Maternal Health Care: Real-World Tactics to Address Health Inequities

Monica E. Peek, MD, MPH, MS, FACP:

Hello and welcome to a very special BriefCase that is part of a series I am leading on diversity, equity and inclusivity with CME Outfitters. Today's CMEO BriefCase is entitled *Maternal Healthcare: Real World Tactics to Address Health Inequities*. Today's program is supported by an educational grant from Johnson & Johnson. I'm Dr. Monica Peek and I'm a professor of medicine at the University of Chicago where I also serve as an associate director at the Chicago Center for Diabetes Translational Research. I'm also the executive medical director for Community Health Innovation and a director of research at the MacLean Center for Clinical Medical Ethics. I'm delighted to be joined today by my distinguished colleagues, Dr. Heather Irobunda and Sierra McClain-Henry.

Heather Irobunda, MD, FACOG:

Hi, Dr. Peek. Thank you for having me here. I'm Dr. Heather Irobunda and I am an attending physician at New York City Health and Hospitals.

Sierra McClain-Henry:

Hi, I'm glad to be here as well. I am Sierra McClain-Henry, full spectrum doula, parent educator, and founder of Sankofa Mama Birth Services.

Monica Peek:

That's such a wonderful name. Heather and Sierra, I am honored to have you joining us today and I'm really excited for our discussion. Our first learning objective for today is to identify the impact of health inequities on pregnant and postpartum patients. I want to remind our audience that this CMEO BriefCase is part of a continuation of our initiative to address unconscious bias, health disparities, and racial inequities. We're building a comprehensive library of educational activities addressing these very important issues, and today's activity continues the discussion in maternal healthcare. The titles of the activities in this series are on the slides, and the links are in the images. You can simply click on the images to review any of those programs. If you participate in at least three of the programs in our D&I Hub, you will also be eligible to receive a digital badge demonstrating your commitment to education on diversity, equity and inclusivity.

As we begin to address maternal healthcare disparities, I want to just review some foundational points regarding historical racism that remind us all how we got here. We've done previous programs that cover these topics in more depth, and those programs can be found in our D&I Hub. I encourage everyone to participate in our foundational program so that we can learn and do better. But just to review, we have to acknowledge that there are three large buckets that I frequently talk about. One is the existence of structural inequities or structural racism, systemic racism, and how that impacts multiple things, including differential spread of what we call the social determinants of health, which includes housing, clean water, food, education, structural racism. It also impacts things like healthcare provider bias. It also impacts things in the community like exposure to differential things in the social and built environment, differential exposure to environmental toxins that we know are hazards to our health. So these direct exposures to structural racism are one thing, and then there have an indirect impact on our health. So, we know that chronic exposure to discrimination, for example, is a chronic stressor that then has pathophysiological consequences for our health. We know that healthcare bias results in,

or can result in, disparities in the kind of healthcare that's delivered to patients or deviation from standards of care for different populations, and so there are ways in which these kinds of systemic racism can begin directly impacting the health of people. And this has long term impacts for not just the health of patients, but also how engaged patients are willing to be and how we can or cannot retain them within our healthcare system. And the long-term epigenetic effects that we're seeing not only for our existing patients, but for their children and for other generations to come. So, the issues that we're talking about today are just of critical importance that we're continuing to learn more and more about. So that's the sort of larger framework in which we are discussing our today's topic.

So now we're going to jump to our first patient case that we're going to discuss today. Heather, can you tell us about our patient who we're calling Macy?

Heather Irobunda:

Sure. So Macy is a 30-year-old black female. She's a G3P2. She's 33 weeks gestational age at her prenatal visit with a new provider. Her prior OB-GYN retired. She's five foot four inches tall. She weighs about 198 pounds. Her BMI is 34. She has two small children at home, ages two and six, and has a partner in the home, but he travels three to four days a week. She also states that she's feeling unusually sad and overwhelmed and has anxiety about her lack of consistent childcare. She said that, "I'm struggling and I am not as excited as I was in previous pregnancies." Her OB-GYN responds with, "That is normal with two children at home and you're working. Try to slow down your weight gain at this stage, but your baby is healthy and you should be able to have a vaginal birth, though C-sections are more common in Black women. Just get some rest and don't worry so much." Macy returns home crying and tells her husband she felt unheard. She is upset that she has been labeled as "non-compliant" in her patient notes after missing some appointments due to her work schedule.

Monica Peek:

So before we move on, I just want to note a couple of things that are there in that patient case that have to do with provider bias, either unconscious or otherwise. So I'm going to kick off on that, and I just want to sort of see, Heather, what your opinions are, and everyone actually, to weigh in. One of the things I study a lot about is how providers document things in the medical record. So, for her to be documented as non-compliant, we recently looked at a study that showed that African Americans were more likely than their White peers to be labeled with negative descriptors, aggressive, non-compliant, all of these things. And that those descriptors were two and a half more times to be associated with African Americans, but they were also associated with patients who were more likely to be transferred from the general medical ward to the intensive care unit. So I think that how we talk about patients has implications for future health. What else did you all notice from this case that indicate some provider bias?

Heather Irobunda:

I definitely have the same issue with the non-compliant term because oftentimes it's used more, and even anecdotally, we know that it's used more commonly in patients of color, especially Black folks. And something that irks me about it is the reason for the label of non-compliance a lot of times has to do with work or childcare responsibilities or things like that, that are out of the control of the person who gets this descriptor label. So it's

like how can you be compliant if you can't leave your children at home by themselves? Or how can you be compliant if you can't take time off of work? If you don't go to work, you can't feed your children. So, I always find that to be an issue. And then talking about how Black women are more likely to have C-sections than non-Black folks, I think is interesting because it's a multifactorial reason as to why Black women have more C-sections than their White counterparts. A lot of it has to do with bias and with the inherent issues with our medical system. So I think it's funny that that's pushed onto the patient like it's kind of like, "Oh, don't worry, this is who you are and what's going to happen to you." And it's not really looking inward to the medical system that has caused this.

Sierra McClain-Henry:

It's interesting also that that was just laid there. This is more common for Black women and ended with, but don't worry, when this has now planted a huge seed of fear, of doubt, of uncertainty, in someone who came in reporting already that they were struggling. So it's easy for someone who's not experiencing what this person is experiencing to have a simple to-do list. If you just did this and this and this, things will begin to improve for you. But when someone is struggling with mental health issues, it seems as if that issue is insurmountable. It dictates how they will carry on in every other area of their life. She said she felt unheard and understandably so, and left not only with her original concerns not being validated, but with new ones.

Monica Peek:

And particularly because we know that pregnancy and the pre-pregnancy period is associated with an increased risk of depression and mental health concerns. And so to not actually name that and to offer support and other resources, but just to say, "Oh, relax."

Sierra McClain-Henry:

It also is a reason why many people will shut down and will stop seeking the help that they need. All it takes is one or two situations of feeling unheard or feeling belittled when you express your concern or being told, "Oh, this is what's really important. What you really need to focus on is this." That could cause this patient to never again reach out for help. And then we see someone go through the postpartum period and we're surprised that they're struggling or that they may be dealing with some anxiety issues or depression postpartum when the signs were there in pregnancy and what it would really do to help this person who was reaching out.

Monica Peek:

Absolutely. Thank you so much ladies. So we're going to now turn to our first audience response question. In the United States in 2020, the maternal mortality rate for non-Hispanic black patients was how many times higher than the rate for non-Hispanic white patients?

So, the unfortunate reality is that maternal mortality is on the rise. Heather, as an OBGYN in New York City, do you see these sorts of numbers?

Heather Irobunda:

Oh, we definitely do. It's actually in some parts of our city, it's even higher than the national average. A lot of it has to do with, it's multifactorial, as we all know. But a lot of it has to do with systemic factors, the social determinants of health and how that impacts Black birthing people in our communities. And so, in parts of the city where you have higher numbers of Black and Brown folks, we do see higher rates of maternal mortality, especially in Black birthing people there. So, it's really distressing because you see higher rates of predisposing conditions. So things like high blood pressure, hypertension. We see higher rates of diabetes, higher rates of people entering their prenatal care later in the pregnancy and things of that nature. It's really unfortunate in addition to some of the biases that some of the medical providers in these areas have towards the patient. So, for example, seeing a lot of things like non-compliance in the chart. When a lot of this stuff is due to systemic factors that cause the patient not to be able to come into their appointments or to be able to stay when we tell them you need to stay inpatient for certain procedures, or things like that. So we definitely see this in New York.

Monica Peek:

Thank you. If we take a step back from just New York, we think about the United States as a whole, we know that the maternal mortality rate for non-Hispanic Black patients was 2.9 times higher than the rate for non-Hispanic White patients. And currently, Georgia has the worst maternal mortality rate of any state in the country, where Black women are 3.3 times more likely to die from pregnancy-related complications than White women. In what ways does Georgia, Heather, maybe you could talk about this, reflect the maternal health of the country and in what ways does it differ?

Heather Irobunda:

I mean, it directly reflects what we're seeing in the country because I feel like every part of the country is a little microcosm or little like micro piece of the puzzle. And in states like Georgia, so Georgia, Mississippi, places like those with higher percentages of Black people, the Black population is higher, you tend to see worse outcomes compared to other parts of the country. And unfortunately, it has a lot to do with systemic racism and barriers to care and social determinants of health. But that's what we tend to see, is when we have states with higher percentages of Black folks in them, we tend to see higher rates of things like infant mortality, low birth weight, babies, maternal mortality, things of that nature.

Monica Peek:

Yes, exactly. And I think that in this next era sort of post-Roe, we're going to be seeing a lot, an exacerbation of these numbers.

Heather Irobunda:

Oh, yeah. And something to also mention is that these markers, like looking at maternal mortality and infant mortal mortality rates, are just markers of overall health in our communities. So by seeing this, because we tend to treat our pregnant people, our pregnant moms and our babies, better than anyone else in the population, so if

you see these numbers for birthing folks and babies, you can only imagine what's happening to non-birthing folks in the Black community.

Monica Peek:

Absolutely. Sierra, you're heavily involved with advocacy, research and reform within maternal healthcare. What are some of the disparities of maternal health seen throughout the United States?

Sierra McClain-Henry:

Well, what's sad is that in those same communities that Dr. Irobunda was speaking about, we see the widest gaps between services like doula support, childbirth education, things that we know can make a difference in those maternal health outcomes. We see the widest gap between the folks who really need it and those services, they're inaccessible often for these communities. And even when we are putting policy into place to try to make those services more accessible, a lot of times those programs expanding Medicaid coverage of doulas and things of that sort are still missing the mark. So, for many communities that are suffering, the most services that could really improve their chances at life and having a greater quality of life are still deemed to be a luxury and just are something that's unattainable and out of reach.

Monica Peek:

Absolutely. Thank you all so far for this wonderful conversation. We're going to revisit our first audience question and see if we've remembered some of the numbers that we've already talked about. So in the United States in 2020, the maternal mortality rate for non-Hispanic Black patients was how many times higher than the rate for non-Hispanic White patients?

So before we move on our second learning objective, I want us to take a moment to touch on the impact of a post-Roe v. Wade world and what that may mean in regards to health disparities and inequities. And I was just sort of alluding to that earlier. Sierra, can you talk a little bit more about this?

Sierra McClain-Henry:

Absolutely. So what this has done, what I've seen in my own practice, is create a population of women who are, and birthing people who are just afraid. They are afraid to even enter into the space of becoming a parent not knowing what is going to happen. As I mentioned before, there's already a lot of gaps in terms of things like Medicaid coverage. And now without the protections that Roe v. Wade provided, there's a whole population of folks who are out here floating. I've seen so many different things out there since Roe v. Wade was overturned in the way of, believe it or not, do it yourself procedures for ending pregnancies at home. I've seen a lot of information being passed around in the birthing community and amongst birthing people and parents. That's a scary situation. There are folks who come for services, for doula support, to support them following the loss of a child whether it's an elective loss or whether it was not. And just knowing that they no longer have those protections has really limited the folks who would reach out to get support. Whether or not you choose to have an abortion, you do deserve to have support and to have your mental health needs acknowledged and validated. And they're folks now who are afraid to even speak up at all. I've definitely noticed less folks reaching out for loss

services for abortion support services, of course. And there's also just a frantic search for information out there. There's no centralized place for people to look to really understand what's next, where to turn. It's sad for the birthing world, for the birthing community, and for the rights of birthing people, period.

Monica Peek:

Thank you. Thank you for that insight, Sierra. Our second learning objective for today is to individualize a holistic treatment plan for maternal care to improve patient and infant outcomes. So let's check back in on Macy. Heather, I'm going to let you pick it back up.

Heather Irobunda:

All right. So Macy is now at her two-week postpartum visit. She delivered a healthy baby boy via C-section, despite prior vaginal birth. She feels like she failed due to having a C-section. Macy feels guilty that she's not happy about the birth and feels unconnected to her baby. She stresses that she's experiencing an overwhelming sense of sadness and anxiety about her ability to address the needs of an infant while caring for two small children at home. And her OBGYN says to her, "Your baby is healthy and there is a lot for you to be happy about."

Sierra McClain-Henry:

I'd like to jump in here on that last section. “Your baby's healthy and there's a lot for you to be happy about.” I've come across countless people who have birthed, and it may be years from the time that they birthed, but that spot inside of them that was wounded from the trauma of their birthing experience was never healed. It was never acknowledged. And even refusing to acknowledge the fact that, "Hey, this was disappointing. This isn't what you wanted." It erases you as a person besides your identity as a mother, you as a human being. It says you can't acknowledge that hurt. And it reinforces this harmful stereotype that motherhood is martyrdom. And once you birth someone through your body, your thoughts, your feelings, you as a person, besides as caretaker for that child, doesn't matter as much or at all. And that we should just carry on and suppress whatever we feel. It sets us up for a lifetime of mental health issues, suffering, depression. What it does is actually create the same cycle for the next generation. We end up modeling that for our children, and that's the example of motherhood or parenthood that they saw. So they take that, and it informs their entrance into their own parenting journey.

Monica Peek:

And you've already done that, but can you explicitly tie that back into our learning objective? So what you guys are talking about, how that specifically ties back into the idea of a holistic treatment plan for maternal care.

Heather Irobunda:

So I actually have something definitely to say about that, especially to providers like OBGYNs, midwives, things like that. From a medical perspective, we're always taught like we're looking objectively at the outcomes. Living, dead, healthy, not healthy, things like that, in a binary. Even not taking into account mental health in that. So people count as a win that the baby came out healthy and mom is alive and doesn't have any major physical issues. But not acknowledging the whole part of the person and not acknowledging what their desires were beforehand and

then what ended up happening and how they could feel afterwards, that is part of holistic health. And that's something that we need to do a lot better with, especially for our marginalized folks, especially for Black women, Black birthing people. Because a lot of times, especially if they have a lot of social stressors in their lives, you may be the only one who's addressed that concern with them where it's like, "Hey, I thought I was going to have a vaginal delivery. It didn't happen that way despite my best efforts. I don't really have anyone else to talk about this with, and I'm just supposed to trudge along." This is a great opportunity for us to provide better healthcare to our patients by acknowledging, "Hey, as much as, yes, you should be happy that your baby is out and healthy. But I understand this is not how you wanted this to go down." Let's hold space for that. So I think it's really important because I don't think we do that very often because we're not really taught to look at that situation that way.

Monica Peek:

Absolutely. Thank you all so much.

Sierra McClain-Henry:

It just reminds me of... I'm sorry. If I may share, it reminds me of a client who at birth, and within the hour of her baby being born, she was crying, a very similar situation to this patient case, and her OB's response was literally, "Chin up, you'll be fine." And then she walked out of the door. And that just to me illustrates exactly what Dr. Irobunda was saying. We have to do better, we have to do more.

Monica Peek:

Yes, yes, absolutely. And underscores particularly for those marginalized people whose existence in the world is frequently one of not being heard, of being ignored, of having our concerns not met. So we have so much to cover, too little time. So before continuing our discussion, let's see our next audience response question. Which of the following recommendations is endorsed by the American College of Obstetricians and Gynecologists, ACOG, regarding perinatal depression?

Macy's mental health appears to have been impacted during pregnancy and now postpartum. Sierra, why should maternal mental health be a core focus for providers and patients alike?

Sierra McClain-Henry:

Mental health, physical health are all connected. And again, it goes back to a holistic view of the healthcare that a person needs in the pregnancy year. We are more than just the physical symptoms that we are displaying. And if we ignore the struggles that someone is having with mental health and we leave them to their own devices, it's likely that we'll begin to see some changes in their physical health. We need to address the whole person, the entirety of what that means, and especially knowing and understanding that in the postpartum period, even during pregnancy, our mental health can be affected by number of things. Circumstances in our lives, hormones, so many different factors. And so we have to broaden our definition of what it means to take care of the birthing person.

Monica Peek:

Heather, in addition to evaluating and addressing maternal mental health, how can we as providers individualized equitable care for our pregnant and postpartum patients?

Heather Irobunda:

I definitely believe that you have to look at your patient as an individual. It's hard sometimes given that we don't have a lot of time in our schedules, just given the structure of the medical system right now. So a lot of times we can feel like we don't have enough time to really deep dive in, or sometimes we may fear having those conversations with our patients because it may open Pandora's box and, oh wait, now I'm like, however many patients behind or whatnot. But it's so important that we do that. Hey, even if you don't have the time to completely delve into everything, you can start that conversation and then bring in our friends, our allies, our team. So that means we can have people, doulas who come in, especially if they had doula care during their pregnancy, they'll already be well-versed in that, but also they can come in just for postpartum stuff to help folks. In my practice, I definitely use social workers and things like that to come up with a plan, even if they need a therapist or something. There are people who you can send your patients to help you provide the most holistic care for these patients. Also too, dismissing people's concerns. Although you may hear the concern and in your mind you're like, "Well, that's not a big deal." That's a big deal for them. They came to your office, came to the appointment and said this to you in that limited amount of time they had speak. So clearly there's probably a lot of stuff behind that that they're trying to tell you. So really listen to what they're saying. And if there's something that they bring up that to you may feel trivial, it's probably not, and there's probably something big behind that. And then, also, too, just if you've seen this patient before and you're now seeing them postpartum and they're saying all the right things, but you notice a change in their affect or how they are, how they present themselves, those are things you need to be honing in on because a lot of times people say, "Well, she said she's okay." I mean, if you've seen her before and you're used to her dressing a certain way, and then she comes in and she looks completely not like herself, she doesn't sound like herself, you need to dig deeper. And so, it's our responsibility for our patients to look into these things because we may be the only person who notices this. We may be the only person who sees them during this time. And you can connect them to such great connections and great resources to help them get through their postpartum time a lot better.

Monica Peek:

Absolutely. We may have the relationship and the rapport with the patients to be honest. I think that noticing, picking up on those cues, can be make a huge difference. So we're going to come back to the second question again and see how our audience is doing for learning check. So we're going to ask the question again. Which of the following recommendations is endorsed by ACOG regarding perinatal depression?

So, a core component of individualizing patient care is through evaluating social determinants of health. Heather, how should we include addressing these social determinants when developing treatments with our patients?

Heather Irobunda:

It's of the greatest importance to integrate social determinants of health and how they impact patients into our daily patient care. One big thing that I see in my practice is that if you don't do that, it's just not going to work out for the patient. Honestly, so many of my patients are impacted by all of these things. If you miss the opportunity to address these things, your patient will not get proper healthcare, period. It's just not going to happen.

Monica Peek:

We'll end up calling them non-adherent.

Heather Irobunda:

Exactly. So one of the big things I like to talk about... So for example, education. Everybody has different literacy levels. Everybody has different health literacy levels, right? So you need to be speaking to your patients in a way that they can understand, you providing them resources in a way they can understand in their literacy, at their literacy level. Because something that I often see is people say, "Oh, well I gave them handouts, or I gave them information." But if they can't understand what it says, if it's not in their language, if it's not in a language written in a way that they can understand, that's a moot point. So, saying you gave somebody postpartum instructions or ways that they can take care of themselves, but they don't understand what you're saying, it's a moot point. Other things too is "adherence" to coming to medical appointments. If you don't allow children in your facility for whatever reason, it can hinder the way in which people come to access care to you. Additionally, if people work, not having hours that are accessible, those are things that all matter. And then another thing that I notice is just even not being flexible in terms of when people can come to you if they're late, if they're going to come a different time. These are all things that matter and we need to think about. Also, insurance coverage. One big thing that's happened in New York that's interesting, which I'm sure has happened all over the country, is there have been changes in what certain Medicaid coverage covers in terms of medications, even when it comes to prenatal vitamins. So I've definitely had patients come to me after you do your song and dance, "Congratulations you're pregnant." And you write them their prescriptions and I'm like, "Okay, I'll write you for some prenatal vitamins." I see them weeks and weeks later ,and then I'm like, "Okay, so how's everything going?" They haven't picked up anything because it's not covered. I've heard people say, "Well, why can't they forego X, Y, Z thing in order to afford their medications?" That's not really the way we probably should be approaching that. We should be trying to figure out how can we provide these resources, these meds, to people who don't have it instead of questioning where and how they spend their money. And then, just even, do these people get quiet moments? So when we're saying, "You need to not be stressed out, you need to relax." What if they live in a one bedroom apartment with seven other people? That is highly common in urban areas, right? So you're telling people that they need to keep their stress down because they're going to get preeclampsia, they have high blood pressure, but how can they realistically do that? So we need to come up with better ways and figure out how we can help people get through that and that's through providing different resources.

So, as I said, we have an army, we have a team of people that we can use that's not just us to help our patients do better. So we can talk to them about what kind of supports they have, who in their lives could help them, if we see a hole, figuring it out. Because that's the reason why I lean on my social workers so much because they tend to have a lot more awareness of different opportunities. Thankfully in my case, a lot of the social workers actually

can link people up with doula care and link them up with different things. But those are the types of things that you should be talking about with your medical practice, with your hospital system, with those types of things, because we really need to make sure we're fully supporting our patients. But also too, even the foods they eat, everything is affected by this. And we have to remember that when we're talking to our patients. So assuming that they can buy whatever food, that they're going to have enough money to do it, or that the stores in their areas, they're going to carry it. You have to change your whole focus and your whole plan because we can't have people try to continue to adapt to what we think is what they should be doing. We should try to adapt a little bit more to where people are.

Monica Peek:

That's exactly right.

Sierra McClain-Henry:

I think-

Monica Peek:

Go ahead.

Sierra McClain-Henry:

... that food piece is so big because there's the whole cultural component that goes along with what we eat and how we eat. So it's easy to tell someone, "You need to follow this diet. You need to eat these things or not." We really have to go deeper. I think it's a wonderful model that Dr. Irobunda is describing in her practice, and I wish that that was more widespread, because that's exactly what it takes being willing to dig deeper. And then once you dig deeper, displaying the fact that what you have uncovered matters. So here's what I'm going to do to meet you where you are. This is what you're telling me. Here's what we can do and it does take a team.

Monica Peek:

One of the things I think is really important is that there are individual providers who have been advocating for this kind of care for a long time, but what we're starting to see is that national organizations and institutions are recognizing that this is really important. So, the National Academy of Science, Engineering, and Medicine has these five A's of how to incorporate social care into regular medical care. So those are awareness, adjustment, assistance, alignment, and then advocacy. So thinking about the social determinants of health and how we're screening for those, how we become aware of these needs, how we're adjusting our practice to address these needs, how we're aligning how we deliver clinical care to meet our patient's needs. And then how we're advocating for these larger social issues outside of medicine along with social service agencies and other advocacy organizations. So, I think that there's... We're at a unique inflection point in our healthcare health policy history and that this is becoming not just the Black people talking about it, or the health advocates talking about it, but large institutions and government institutions that are recognizing the importance of addressing these issues for everyone, but particularly marginalized populations.

So, thank you ladies. This has been such a robust conversation. Heather, I'm going to loop back and say that during pregnancy and following birth, Macy has had a difficult time emotionally. So we're looping back to the patient case. What can you tell us about her mental health status?

Heather Irobunda:

So Macy's OB-GYN evaluates her for postpartum depression with the EPDS, and Macy's score is a 19, so that meets the criteria for depression. And she's prescribed sertraline and directed to follow up in three weeks. She's also provided information on other resources available to her, including behavioral therapy, telehealth appointments, and postpartum doulas. And so, I'm actually happy that this instrument was used. So the EPDS, which is the Edinburgh scale for postpartum depression and peripartum depression. We use this often. It should be used at the first visit. I usually do it around 28 weeks, and then I do it at the postpartum visit. And from then, you can also see if there's been any changes in a patient's affect or depression or anything like that, and you can identify issues. So I'm glad that she was treated, but not just treated, but also given other information. Because a lot of times... Again, we're told very clinically, "Okay. She takes the EPDS. She scores high." Reflexively, offer her medications. And medications do help. So, we need to also destigmatize things like that. But we should also be talking about what are other things that are causing the situation to be worse. Because to me, something that I felt like get really discouraged by sometimes is people just giving the medication and not really addressing any of the other things. Not asking her if she would like to talk to somebody, a therapist. Does she need some support? Because a lot of people feel isolated, especially in that postpartum period. So a lot of times talking through some of this stuff can be helpful. And because of barriers that we may have to getting people, especially behavioral therapy, health therapy. Behavioral health is also a crisis in this country. And finding therapists, especially therapists that take Medicaid or don't take insurance and have a sliding scale is really hard. So trying to find other resources, support groups, postpartum doulas, things like that, people who can help patients like Macy get through this is important, and not just the medication. And then also close follow-up with us. So not giving her the medication and say, "See you. Go see your primary care. Go see your primary care doc." You know what I mean? It's making sure you have close follow-up. I usually see my patients about two weeks later. Not that I know that the medication is going to be working for her by that point, but I just want to see where she's at. You know what I mean? And also for her to know that someone's looking out for her. Somebody is wondering how she's doing and expecting to see her because what I've heard from so many patients dealing with postpartum depression is that, that act in and of itself, having an appointment in two weeks where they know someone cares if they show up or not-

Monica Peek:

Accountability.

Heather Irobunda:

... is a big deal.

Sierra McClain-Henry:

I think it's the same with postpartum doula support because, I mean, you can't have someone from your doctor's office or midwives office call you every single day. But we can. As doulas, we're able to fill in the gaps between care, which is why it's so important for doulas and medical professionals to not see each other as opposite ends of a spectrum, but rather as parts of a team, and we all have the same goal. And if we see it that way, we can better work together understanding that a lot of times compliance that clients of mine may be displaying is due to conversations we've had. When they've left disappointed, totally doubtful and committed to, "No, I'm not going to do that," until we talk through it, because we built that relationship with them and we are able to meet with them every single week. We're able to go to their home and be there and sit with them. So I think it's important that, again, that we have the team and definitely underscoring what Dr. Irobunda said about the medication, yes. But what else? Because the medication isn't getting to the root of the problem. If we see this person as a whole person, then we can recognize, part of the problem is, you have a lack of groceries or resources in your home. Maybe we need to connect you to some services that can change that. Or maybe you need some job training or job placement assistance or something else. Or maybe you need a support group. Something beyond that medication that's going to begin to help see improvement in their whole lives.

Monica Peek:

Yeah. Additional psychosocial stressors that may be triggering this. So there are a lot of things that were offered to this patient, which were great. And one of the things that's newer for us as a country coming out of the pandemic is telehealth. And so that sounds like it may be a good match for Macy given our shortage of mental health services. So we have our third audience response question. So which of the following statements... I'm going to ask the audience, regarding the use of telehealth for postpartum depression, is true.

So, switching gears a bit, Sierra, you were just talking about the importance of having a multifaceted team and having the doula and the provider and social workers all working together to form a bond around a patient for ideal care when it comes to pregnant and postpartum patients. What can you tell us a little bit about do you think a team based care model should consist of?

Sierra McClain-Henry:

So there are a lot of programs that exist now to provide free or low cost doulas on a sliding scale basis or on a scholarship basis. And on the surface, those programs are wonderful. They appear to just bridge a gap where we need a gap to be bridged. The sustainability of programs like that is what concerns me as a birth worker. I've been a birth worker now for nearly 10 years, and what I have seen is programs like this that come in and it's exciting for the public, but when you consider the effect that it has on the birth workers who are a part of those programs, we can understand why these programs are not easily replicable. Oftentimes doulas are offered very low wages to cover these births and the amount of work that's involved in working with folks who sign up for the majority of these programs, we're dealing with some compounded situations. And so you have doulas who are here to serve and want to serve, but are being paid pennies for the work. And I think a solution to this that I see and that I've been very vocal about in terms of policy here in Texas is simply bringing doulas to the table when we are crafting policy that involves these types of programs. We can talk about what works. Many of us are ourselves offering services at a sliding skill or taking on pro bono clients. And there's certain ways that we do that and that we make

it work, but I think when we talk about issues of equity, we can't ignore the fact that oftentimes those are creating more issues of inequity by paying someone a lot of times less than a third of what the going rate is in that state for a doula. So, looking for other ways to fund doula support is huge for me. I know when I take on a pro bono client personally, I encourage that person to apply for a scholarship. The Baby Dove Foundation is the one that I send most folks to. And there's many others that exist, the Victoria Project based in California. These are organizations who are committed to fair pay for birth workers. So they offer training and they offer placement, and they offer that fair pay, which makes the difference. And then you have a program that folks want to sign up to participate in. The other aspect of a lot of these programs is making sure that the doulas that are a part of the program are also a part of the communities that we aim to serve. That makes a difference. If we have this program, but I still can't get someone who I feel speaks my language, who understands my cultural experience and the impact that that's going to have on my pregnancy and my birth, my recovery, my life. How successful is that interaction going to be? And in those types of cases, we see the opposite of what we're hoping for, which is someone who is able to help this person open up in ways that they need to get the help that they need.

Well, there's a care provider who's going to provide your primary medical care during pregnancy. It should be someone that you trust, someone that you feel is listening to you, is validating your concerns, someone that cares. You also need a doula who can bridge the gap and provide more emotional support, provide support in other ways, hands on logistics as you prepare to bring a child into the home as you prepare to go into postpartum. It's important that you have some type of educator on your team, that may be a doula or it may be education that you seek from somewhere else. Childbirth education though is something that I think is overlooked far too often, and competent childbirth education, I will say that addresses things such as what Macy went through in the beginning where she felt like a failure because she had a C-section. Then there's also definitely the need for a mental healthcare professional on your team. Having a therapist during pregnancy that you already have a relationship with that you can continue seeing in the postpartum period is really important. I also think that it's important that those who are in the home with you, that you see them as a part of the team and you evaluate their role. How effective is this person? Are they helping me or are they causing more harm? What should their involvement in this situation be? But understanding that our goal is to get both the birthing person and the baby to come through in the most optimum health possible in every way.

Monica Peek:

Absolutely. I think it's important that you noted that sometimes people in the home may not necessarily be helpful. We always think about family equal social support, but sometimes family or people who are living in that space may not be... They may be drawing resources from that individual or just frankly harmful to that individual. So assessing.

Sierra McClain-Henry:

Oh, absolutely. That's something that can be usually pulled out of a conversation. If you really hear what the person is saying in between the words that are coming out of their mouth. Sometimes home is a place of stress. It's not a place of peace. And if you have no choice when it comes to where you live during pregnancy or in postpartum, then you're going to be in a situation of stress each time you return home. Unfortunately, that's the reality for so many people. So having that doula support can really... I mean, for some people it's the emotional aspect of it. That is everything. That's absolutely everything. Having someone that you know cares, and not only

do they care, but they're knowledgeable as well. So you're able to come. I tell folks sometimes it's like having a really good friend who just so happens to have special expertise in all things, pregnancy, birth, infant feeding, what have you.

Monica Peek:

Absolutely. So this is really important sort of thinking about all the people that are part of the care team, but there are also additional resources and organizations that can equip patients with information, and support, and resources to achieve better maternal health outcomes. So Sierra, can you tell us a little bit about some of these organizations and resources that they can provide?

Sierra McClain-Henry:

So, organizations like the Shades of Blue Project where folks can come and get social support, they can get resources they need in the form of things like diapers and wipes to provide immediate needs. But beyond that, we're looking at their mental health. So we have support groups available. We have access to therapists at no cost through our programming. We are one of many programs that exist like this in the country. We center Black birthing people in the work that we do, and we exist because all of us in leadership are ourselves, Black birthing people. We have been at one point or another. And our stories vary. The stories from our pregnancy year vary. My pregnancy year, me, when I had children years ago, didn't look like the me now. And I still remember everything I went through. I remember myself being a mom on Medicaid. I remember myself having to get rides to get to prenatal appointments. I definitely remember the stress from knowing that I really needed to... Here in the state of Texas, you have to attend a minimum number of prenatal appointments, or else you are recommended for a CPS case. How stressful is that to have as knowledge as a Black person, knowing all we're up against and then knowing that as well. You all mentioned earlier being labeled non-compliant. I was so concerned about that. I remember those things that I remember what that felt like, and it informs everything I do in the way that I care for folks. I think that's the wonderful thing that I see about the organizations and the individuals who are doing birth work right now. It's coming from that place, from remembering that I'm a human being and I'm here to serve other humans who are having very human experiences.

Monica Peek:

Yes, who are having challenges, and how can I give them love and support and encouragement as opposed to-

Sierra McClain-Henry:

And even just listening and being willing to say, I hear you speaking fellow human being. I hear you. What you're saying is registering with me and it's actually motivating me to action whether it's just a referral that I give you to see someone else or whether it's, okay, I hear what you're saying. Things didn't go well with you last time when you were on that medication. Let's see what else we can do. Just being willing to listen.

Monica Peek:

And that goes so far as we know from being in those places ourselves, that when you are in a place of need, a helping hand, someone who just stops and cares, it makes the world of difference. It seems like someone is doing just so much more than the simple act that they are. And so all of the work of these organizations and that you're doing is just incredibly important and so meaningful. So thank you. Thank you for that.

We're going to go back to our third audience response question. We always ask each question twice. And so this one is regarding the use of telehealth for postpartum depression.

And then Heather, we're going to loop back once again to Macy, our patient, our ongoing patient. How is she doing? What's her status now?

Heather Irobunda:

Okay. So Macy on her four-month follow up is doing very well, and reports feeling calmer and happier. She tolerated the medication well and was able to work with a postpartum doula. So it sounds like she had more than one person on her team to help her through this. And then also the medication helped her. So it sounds like a win for now.

Monica Peek:

I feel excited for Macy like she's a real person that we've helped through her challenges. Thank you, ladies. All right, so we are going to summarize our discussion with our smart goals, and those are goals that are specific, measurable, attainable, relevant, and timely. So that is what I hope you'll take from this presentation to apply to your practice. So first, recognize the widespread impact of the post-Roe world on preexisting maternal health disparities and inequities. Next, inquire about a patient's mental health status, both during and after pregnancy to reduce barriers to care and formulate an effective treatment plan. Also, assess each patient's social determinants of health with awareness, adjustment, assistance, alignment and advocacy. And then finally, use a team-based approach to care to provide emotional, physical, and informational support for patients and their families. Heather and Sierra, are there any other action items that you'd like to add that I've missed?

Heather Irobunda:

I think you hit it.

Monica Peek:

Great. Thank you all so much again. Here are just some of the topics that we've covered so far and we'll be adding new content every month. We really want to hear from you, our audience, on what you need so that we can make an impact on these very important issues. Please email us at questions@cmeoutfitters.com with your comments and feedback. We assure you we read every email and we really appreciate your feedback. CME Outfitters also has a Diversity and Inclusion Hub with a number of excellent resources to share with your patients. So thank you again to the faculty joining me today. You all have been awesome. It has been so much fun. Thank

you, thank you, thank you. And also to our audience for joining us. Please be safe and take care of yourselves so you can provide the best care for your patients.