (Washington, New Mexico, and Oregon) had the best outcomes for moms and babies compared to states with the most restrictive midwife laws and practices (Alabama, Ohio, and Mississippi).<sup>88</sup>
- A 2014 Lancet study found that integrating midwives into health care systems could prevent more than 80 percent of maternal and newborn deaths worldwide.<sup>89</sup>
- A review by the Cochrane group found midwives are associated with lower rates of episiotomies, births involving instruments such as forceps, and miscarriages.<sup>90</sup>

- The Women’s Health Improvement Collaborative could assess the availability of midwives, doulas, and other women’s health support workers in DC and put forward a recommendation and estimated cost needed to expand access to low-income women of color in the District.
- **Hire more providers of color**
  - Several providers suggested that more providers of color would help engender greater trust and understanding from patients of color.
  - The interviews revealed a lack of trust in health providers by women of color, and ensuring more providers of color are available to treat women of color could improve trust and culturally aware care.
  - Nationwide, only 6 percent of practicing physicians are black<sup>91</sup>; 7 percent of OBGYNs are black<sup>92</sup>; and fewer than 4 percent of certified nurse-midwives are black; while black people make up 13 percent of the total U.S. population.
  - The Women’s Health Improvement Collaborative could assess the number of providers of color in the District and decide to make a recommendation and estimated cost associated with generating more health care providers of color to care for women of color in DC.
- **Adopt use of “safety bundles” for excessive bleeding, blood clots, high blood pressure and other risks.**
  - According to the Council on Patient Safety in Women’s Health Care, a safety bundle is “a collection of 10 – 13 best practices for improving safety in maternity care that have been vetted by experts in practice.”<sup>93</sup>
  - The California Maternal Quality Care Collaborative created hospital toolkits and safety bundles targeting preventable causes of maternal death and saw the state’s maternal mortality rate decline by half over ten years.<sup>94</sup>
  - According to ACOG, “maternal safety bundles represent best practices for maternity care and are developed and endorsed by national, multidisciplinary organization.”<sup>95</sup>
- The Women’s Health Improvement Collaborative could partner with the newly-created Maternal Mortality Review Committee to ensure recommendations made by the committee are rooted in the needs of women and implemented in the community effectively.
- **Consider opening a birthing center in Wards 7 and/or 8.**
  - This could be a popular option among women and could be done at a lower cost than reopening an obstetric ward.
  - A birthing center would need to be in a location that allows for quick transfer to a hospital in the event of an emergency.
  - One note of caution from several providers is that some women on the east side of the city may not be eligible to deliver at birthing centers due to risk factors.
  - Early research in the New England Journal of Medicine found that “birth centers offer a safe and acceptable alternative to hospital confinement for selected pregnant women, particularly those who have previously had children, and that such care leads to relatively few cesarean sections.”<sup>96</sup> Still, since this early research there has been some research showing out-of-hospital births can pose risks.<sup>97</sup>
  - Additional research could be undertaken by the Women’s Health Improvement Collaborative and Maternal Mortality Review Committee to determine whether an additional birthing center on the east side of the city would improve health outcomes for women living in the District.
- **Auto-enroll women into postpartum centering/group care.**
  - Some providers auto-enroll women into Centering and pre-book all of their appointments.
  - A similar approach could be taken to postpartum care.

- One potential problem is that if women don't show up for pre-booked appointments, the provider then loses funds on an unfilled slot.
- Behavioral economics research indicates that autoenrollment can be useful tool to increase uptake of certain services.<sup>98</sup>
- The Women's Health Improvement Collaborative may want to examine the use of autoenrollment in maternal health programs and also explore other tools found to increase utilization, such as reminders<sup>99</sup> and reduced wait times.<sup>100</sup> The Collaborative could choose to put forward a series of recommendations and estimated costs needed to implement, test and scale these solutions.
- **Expand Mamatoto Village's Workforce Development Model.**
  - Mamatoto Village helps women access job training programs.
  - They also offer a perinatal health worker training program that allows women who have used their services as mothers to participate in a year-long training program to become perinatal health workers and in turn help other women in the community. These health workers have a deep understanding of the needs of the women they are serving because they have experienced similar challenges.
  - Mamatoto Village also offers wrap around services for women, and connects them with all the various programs available in DC.
  - The Women's Health Improvement Collaborative could explore how to expand this model and provide a cost estimate for the resources that would be needed to scale.
- **The city could pay community health centers directly rather than the MCOs.**
  - One provider suggested having DC pay community health centers directly rather than going through the MCOs in order to save money and improve outcomes, as it's the community health centers who are designing and implementing programs with impact.
  - As of 2016, twenty-nine states are already providing direct funding to community health centers. The two most common uses of these funds are the provision of care to uninsured or underinsured patients and the increased expansion of care into underserved communities (e.g. longer clinic hours, the expansion of enabling services, and the use of telemedicine).<sup>101</sup>
- **Leverage mobile units to provide reproductive health care.**
  - Every patient interviewed mentioned mobile clinics as something they would like.
  - Several patients mentioned the mobile clinic used by Children's hospital and suggested it be expanded to cover reproductive health.
  - Several patients also mentioned receiving HIV testing in a mobile unit, but had never received contraception or other reproductive health services.
  - Mary's Center used to have a mom and baby bus. They saw many patients but then lost funding and stopped the service.
  - Existing mobile units could add reproductive health services, so when moms visit them with children, they can receive needed care too.
  - Some women flagged that they would need to know when and where the van would be in order to use it.



# Call to Action

DC has some of the worst reproductive, maternal, and infant health outcomes in the country, but we also have the power to change these outcomes, and relatively quickly.

The good news is, DC has much of the healthcare infrastructure, including clinics, health workers, and insurance, needed to serve women of DC and their families. Based on our discussions with women and service providers, the missing pieces are provider awareness of the complex circumstances that impact the reproductive lives of women, recognition of implicit bias, and strategies to address it. In addition, increasing women's knowledge of quality services and facilitating easy connection to are critical. Provider training, quality improvements, and increased awareness are relatively low-cost solutions that will have an outsized impact in the lives of women and their families.

We can't do everything, but we can do something. The 12 solutions put forth in this report outline a clear and actionable roadmap. Using the Women's Health Improvement Collaborative to drive change, we can work with funders and providers to expand what we know works and continue the human-centered design process to develop new and innovative solutions to meet the unmet needs of women in DC. The District is well-positioned to move from crisis to a cutting-edge example for states across the United States.

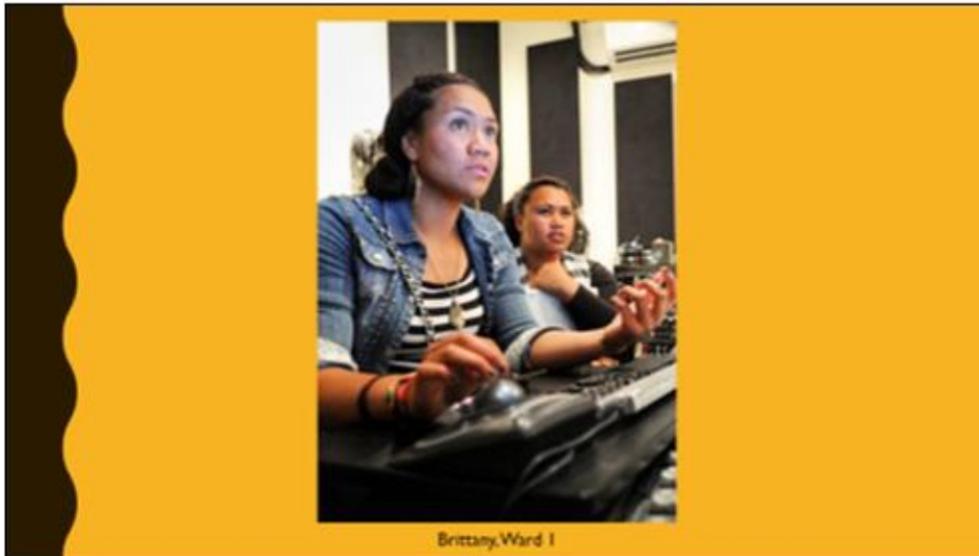
DCPCA looks forward to charting a path forward with policymakers, service providers, and community members to improve the health and wellbeing of women in District.

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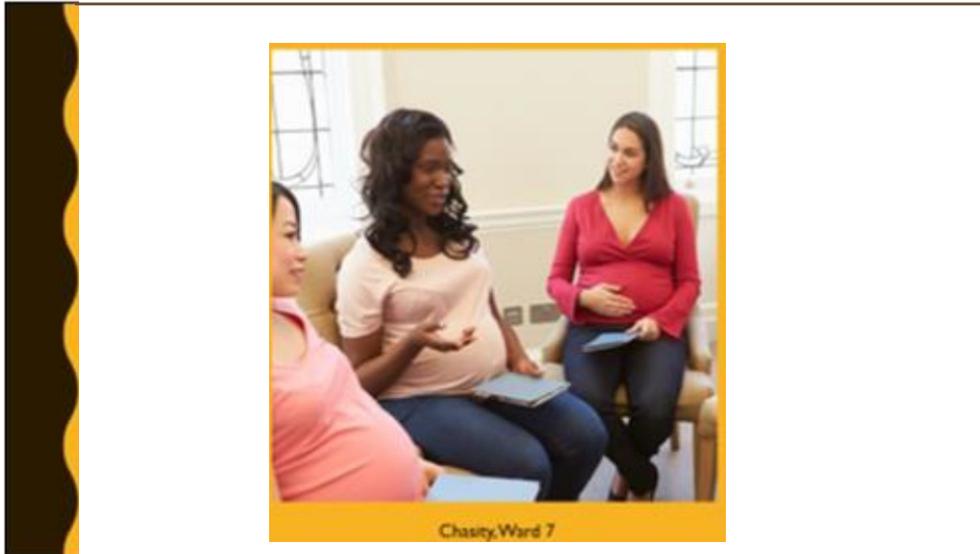
# Appendix A: Commercial Prototype



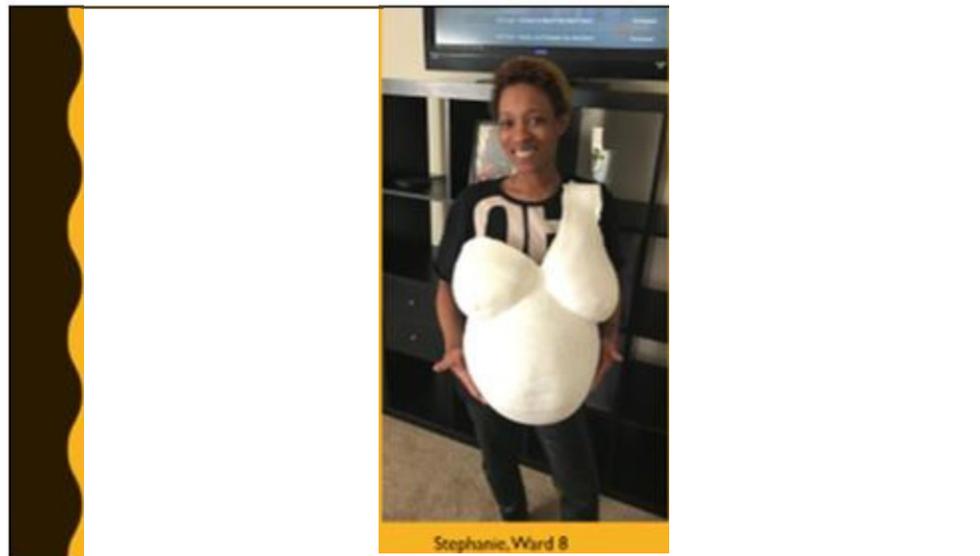
Voiceover: Whether you are still in school or focused on your job, planned to get pregnant, or are already pregnant- there is support for you.



Video Testimonial of real woman in D.C. (student/Worker): "I made an appointment on my phone, came in on Saturday, got the birth control I wanted- for free- and was out in under an hour. Now I can focus on making a living."



Video Testimonial of real woman in D.C. (pregnant woman) - "I came in for a pregnancy test, and the workers were so nice. They signed me up for prenatal care on the spot. Now I come every few weeks to meet with the midwives and other pregnant women to learn about my body, the baby, and how to have a healthy pregnancy. They answered all my questions."

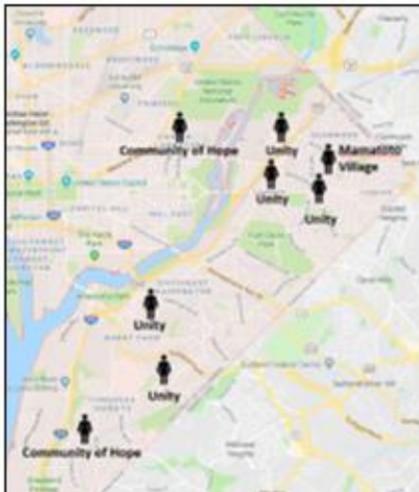


Video testimonial of real woman in D.C. (Women who had baby) - "I had no idea you could do a water birth in Northeast DC. I wish I had had all my kids there!"



Ex. Word 4

Video testimonial of real woman in D.C. (Women who had baby)- "I felt overwhelmed after the baby was born. But I got the support I needed. A community work came to our house, provided diapers and formula, and got me the counseling I needed to feel better."



Community of Hope

Call or text (102) 407-147

Mamatoto Village

Call or text (102) 248-3434

Unity Health

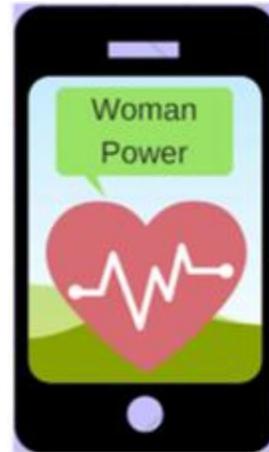
Call or text (202) 388-8160

Video cover: "Did you know there are eight women's health centers on the east side of the city?"

"Invest in your health, your future, and the health of your family."

"Call or text today to set up a free or low-cost appointment AND get a \$10 gift card to Walmart with your first visit."

**TEXT "WOMAN  
POWER"  
TO 202-123-  
4561  
TODAY**



Voiceover: "Not sure where to find what you need? We make it easy. Simply text "woman power" to 202-123-4567 to get personalized assistance"

"All you need to text is what you need, your insurance, and address, and our staff will connect you directly with the provider nearest you."

"And you get a \$20 gift card with the first appointment you book using this text service."

**ASK YOUR SOCIAL  
SERVICE CASE  
WORKER FOR THE  
WOMEN'S WELLNESS  
PACK TODAY.**



Voiceover says: "Ask your Social Services case worker for the Women's Wellness Pack today to get free gifts and more information about health services just for you."

# Appendix B: Women's Wellness Pack Prototype



Still in school or focused on your job?  
Not ready for a baby yet? We got you!

Check out these services near you today for  
free or low-cost birth control options:

- Mary's Center - Call or text: (202) 483-8196
- Community of Hope: Call or text: 202-407-7747
- Unity: Call or text: 202-388-8160
- Mamatoto Village: Call or text: 202.248.3434

"I made an  
appointment on my  
phone, came in on  
Saturday, got the  
birth control I wanted  
-for free- and was  
out in under an hour.  
Now I can focus on  
making a living." -  
Ward 7 Resident



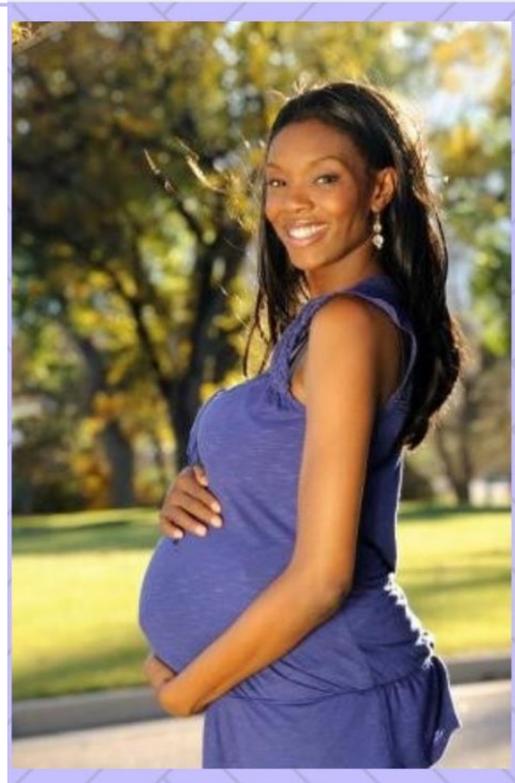
# Pregnant or planning to be? We've got you covered!

Text "Woman Power" to 202-123-4567 today to get Qersonalized support.



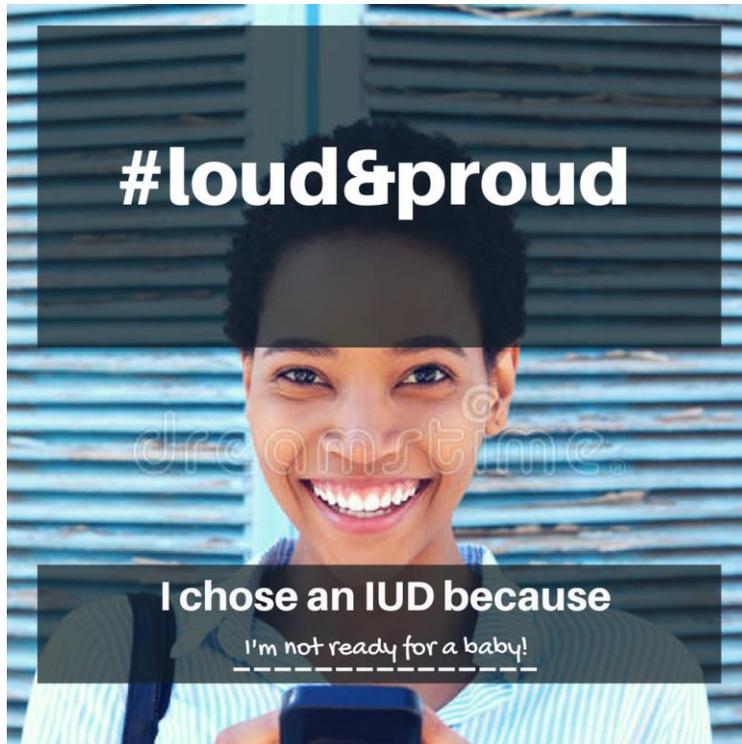
- Takes 5 minutes.
- Connects you directly with a provider close by.
- \$20 gift card with first appointment.
- Most women in DC are in care in their first trimester.

"I came in for a pregnancy test, and the workers were so nice. They signed me up for prenatal care on the spot. Now I come every few weeks to meet with the midwives and other pregnant women to learn about my body, the baby, and how to have a healthy pregnancy." - Mom, Ward 8



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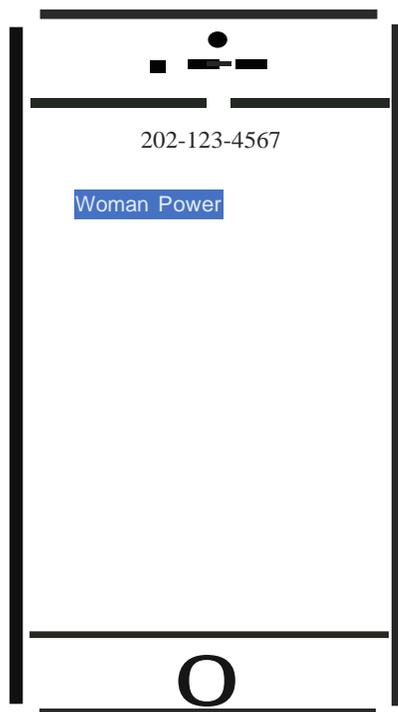
# Appendix C: Social Media Campaign Prototype



# Appendix D: Personalized Text Service Prototype

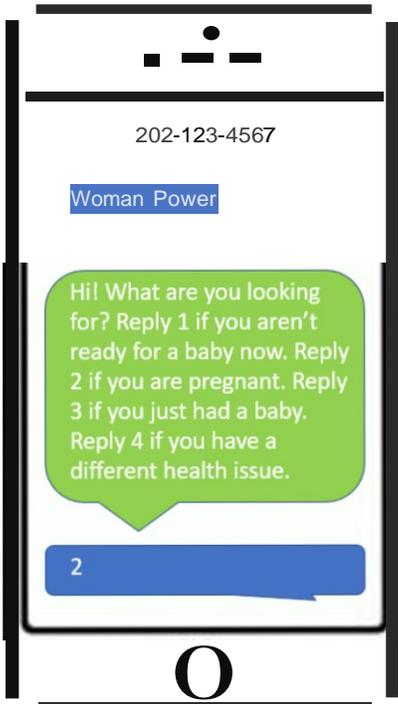
## "Woman Power" Personalized Text Service

- What: The Woman Power text service allows women in D.C. to text "woman power" to 202-123-4567 to get connected with women's health services in the District.
- Why?
  - According to DC Health's 2018 Perinatal Health and Infant Mortality Report, almost half of black women and 1 in 3 Hispanic women in D.C. aren't getting into care until their 2<sup>nd</sup> and 3<sup>rd</sup> trimester or aren't care at all. This is driving poor outcomes in D.C.
  - According to a recent survey by the DC Primary Care Association, one of the most common reasons women don't get into care is that women are unaware of the many quality services near them that accept their insurance.
- Solution: This text service, which will be advertised at the Social Service offices via commercial and in the women wellness pack, will make connecting with services easy for women in D.C.



## Step 1: Get Started

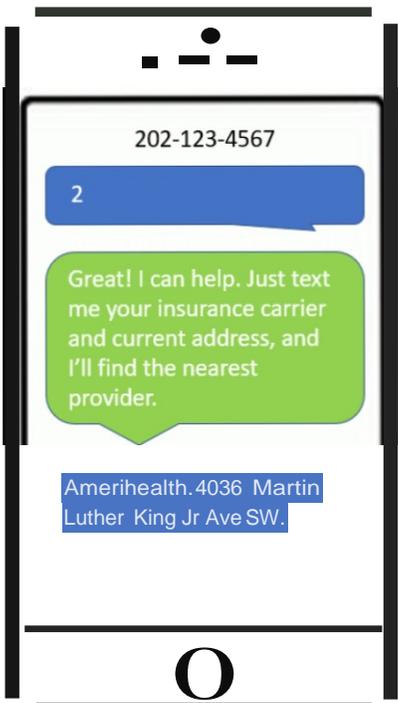
You text "Woman Power" to  
202.123.4567



## Step 2: Discover Need

Staffer at "Woman Power" responds to you.

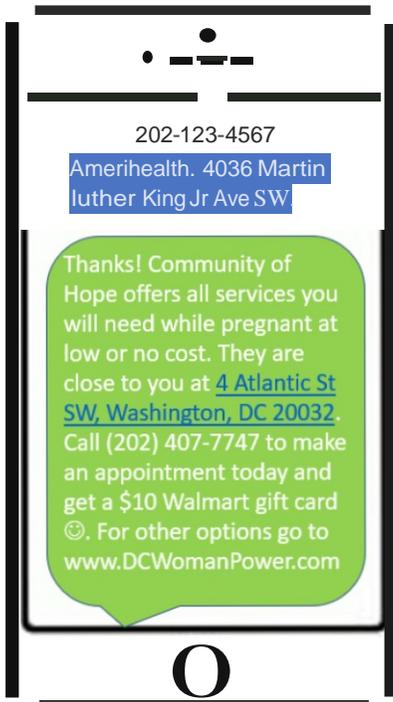
You respond with what you need.



## Step 3: Gather Key Info

Staffer at "Woman Power" replies with two key questions.

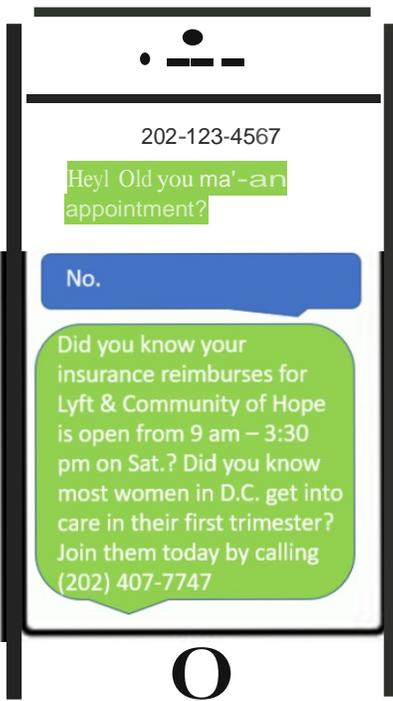
You reply with your insurance and address.



## Step 4: Connect

Staff replies with the nearest health provider.

- Hyperlink to address
- Phone number
- \$10 gift card
- Link to other options



## Step 5: Follow Up

Staff reaches out to make sure you made an appointment and tells you about ways to make it easy.

- Lyft
- Saturday hours
- Most women get into care early

# Next Steps

- Who will run the text service?
- Can a program respond to most texts and allow a human to respond to women with higher needs?
- What would it cost?
  - Staff time
  - Incentives/gift cards
- Need to create a catalog of all women's health services, including insurance accepted, locations, services offered.
  - [www.auntbertha.com](http://www.auntbertha.com) be partnered with on this project, as they have already mapped such services?
- Need to create a microsite – [www.DCWomanPower.com](http://www.DCWomanPower.com) – where people can enter same information and see full list of available services near them.
- Major benefit: Use the data collected to learn more about the unmet needs of women in D.C.
  - Where are they?
  - What services are most in demand?
  - Could build in a survey to see how they liked the services received, what could be improved.
- Give gift card at provider office? Have provider mark "women power" in file when appointment made to ensure patient receives gift card above arrival.
- Where else could the service be advertised? Universities? Buses? Shelters? Food Pantries? Unemployment office?
- Need an opt-out option.
  - Perhaps after appointment is completed, follow-up with: Want to stay connected with quality health service in the District? Reply "YES." If you want to leave this service, reply "STOP."
- Add services beyond reproductive health? Dental, mental health, etc.

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