



POLICY BRIEF

Human-Centered Solutions to Improve Reproductive and Maternal Health Outcomes in DC

A Summary of Implications for Policies and Programs

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This policy brief summarizes the key findings and recommendations from the report, “*Human-Centered Solutions to Improve Reproductive and Maternal Health Outcomes in Washington, DC.*” This report and accompanying policy brief shine a light on unmet reproductive and maternal health needs of low-income women living in the District of Columbia. The 12 actionable and costed initiatives can provide policymakers and providers with a clear roadmap for action that can be pursued to improve the health and well-being of women and their families.

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.¹ Only four states have worse maternal death rates, and DC's rate is more than fifty percent higher than the national average.²

Death rates are even higher among women of color.

While DC has one of the highest maternal death rates in the country, the rate of maternal mortality for black women in the District (70 per 100,000) is even more troubling, indicating deep racial and ethnic divides.³ Nation-wide, black women are over three times more likely to die from pregnancy-related causes than white women.⁴

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.⁵ 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.⁶

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.⁷ The closures of the hospital maternity wards amplify the unmet reproductive and maternal health needs of low-income women on the east side of the city.

Rates of newborn deaths, unplanned pregnancies, and sexually transmitted infections 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.⁸

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.⁹

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.¹⁰ 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 factors¹¹. 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.¹² 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.

Using Human-Centered Design to Develop Solutions

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) approach to the reproductive and maternal health challenges facing women in DC.¹³

Objective

Our objective is to shine a light on unmet reproductive and maternal health needs of low-income women living in the District, 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.

Approach

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. HCD involves three phases:

- **Phase 1 – Inspiration:** Carry out deep dive interviews to understand the needs of the people for whom you are designing.
- **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 serving in order to land on solutions that are effective and sustainable.

The Fellows completed Phase 1 of this process, conducting 31 in-depth interviews with key maternal and reproductive health providers and experts in DC, as well as low-income women of color on Medicaid between the ages of 18 and 38 who receive care through the system.

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. Nor is it meant to duplicate the Maternal Mortality Review Committee.

What Women & Health Providers Told Us

Contraceptive use is intermittent, and providers are challenged to reach women before pregnancy.

- While most women interviewed reported not planning their pregnancies, challenges go deeper than not being aware of contraceptive methods, and providers may need a more nuanced understanding of intention in order to support women in their care.¹⁴
- Many women chose their contraception based on recommendations from their social circles.
- Contraceptives are not hard to access; the main barriers are misconceptions, nervousness, distrust, and side effects.
- Most women interviewed were uncomfortable with long acting reversible contraceptives (LARCs).

“A lot of us don’t have a plan when we get pregnant...You’re not taught to think of yourself.”

— 32-year-old mother of one, Ward 7



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

— Mother of three, Ward 7



Comprehensive sexual education and youth friendly health services are not readily available.

- Although comprehensive health guidelines for schools were instituted, they are not being fully implemented.
- Most of the interviewees had not received comprehensive sexuality education; but all interviewed think more sex education is needed.

- The needs of young people, in particular, go beyond information—they also need to know where to get convenient and accessible services.

Late entry into prenatal care is a persistent challenge.

- Many women are not getting into care until their 2nd or 3rd trimester.
- The challenge does not appear to be a lack of services, but that many women don't know about quality services available.
- Every woman who participated in centering (group prenatal care) 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



Perceived quality and reputation matters and drives the decision on where women go for care. Respectful and culturally aware care is needed.

- Reputation matters and women make decisions on where to go based on reputations.
- Staff attitudes were the most important issue mentioned.
- Few women had complications; however, those who did reported not feeling listened to.
- Word of mouth is very powerful. When asked how they heard about a health facility, most women said a friend or family member.
- Providers need more and better feedback on patient outcomes and satisfaction.

“Since I've been in South East for ten years, I haven't received an internal training on reproductive justice ... That would be helpful.”

— Provider in Ward 7



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.”

— Service Provider



“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.’”

“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



Awareness of quality services was identified as the leading barrier.

- Most women reported being unaware of quality services in their own communities such as midwives, centering, home visiting, and other support services.
- Many women's first interaction with the health care system is once 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 themselves.”

— Mother of one, Ward 7,
Family support worker



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



— First pregnancy, Ward 8,

Postpartum care is lacking and is ripe with opportunity for improvement.

- All women and most providers expressed a lack of postpartum care.
- Many of the women reported some form of postpartum depression.
- Women prioritized care for their children over themselves.
- The women who received home visiting in the postpartum period liked it.
- Provider- and payer-based barriers to postpartum contraception still exist.

“In our community, women are supposed to be strong ... so they don’t say anything

People don’t want to talk about postpartum [depression]...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, Ward 7

“There is very little postpartum care because the hospital is eating the cost.”



— OBGYN, Wards 5, 7, 8

Challenges outside the traditional health system contribute to poor health for women. Homelessness is the number one problem.

- Every single woman interviewed had experienced homelessness or housing insecurity.
- Transportation is a challenge, but appears to be a greater barrier for those with high-risk pregnancies.
- Other major challenges cited included nutrition and child care.
- Health systems around insurance, communication, and electronic medical records could be improved.

“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

“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

Recommended Actions

The 12 recommendations below 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.

Top Three Solutions

1. Expand the Centering Pregnancy Model and invest in personnel to ensure coordinated, quality care across a woman's reproductive life.

a. Expand Centering Pregnancy model.

Centering Pregnancy is an evidence-based approach to prenatal care that brings women together for a series of 10 prenatal visits, in a group setting, to learn about a variety of topics and build community. All the women interviewed 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. Many of these women do not have support systems, and Centering creates a supportive environment and more hands-on, interactive care from midwives and health workers who can spend more time with the women than physicians.

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

The interviews with both women and providers revealed a serious lack of postpartum care. Without concerted postpartum care coordination, the burden falls to women to actively reach out to schedule their postpartum appointments and future healthcare services. Postpartum coordinators move the burden from the women and the providers by creating a dedicated position to coordinate subsequent care for women.

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

Many providers interviewed suggested creating a coordinating platform to gather and share ideas, as well as to innovate. The Washington Area Women's Foundation, along with Mary's Center, Mamatoto Village, and DC Action for Children has begun convening a group of interested providers and community organizations. If funded, this collaborative could house an

innovation lab to continue the human-centered design process and pilot innovative new solutions. For example, the collaborative could meet for 3 years, launch one new innovation every 6 months, and report out on progress yearly.

3. Create and test a respectful care toolkit and training.

The interviews underscored the importance of perceived quality and reputation when women make decisions on whether and where to seek health care. Providers similarly shared that they were often unsure if the care they were giving was culturally aware and noted that they would welcome additional training and guidance. Two providers in DC are developing a respectful care toolkit and training, and funding should be provided to enable their work.

Solutions to Scale-up

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

A mapping of providers revealed that for most women, there are a number of prenatal and reproductive health care providers in their communities, including in Wards 7 and 8. However, women with high-risk pregnancies, who need to see Maternal Fetal Medicine (MFM) doctors face challenges accessing prenatal care as these specialists are only located at hospitals on the west side of DC. One solution would be to support community health centers located in Wards 7 and 8 to use telehealth consultations with MFMs so women don't have to travel to the other side of the city to access care.

5. Ensure providers are aware of the separate payment option for postpartum LARCs and that access to devices is easy.

Several providers reported that the current reimbursement system disincentivizes postpartum LARC insertion, claiming that because the payment for LARCs are bundled in a "maternity care bundle" there is a disincentive to provide them due to the high cost of LARCs. Providers also reported that accessing LARCs in the hospital can be challenging. DHCF issued

guidance clarifying Medicaid coverage of LARCs, including separate payment for postpartum LARCs. Still, DHCF, MCOs, and hospitals should ensure separate payment options for postpartum LARCs are available, that providers are aware of this policy, and that LARCs are easy to access in hospitals after delivery.

6. Improve transportation by expanding access to Lyft and Uber through MCOs.

While transportation was not identified as a leading barrier to accessing care, the poor transportation offered through Medicaid and the high cost of public transport were acknowledged as issues. All interviewees agreed increased access to Lyft and Uber is preferred over the Medicaid van service due to the reliability and convenience that these rideshare platforms offer. Several interviewees added that Lyft and Uber should offer car seats.

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

Homelessness and housing instability were identified as a significant challenge by every woman and provider interviewed. The lack of affordable, stable, quality housing is impeding women's ability to focus on themselves, plan their families, and get into care once they are pregnant. Poor housing is also driving stress and poor nutrition, which exacerbate maternal and infant health risk factors such as diabetes and hypertension.

8. Better utilize school-based health centers.

The 2018 Family Planning Community Needs Assessment found that 42 percent of 15 to 19-year-olds interviewed report having never been to a provider for family planning services.¹⁵ This figure indicates a need to reach adolescents with information and services. One respondent noted that while DC law mandates comprehensive health education in schools, many schools are not fully implementing the curriculum. Several adolescent health providers interviewed shared that School-Based Health Centers (SBHCs) are significantly under-utilized. Through a series of outcomes-based grants, SBHCs could drive

improvements in reproductive and maternal health outcomes.

Solutions to Develop & Pilot Test

9. Ensure that women are aware of the quality reproductive health services available.

Most women reported being unaware of quality services such as midwives, centering, home visiting, and other support services available in their own communities. Together with the women interviewed, the researchers co-developed the potential solutions below.

a. Create and test a commercial to play at key locations where women go, such as Economic Security Administration (ESA) offices.

All women interviewed noted they have been to and usually visit multiple times per year the ESA office to apply for benefits. However, none of the women had ever been connected to nearby health services through ESA. 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 and that messages about reproductive health care in the District could be provided during that time. Several also suggested advertising at hair salons, the unemployment office, and WIC locations.

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

Women reported often not reading brochures or long reading material given to them. To capture the attention of women and reframe reproductive health services as something fun and positive, a pack including fun freebies such as a lip gloss, a pad, condoms, a snack bar, and three or four easy to read cards highlighting women's health services with testimonials on the back could be distributed at key locations. 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.

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

The majority of the women interviewed suggested advertising services on social media, specifically Instagram. 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 #hashtag 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.

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

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

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. While they reported advertising is good, they stressed that being easily connected with care from the ad was equally critical. 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 may not.

b. **Leverage pregnancy tests as an opportunity to get women into primary 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. Specifically, women who take pregnancy tests in the ER should be linked directly with care, and the text service number could be added to pregnancy tests provided in SBHCs or even advertised near tests in CVS.

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

While some general surveys exist, none provide rapid, actionable feedback on reproductive and maternity care provision. All the providers interviewed expressed a desire to improve the way they deliver care using real-time feedback from their patients, collected through a basic survey. Lean data collection is a low-cost feedback tool that requires a short survey to patients (no more than 10 questions) via a point of interaction with the patients, such as check-in, or by phone or email.

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

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. Several providers in DC are continuing group prenatal care into the postpartum phase and are well positioned to test and develop an effective program with targeted support.

The full report, ***“Human-Centered Solutions to Improve Reproductive and Maternal Health Outcomes in Washington, DC”*** details concrete action steps along with cost estimates for each of these recommendations. The report also includes additional considerations for programmatic implementation and future investment.

A Call to Action: Putting Young Women and Mothers at the Center of Care

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 the women of DC and their families. Based on our discussions with women and service providers, the missing pieces include provider awareness of the complex circumstances

that impact the reproductive lives of women, and recognition of implicit bias and strategies to address it. In addition, increasing women’s knowledge of quality services and facilitating easy connection to quality services are critical. Provider training, quality improvements, and awareness are relatively low-cost solutions that will have an outsized impact in the lives of women.

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.

Acknowledgements

This policy brief was written by Robyn Russell, Fellow, and Carolyn Rodehau, Fellow at the District of Columbia Primary Care Association (DCPCA). This policy brief summarizes the key findings and recommendations put forth in the report, “Human-Centered Solutions to Improve Reproductive and Maternal Health Outcomes in Washington, DC” Special thanks to David Poms, Rob Nelb, and Avery League for their research support. The authors gratefully acknowledge the following experts for their time and comments to improve the report: Patricia Quinn, DCPCA; Dr. Carla Henke, Community of Hope; Karen Dale, AmeriHealth; Dr. Siobhan Burke, Unity Health Care; Joan Yengo, Mary’s Center; and Fernanda Ruiz, Mary’s Center. The authors would also like to acknowledge the experts, service providers, and most importantly the women who were interviewed as part of this project; without their contributions this report would not have been possible.

Read the Full Report

To read the full report please visit:

<http://www.dcpca.org/reports-publications/human-centered-solutions-to-improve-reproductive-and-maternal-health-outcomes-in-washington-dc>

About the D.C. Women’s Health Improvement Project

The *D.C. Women’s Health Improvement Project* is championed by the DCPCA 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.

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