Head Start Services as a Maternal Health Intervention

Ndyia Ntouda: We have the co project director of the Center, Nancy Topping-Tailby with us, who will introduce herself and today's speakers. You can take it away, Nancy.

Nancy Topping-Tailby: Thank you so much, Nydia. Welcome everyone. I'm so pleased to be able to share this presentation with you today. As Nydia said, my name is Nancy Topping-Tailby, and as you can see, I'm the co project director for our National Center. I'm so pleased to introduce our speakers who are here with us to help raise awareness about pregnancy-related deaths and strategies to ensure better outcomes for pregnant people and their families.

The first speaker that you'll hear from today is Khadija Gurnah. Khadija is a subject matter expert for our center on maternal health equity. She's a graduate of the Yale School of Public Health where she received the emerging majority award in health disparities for her advocacy for policies that improve the health and well-being of pregnant postpartum people and their families.

Our other speaker today is Brittany Behm who is a health communication specialist in the Center for Disease Control and Prevention's division of reproductive health supporting the National Hear Her communication campaign that seeks to reduce maternal mortality in the United States. Ms.Behm supports the division's efforts to communicate timely and accurate information in an understanding and actionable way. She has been at CDC since 2010 working as a liaison to the news media and the Office of the Associate Director for Communications and serving as a spokesperson and strategic communicator in the division of foodborne waterborne, and environmental diseases. She received an undergraduate degree in public relations and a Master of Public Health.

Those are your speakers for our webinar today. Next slide, please.

I wanted to frame this discussion at the beginning because this work is very much part of our center's work in the area of health equity. I wanted to share with you. I don't know if others of you have seen this definition before, but if not, do whatever works for you. Either read it or listen to me. As I read it, I'm just going to read it for folks.

“Health equity is a principle underlying the commitment to reduce and eliminate disparities that impact children, families, and staff. Pursuing health equity means striving for the highest possible standard of health and behavioral health for all people. It includes ensuring equitable access to a continuum of resources, services, and positive experiences within systems. It also includes giving special attention to the needs of those at greatest risk of poor health and behavioral health outcomes based on systemic and structural racism and other forms of oppression.”

We really have developed this definition because our center is committed to trying to reduce and eliminate disparities that lead to differences in health outcomes among families who enroll

in Head Start and other early childhood programs. This includes supporting positive infant and maternal health outcomes. We know that for this to happen, people need to have equitable access to resources and services. We also want them to have positive interactions with the providers that care for them, so that families can receive the services that they need and that they deserve. We recognize that systemic and structural racism has contributed to many health disparities, and by disparities, we're talking about the differences in health outcomes and their causes that affects certain groups of people.

With that frame, I'm going to now turn it over to Khadija who will discuss some terms that we're using when talking about families during pregnancy and the period after birth, which may not be familiar to you. We wanted to make sure that everyone had this common language moving forward. Then, Khadija will review the learning objectives for today's webinar. Khadija.

Khadija Gurnah: Thank you, Nancy, and thank you everybody for being in community with us today. The first term I'm starting with is “pregnant people” and “birthing parents.” To be inclusive of all people who give birth, regardless of their gender identity we're using the terms birthing parents and pregnant and postpartum people to describe people who may be female, male, non-binary, or other. These terms are relatively new so much of the data that have been collected to date refers to women, therefore might not be inclusive of information on all pregnant and postpartum people.

The next term is birth equity. Described by Dr. Joia Crear-Perry of the National Birth Equity Collaborative, birth equity is the assurance of the conditions of optimal births for all people with a willingness to address racial and social inequities in a sustained effort. Next slide.

The things, the learnings that we hope to leave with you today are to understand the current state of maternal and perinatal health … perinatal meaning the time before and after birth. Understand the underlying causes for disparities in maternal health outcomes. Understand modes of intervention that head start programs can engage in to improve health outcomes for pregnant and postpartum people.

Now, Brittany – we're very fortunate to have her – will share data about pregnancy-related deaths that highlight health disparities experienced by some pregnant and postpartum people. Brittany, thank you.

Brittany Behm: Thanks so much. We can advance to the next slide. Here we go. Thank you guys so much for the opportunity to join. I'm really pleased to be here and I'm going to speak a few minutes on national data on pregnancy-related deaths, and then I'll be talking a little bit later about a communication campaign we launched that may be helpful to implement and some of the Head Start and Early Head Start programs. Next slide.

Just to start with some high-level statistics that you may be aware of. Overall, each year about 700 women die during or within a year of the end of their pregnancy in the US as a result of pregnancy or delivery complications. Unfortunately, there are considerable racial disparities. American Indian, Alaskan Native and Black women are two to three times more likely to die of

pregnancy-related causes than white women. What makes this number so tragic is that at least two out of three of all pregnancy-related deaths could be prevented. We know that maternal mortality is just the tip of the iceberg, so many more people suffer from severe complications each year. Next slide.

This graph is a little older data, but it shows that over the last two decades pregnancy-related mortality has not been improving, and that is a problem. This data is from our pregnancy mortality surveillance system, which reports deaths during pregnancy or within a year after. It gives us overall mortality rates, rates by state, race ethnicity, and the timing of death in relation to pregnancy. Next slide.

This slide shows the pregnancy-related mortality ratio by race ethnicity and by education level. You can see that there are disparities that exist among Black people and American Indian and Alaskan Native, as represented by the dark purple bar and the light purple bar, regardless of their educational attainment. Next slide.

Data from the same system also shows some of the timing of the death in relation to pregnancy. We know that about a third of pregnancy-related deaths happen during pregnancy. Another third happened during delivery, and up to that week after. Then, another third happens in that year after pregnancy. Next slide.

Because maternal mortality is a very complex issue, we really need robust detailed data to better understand and prevent these deaths. We look at maternal mortality review committees, which are committees out a state and city level that can identify and review pregnancy-associated deaths. They have access to multiple sources of information that can provide us deeper understanding of the circumstances surrounding each death in order to develop actionable recommendations to prevent future deaths.

Based on data from 14 of these maternal mortality review committees, we found that some of the leading causes of pregnancy-related death, which are found on this slide, are cardiovascular and heart conditions; hemorrhage, which is just excessive bleeding; infections; embolism, which is an obstruction of an artery, typically by a blood clot; cardiomyopathy, which is just a disease of the heart muscle. Cardiomyopathy and mental health conditions are more common in the postpartum period, but they're actually leading causes of death overall. Then, pre-eclampsia, which is a type of high blood pressure that happens during pregnancy. Next slide.

This slide really just shows that the leading causes of maternal death do vary by race ethnicity. In order to really address the needs of these populations we need to look at the detailed data and tailor and prioritize interventions appropriately. Next slide.

As part of that communication campaign I'm going to be talking more about shortly, I wanted to share these. These are the 15 urgent maternal warning signs that we promote through this campaign that could indicate very serious complications. Some of which were shown on the previous slides. This list was developed by the former Council on Patient Safety and Women's Health Care. It now lives on the Alliance for Innovation on Maternal Health website. While we

encourage anyone who has any concern during pregnancy or in the postpartum period to speak to their health care provider, if they experience any of these warning signs, we really recommend seeking immediate medical attention because they could be very serious. This poster is available on the CDC's website and can be available to order through our CDC info on demand. I look forward to chatting a little bit more further and we'll turn it back over to Khadija.

Khadija: Thank you. Hearing the voices of Black birthing people is central to achieving birth equity. To that end, we're going to play a video where Serena Williams shares her birthing experience. Before we start it though, I want to note that this video can be triggering, especially if you've experienced a traumatic birth event. Please prioritize your wellness and participate to the extent that you feel comfortable. At the end of the video there will be an opportunity to share your reflections in the chat.

[Video begins]

Alexis Ohanian: What did you say when someone said that our little girl was going to win Wimbledon and like 15, 20 years?

Sarena Williams: Not if I'm still on tour.

Alexis: You're ridiculous.

Sarena: Everything went great, and I put a little makeup on. I could take pictures with the baby, and I just remember getting up, and I couldn't breathe. I was like, “I can't breathe.” Like, I couldn't take a deep breath. I told the nurse, “I can't breathe. I need a mask.”

I put the oxygen mask on and —

[Video pauses]

Khadija: I’m sorry.

Nancy: Yeah, can you start over?

[Video resumes]

Alexis: What did you say when someone said that our little girl was going to win Wimbledon and like 15, 20 years?

Sarena: Not if I'm still on tour.

Alexis: You're ridiculous.

Sarena: Everything went great, and I put a little makeup on. I could take pictures with the baby, and I just remember getting up, and I couldn't breathe. I was like, “I can't breathe.” Like, I couldn't take a deep breath. I told the nurse, “I can't breathe. I need a mask.”

I put the oxygen mask on, and I started coughing because I couldn't breathe. It hurt so bad. It hurt so bad that my stitches broke. I remember I was in the bathroom with my mom, and I was just crying and crying. She was crying. She was like, you just got to breathe. I was like, I can't, I can't breathe. It was just really hard. [Crying]

After that, I remember being wheeled back to the operating room because I had to reopen my c-section and re-stitch it. Then, they had to check for blood clots and everything, so they were doing all these different tests and everything was negative. I'm like, listen, I need you to run a CAT scan with dye because I have a pulmonary embolism in my lungs. I know I've had this before. I know my body.

Alexis: She was undoubtedly battling for her life, and I was terrified that she might die, but I was grateful that she had the wherewithal to speak up because she knew her body better than any of us.

Jill Smoller: The enormity of everything was scary, but fortunately because she advocated for herself, they ended up taking her in for a CAT scan, and they found the pulmonary embolism.

[Video ends]

Khadija: As we reflect on this video, I want to ensure that you have the opportunity to attend to your wellness. If and when you're ready, I invite you to share your reflections in the chat. We're going to move on now. Next slide, please. Please do continue to share any thoughts that you have around the video in the chat. We will be tracking them. Yes, thank you, Haven. Please continue to use the chat to have this conversation.

Now, when we've talked about the state of maternal health care in the United States, but what I would like to move on is to speak about the underlying causes. Systemic racism has an outsized impact on maternal health. Disparities and maternal and infant mortality are a result of inequitable systems and practices that contribute to inadequate outcomes for people of color. Bias that we're talking about in terms of delivery of care … It refers to attitudes or stereotypes that favor one group over another.

Explicit bias – conscious beliefs and stereotype that affects one's understanding, actions, and decisions, as described in these studies that show pain is undertreated in Black patients, and that Black pregnant and postpartum people frequently report that doctors and nurses don't take their pain seriously, which is why I very much wanted to share that video with you because Serena Williams, to me, is an incredibly powerful and accomplished Black woman. But she struggled with this. To extrapolate how many other Black women … Black pregnant people are experiencing the health care system. Next slide.

This concept of weathering. The concept of the weathering is the cumulative life experience of racism and sexism have a profound impact on the physical and mental health of Black women and birthing people. This process is known as weathering. It can lead to premature biological aging, leading Black birthing people at higher risks for conditions, such as preeclampsia, eclampsia, and embolism.

I know this is an abstract concept, but to share with you some of the ways that I process this information … There is emergent studies that look at the birthing outcomes of foreign-born or immigrant Black women. They have better birth outcomes than US-born Black women. Whatever protective factors relate to the foreign-born Black women having better birthing outcomes disappear by the time that their daughters are birthing. The daughters of immigrant Black women have the same birth outcomes as all other Black women. There is something that in the way that a body is processing these systems that has a profound impact on the way that Black birthing people experience birthing. Next slide.

What can Head Start and other early childhood programs do to promote more equitable outcomes, understanding that this is a systemic problem. Head Start and other early childhood programs, you all are providing a very comprehensive early care and education system. You actively engage with communities. Just by starting and recognizing that, you can partner with and advocate on behalf of families. That's an intentional health equity intervention. This space and this time that we're taking together is an intentional birth health equity intervention. It can contribute to closing racial disparities across an array of outcomes that are due to systemic racism and other forms of oppression that result in inequitable access to resources. Next slide.

Now, I'm coming to this with a lot of gratefulness. We have been working on this body of work for quite a while. When I say we, it's many people across many different offices, not just those of us on this webinar today. A lot of love and intention has been put in to collating these resources, that not only describe the problem around maternal health equity, but how Head Start staff can collate resources and help and support birthing families in their program. This fact sheet that we're going to speak of and go through today is, as of last night is live, that URL. It's available in English and Spanish. We're going to the next slide.

We're going to go through some of the materials that's available on that fact sheet. Thank you very much, Steve. If you look in the chat right now, you'll find a link to … There's a text of this fact sheet, but then there's also the graphic that you just saw before that you can click and download and print out and have with you. We're going to talk about modes of intervention. As Brittany described, there's different warning signs that we can look out for that could indicate that the pregnant person is in distress and needs immediate medical attention.

Knowing that understanding what those warning signs are and understanding how they differ by race is a mode of intervention. Listening to pregnant and postpartum people's concerns and talking to them about the urgent maternal health warning signs, so they have them. It's not just something that the staff observes, but they themselves know and understand that they know their body and that when something isn't right, that they should seek urgent health care. Share resources with pregnant and postpartum people and their loved ones, so they have the tools

they need to advocate for healthy pregnancy and birth outcomes. Support pregnant and postpartum people and make sure they get the medical care that they need and deserve, understanding that Black communities experience bias care where they're not believed or taken seriously. Next slide.

Now, as Brittany described, when we're talking about adverse maternal or adverse maternal pregnancy-related outcomes, we're talking about up to a year after birth. Ensuring that pregnant people have ongoing health care before, during, and after pregnancy. Because not receiving pregnancy-related care until late in pregnancy, or receiving racially biased care, or not receiving any kind of care can increase the risk of pregnancy complications. Now, this is a sensitive one and will be one of the more complex forms of intervention to navigate, but collaborating with your program's mental health consultant to address concerns and make appropriate referrals if a birthing parent expresses thoughts of self-harm or harming their baby. This might be one that you want to have a conversation with your program's mental health consultant before you see the ways that you can implement some of these interventions in your program because if this does come up, so that you have the tools and the support you need to navigate this. Pay attention if a pregnant or postpartum person tells you they're experiencing bias care. Next slide.

Biased care, what does that look like? On the fact sheet, here are some things that you can look out for that are red flag of the pregnant people might be experiencing biased health care. Things things like stigmatizing language, dismissing concerns, delaying treatment, required labs not ordered or delayed, inadequate prenatal and postpartum care coordination. Next slide.

Now, there's a power dynamic where if a family walks into a health care facility they might not have … They may not feel empowered to ask for the health care that they need and deserve. Part of the fact sheet is a conversation guide. It is something that you can share with your families that they can take with them when they go and seek health care, so that they can ask the questions to navigate the situation, so that they can get the health care that they need. It's questions like, “What could these symptoms mean? I need to speak to someone now. Can someone call me today? Is there tests that can rule out a serious problem? Should I go to an emergency room?” Next slide.

If a person tells you that they still don't feel heard or reports that they've had a negative interaction with a health care provider or practice, you can help them find more responsive care. Part of the fact sheet is a conversation guide. Some questions you might ask as you seek to help pregnant and postpartum people look for alternate care. Things like, “What languages do the stuff speak? Is their office accessible by public transportation? Do they take the family member's insurance? Does their practice include doulas or midwives for pregnant people? Next slide.

As a team in your program, here are some systemic ways that you can work together to shape the experiences of the pregnant people in your program. You can ensure that people of color are included in the shaping and delivery of services to pregnant and postpartum families. You can engage perinatal health workers … That's midwives, doulas, nurses, on your health services

advisory committee. You can partner with local health care providers on messaging and outreach to strengthen referral networks. You can review feedback from families and find out what's working well and identify opportunities to strengthen linkages and partnerships. You can save a life by helping birthing parents find health care providers who will listen to their concerns and provide the medical care that they need. With that, I'll pass it back to Brittany to share with us an incredibly important resource from the CDC, the Hear Her campaign. Thank you.

Brittany : Thank you so much, Khadija. That's so powerful and a lot of what I'm going to talk about just dovetails very nicely with all of those resources Khadija just mentioned. CDC is involved in a number of activities to reduce maternal mortality and eliminate racial disparities, but today, I really want to talk about this communication campaign titled, Hear Her. We launched it in August 2020 and it really speaks to the call to action to really hear pregnant and postpartum people's concerns and take appropriate action. Next slide.

You can visit the Hear Her website at cdc.gov/hearher. It is available in English and Spanish. On this page, you can find information about pregnancy-related deaths in the US, more information about those urgent maternal warning signs we referred to, and then we have specific pages for pregnant and postpartum people, their support systems – friends, family, partners – and a variety of health care professionals. Next slide.

The campaign really seeks to reduce pregnancy-related deaths in a few key ways. One, increasing … You can go back to the previous slide if you don't mind. Increasing awareness of those urgent maternal warning signs. Two, empowering pregnant and postpartum people to speak up when they have health concerns, but equally important, we need to make sure people are hearing them when they do speak up. Encouraging the support system – friends, families, partners, grandparents, aunts, uncles, everybody – to engage in those conversations with her. Support them in getting medical care when they share concerns, and really advocate for their care when in the hospital setting or any medical care setting. Then fourth, improving the communication between health care professionals and those pregnant and postpartum people. Next slide.

Again, when we're talking about the audience, of course, pregnant and postpartum people are key. All the people who surround them, including doulas, midwives, all the important staff that might interact with those people. Then, when we talk about health care professionals, we're really talking about a variety of professionals. Obstetric providers, certainly, but also emergency medicine providers – nurse, midwives, family physicians, primary care, pediatricians. Really anyone who could potentially see a pregnant and postpartum person. Next slide.

Here are some of the guiding principles and messages that we really emphasize throughout the campaign. We all know pregnant and postpartum people, they know their bodies and they can often tell when something is not right. We know listening and taking the concerns of these people seriously is simple, yet powerful. It really can make a difference in preventing pregnancy-related deaths. We know that getting timely treatment and quality care can prevent many of these deaths. We know that partners, family, and friends, they're all-important

advocates to make sure any health concern is appropriately addressed by a provider. Really, the message is that everyone … We all have a role to play in supporting pregnant and postpartum people and making a difference in their health. Next slide.

Here's just kind of a high-level overview of some of the materials we have available on our website. Of course, we have the website in English and Spanish, and some microsites that can actually be syndicated on partner websites. We have several testimonial videos, similar to what you just saw with Serena Williams.

One of our videos includes that of Allyson Felix, who is an Olympic track and field star and their story with a very serious pregnancy-related complication. We have several printable resources that we would encourage you to check out, including conversation guides, similar to what Khadija was talking about with questions on how to kind of talk to your health care professional and just kind of get the conversation started. We have palm cards, short versions of that as well for pregnant and postpartum people, but also a conversation guide for the support system to kind of help understand how to best talk to your loved one.

We have that urgent maternal warning sign poster and also a variety of digital graphics that we use through paid media ads that are also available to download and put on your website. We also have the Hear Her Facebook page that builds a sense of community online and really drives some social media and conversation around this topic. We also have PSAs for broadcast and radio in both English and Spanish. Next slide.

I just wanted to mention we have some of those materials in 21 different languages shown on the screen. I would really encourage if you serve populations that speak one of these languages to check them out, download them. Some of these are also available to order through our CDC info on demand program as well. Next slide.

I want to share a few ideas for how you might be able to use some of this messaging or materials, certainly just including the messages around urgent maternal warning signs. The importance of supporting pregnant and postpartum people throughout your program. Making it a core value from the top down, and sharing these messages and resources through newsletters, or listservs, meetings, presentations, other communication channels. You could certainly directly distribute any of these posters or conversation guides or palm cards to pregnant postpartum people, their friends, family, and support systems, doulas, anyone who supports them. Next slide.

We also invite everyone to connect to the campaign through social media where appropriate, especially that CDC Hear Her Facebook page and the CDC Division of Reproductive Health Twitter account. We do have a social media kit with messages and images that you can download. You can also create your own and tag us and post to engage. We really want these to be helpful for the communities you serve. We do welcome ideas and feedback on what would be helpful moving forward. Please feel free to reach out and let us know what you would like to see moving forward. Hopefully, there's some additional ideas that might be coming to your mind to be implementing and using some of these resources. Next slide.

Lastly, I do just want to share that we do have some ongoing work to develop a segment of the Hear Her campaign specifically to reach American Indian and Alaskan Native communities and people. We have conducted focus groups, received input from tribal leaders and others in the community, and we're right now in the process of recruiting people to feature in these materials, and are hoping to launch this later this summer. Keep your eyes out for that. Next slide.

I think I will turn it back to Khadija. Thanks so much.

Khadija: Thank you. I just want to turn to the chat because there's some powerful testimony happening in the chat. I want to start off with Miriam who shared, “We as Black women I expected to be strong. We must advocate that we do not always have to be strong and it's OK to not be OK.” Tricia shares, “We need to teach and learn to avoid shame. Many of us avoid help and do not advocate for ourselves because of shame.” Colleen shares, “During my first labor, my doctor made a statement that if I didn't progress soon she would administer a c-section because she had to pick up her daughter. This was 24 years ago. I was 20. It was my first pregnancy and I wasn't even dilated that much.”

Valerie's story, to be personal, resonates deeply with me because I similarly haven't … I think it took me a while to recover from my own birthing experience. Valerie shares, I'm still recovering from my youngest child's delivery. My issues were not addressed and I went into labor at 29 weeks due to this. I later found out that the OB misrepresented my concerns to her peers. I was mortified.

There's Kerry. Kerry Williams shares, lifts up an important point that doulas can help birthing parents to be heard. That's why I got certification. That is a very important resource that we've discussed. Very briefly, that doulas are available to advocate on the behalf of birthing people. There's a story here that … I'm sorry, Christy. Christy Garcia shares, in Spanish and I have very rudimentary Spanish. But she shares here that this also happens to Latinas. It absolutely does.

Something that I want to lift up is that maternal health outcomes in Puerto Rico are very different to the maternal health outcomes of Latinas on the mainland, so there is a lot of complicated interactions between race and socioeconomic status that all contribute to adverse maternal health outcomes. Language barrier difficulties to pregnant women – that's absolutely true. Rose asks, how can somebody become a doula. I believe there's some resources in the chat. Thank you very much, everybody, for sharing with us.

This is an incredibly important conversation. As I'm reading this chat, what is resonating with me and even from my own birthing experience that it's an incredibly vulnerable time giving birth. It's very difficult to advocate for yourself when you're going through something so transformative, which is why you as Head Start staff, can be such an important health equity intervention. By helping birthing parents find health care providers who will listen to their concerns, for example, speak … make sure that they have the language capacity to hear the birthing people.

The information and resources that Brittany and I shared today are intended to raise awareness and provide Head Start staff with tools to support and empower all of the families they work with. To guide staff on how to be responsive to those at greatest risk, specifically Black and American Indian and Alaskan Native pregnant and postpartum people. On that note, I would like to also share that the fact sheet that you have right now is very centered on Black women, Black pregnant people, but we're also developing a fact sheet on the experiences of American Indian and Alaskan Native pregnant and postpartum people. That will be available soon.

To close things out, some of the messages that I would like to leave you with is that you can support the health and well-being of pregnant and postpartum people by sharing this information with all the staff at in-service and pre-service trainings, sharing this information with policy counsel and health services advisory committee members, sharing copies of CDC's Hear Her campaign resources with the families at meetings and home visits. Steve has been sharing in the chat that these resources are available on the center website. Thank you.

Nancy: I see that we're at the point where we can take some questions. If you haven't already ... This is Nancy. Please put your questions in the chat. There is a question about whether doulas are covered by insurance and … Do you want to take that? I was just going to say it depends on where you live, but go ahead, Khadija. I'd love for you to answer that. Thank you.

Khadija: Yeah, that's a great question and the answer is not always, as Nancy indicated. There's a lot of movement on policy to make sure that to try to have doula services covered by Medicaid, but that's not a reality in most states right now. But then there's also programs throughout the United States that make doula services more accessible. The best way to find out if there are resources in your state is by searching doula services in your state and connecting with those doula services and exploring with them different resources to make the services more accessible.

Nancy: Thank you very much, Khadija. Brittany, I don't know if you have any information related to studies around changes in prenatal care and outcomes during the pandemic. Is that something that CDC has looked at this point?

Brittany: No, I'm not sure. I could look into that. I know there are a lot of ongoing studies being done through the COVID response looking at pregnancy and infant outcomes. I know there are a lot of articles come through the CDC's website, specifically the COVID website, but I am not sure on that answer right now, but I know it's going to be something they continue to look at.

Nancy: Thank you for that, Brittany. When we send out the information … I think I saw one study, but I can't even remember where. Certainly, I've had the same experience. I haven't seen a lot of information either. If we do find anything we can certainly post it in my peers later on in the health, safety, and wellness community. If there is anything, if Brittany and Khadija and I put our heads together and see anything, when we send out the links we can include that. But I think there hasn't been very much so far.

There's a question that I'm going to answer about whether we're going to be updating our forms to include inclusive language, such as pregnancy – pregnant people and birthing parents. If you're talking about your forms, Alexis, that's something that you would do at the recipient or program level. You'll see gradually that we are shifting to this language. Really because we think it is more inclusive justice Khadija said, but we're not going to go back and sort of change things that were written earlier with different language. But moving forward, we're moving to pregnant people. It's the language that CDC uses right, Brittany, and it's also the language that healthy people 2030 is really using. Within the public health community, you're seeing a shift to this more inclusive language. You'll see as we develop resources for the Head Start community, we will be using this language moving forward. But it's not a cancel culture. We're not going to go back and change other language. We just know that we want to be more inclusive when we think about the families that we're serving in the birthing parents and their kids.

There is a question that I'm also going to just say that I'm not going to respond to … around the recent IM documenting services to enroll pregnant women. Again, the Head Start program performance standards uses the term pregnant women. If you do have questions about the IM, then I encourage you to either chat in my peers. If you're not a member of my peers and you are wanting to figure out how to do that, write to us at our info line, and we can tell you. If you have specific questions that would be a good question, perhaps, to direct to your program specialist.

Here's a great one around the needs in rural areas, which are so much more challenging because of the … Talk about accessibility issues. There's a question about "how are the needs of pregnant people in rural areas being addressed?" Jennifer is speaking specifically about rural West Tennessee where there are counties without any medical providers at all. I don't know if anyone has an answer to that, but I don't know if you have any thoughts, Khadija or Brittany, about what to do around really rural and particularly under-resourced areas?

It's OK to say we have no answers for these bigger societal problems, but …

Khadija: Yeah. Brittany, please go ahead.

Brittany: Well, just from Hear Her campaign perspective. I mean, certainly that's a critical issue. I mean, I think from a communication campaign perspective we are always looking to figure out ways to disseminate that information to reach all types of people. It's been largely a digital campaign, but there's efforts to do more out of home advertising and can get the messaging to the people who need it. But we recognize it's a complex issue and there are things at many levels that need to be addressed to reach rural populations.

I know doing our work with the American Indian and Alaskan Native segment, that's a key consideration how to reach these people. It's something that we're talking about ongoing.

Nancy: Thank you, Brittany. I have a couple more for you. Luisa is interested in knowing is there inclusive representation of pregnant people in the CDC Hear Her campaign, wondering if there is an expanded gender option?

Brittany: Yeah, that's a good question. So far, in the testimonial videos we've captured, there's only been about six people that we've had that kind of extended form conversation and several Black women, couple of white women. We do hope this campaign is going to be ongoing for several years. We hope to diversify that representation more with the stories that we're receiving. No, we don't currently have kind of that type of representation, but I think that's something we're certainly open to moving forward. Thanks for bringing that up.

Nancy: Thank you. I have another one for you. Kat is interested in knowing, Brittany, what are the most common health concerns, and the reason for mortality after eight to 12 months postpartum post-delivery? Mental health and cardio and embolism would be the most frequent. Are there any other reasons that are common during this later stage post-delivery?

Brittany: Yeah. That's a good question. I'm not sure I have the answer to that. I know that when we look at our maternal mortality review committee data, it's really looking only until that year after pregnancy. After a year I'm not exactly sure, but I could check into that later stage post-delivery period. I know that we see mental health conditions and cardiomyopathy, which is that weakening of the heart muscle, in the postpartum period. We also see some hypertensive disorder issues, hypertensive disorders of pregnancy. Those are some common leading causes that I could get back with you specifically about the late stage post-delivery, that 8 to 12 months.

Nancy: That would be great. Then as a follow up question. One more for you Brittany. Because you do have materials that are fabulous for both pregnant people and postpartum people, and their friends, family, and loved ones, and for the provider community. Here is a specific question around “how is CDC sharing this material with OBGYNs and other health care providers?”

Brittany: Yeah. Great question, which we didn't get a chance to talk a ton about the health care provider resources. But we just launched a few weeks ago some specific information for obstetric providers, pediatricians, and then other professionals such as emergency department, mental health providers – anyone who serves these patients. We're working closely with national associations and organizations partners to kind of disseminate information that way. We're going to be continuing really that partnership piece to get the materials out to those organizations that need to see it.

I know Khadija had maybe a couple of things to say from maybe a previous question. I want to give her an opportunity to.

Khadija: Thank you so much, Brittany. One of the things … The thing that I wanted to share is that from the work that I have done previously in policy around maternal health … One of the things that we've worked really hard to promote is to extend Medicaid coverage for pregnant people up to a year. Up to 12 months postpartum. The reason being is that once the continuity … Having a regular health care provider and going to that health care provider, it improves your maternal health outcomes.

It's true before, like if you think about it when you're pregnant or the visits that you go on, it's equally as important to go on those visits after you give birth because a health care provider does screenings where they watch out for different warning signs. One of the interventions that is being worked on is extending coverage for pregnant people for up to 12 months, so that they can continue to go to providers. What does that mean for Head Start staff?

It could be that keeping tabs or at least keeping communication with people who've given birth and making sure that they continue to attend, continue to go to health care provider up to 12 months after having their baby.

Jennifer shares in the chat that, "I needed care well after a year after my last birth to correct a health issue that resulted from delivery." The having access to health coverage is a critical intervention, is a way to address some of these maternal health adverse outcomes.

Nancy: Thank you, Khadija. There was a question also that came in earlier about the fact that, if you don't have health care coverage after your postpartum follow up visit, a lot of the folks who might need care don't want to go to the emergency room. There's really … They're in a bind and even if Head Start is the payer of last resort, it's really hard if you don't have a relationship with an ongoing provider. Because health insurance is a barrier, so that certainly is a challenge.

Khadija: That is changing, Nancy. I did want to share that is something that's changing. More and more states are providing or ensuring that health coverage extends to those 12 months. That is something that's been actively been worked upon. Another thing that I was … around the question around access to care in rural areas. I'm in Connecticut, and part of the state government in Connecticut is having … They have advisory committees where you can go for health care advisory committees where you can go and you can speak to government officials about the kind of experience, health care problems that you're experiencing, or you're seeing to give them feedback in extended care to areas that you see vulnerabilities or opportunities. I know that, that is a more complicated intervention. Not something that most people can do, but I just wanted to offer that up that in every state there would be health services committees where they do seek input from the public.

Nancy: Thank you. That's great information and encouraging that things are trending in the right direction. Marco, I just want to be sure that everyone saw on … Marco Beltran, who is with the Office of Head Start, the health lead and our project officer for our center, said that the Office of Head Start is planning a webinar that will address the IM soon. It's being planned, so stay tuned if you had that question, and that would be something to look forward to. There were a number of questions regarding mental health services because one of the warning signs is feelings of self-harm or harming the baby is another concern, which is why we always advocate to do screening, to check in around maternal depression. You said you had some resources that were addressing mental health providers. Is that right, Brittany?

Brittany: We do have some resources online. I was actually just pulling it up. I know for pediatric staff who see postpartum people, some postpartum people who are going in for infant well checks, AAP recommends routine screening for postpartum depression during those

well child visits at one, two, four, and six months of age. We have some language specifically for pediatric staff around looking for the warning signs and asking mom how she's doing and encouraging her to get care when needed, whether that's additional support services, connecting to emergency care, if needed, or another medical professional or support service related to mental health professionals.

We don't have specific language for that, but I think it is really important to acknowledge that mental health is such a critical thing to be considering during the prenatal, but especially I think the postpartum period. That mental health is something that we need to be paying attention to in these new moms, to ask those questions around well-being, and to really just provide support and connection to care, depending on what that might be, whether that's emergency care needed, another type of social service support, or so forth. But I think for those people to really understand that pregnancy-related deaths can happen in that year after pregnancy. One of the warning signs really is thoughts of harm. Something to be on the lookout for and trying to seek additional resources for those people.

Nancy: Thank you, Brittany. Nicole, you had a question about … You have feedback for our mental health consultant who works with several Head Start sites and how to best use this information to support the sites and families. The first thing that I would say is to share the information, and to have a conversation with folks about are they screening routinely? Do they have a tool in place? There in the chat, the Edinburgh was a tool that a lot of programs are using. A lot of folks also use a tool called the PHQ9, which is a fairly easy tool to use.

I think what's most important is that people are comfortable having the conversations and know how to start a conversation. Know if they are feeling concerned or a pregnant person or a postpartum person is feeling concerned, that they know that they can talk to the infant and early childhood mental health consultant in the program and that there's a protocol in place. I'm also … As Nydia closes out, our center is offering I think a wonderful series through July of office hours for mental health consultants. Anybody can come and it meets once a month. You can bring all of your questions, and so I think that would be a great question to bring to Amy Hunter and Khadija Johnson, who are running the series. I will look and put the link to register in the chat for everyone while Nydia closes out.

Khadija: Nancy?

Nancy: Yes?

Khadija: I'm sorry. I just wanted to point to I think the resource that Steve has been sharing in the chat that it's an excellent resource, part of the Center's work, and it speaks to action steps to address maternal depression and Head Start programs. It's definitely an incredible resource there, and that I just wanted to point to that.

Nancy: Thank you, because I was actually going to, before I turn it over to Nydia, see if you had other comments, Khadija, that you wanted to add or if you did as well, Brittany? Anything else you want to share? It's been a great conversation.

Khadija: Yeah. I think the takeaway is something that I said earlier on that this is a health equity intervention that the conversation starts here. You are a part of it. We're a part of this. I feel very fortunate to be part of this body of work and there's more coming. This is the start of a conversation, not the end of one. Everything that you've shared with us today is great feedback, we can think a little bit more about the work that we're doing and the kind of services and resources that you need. I want to thank you all again for being in community, but also being an active and proactive health equity intervention.

Nancy: Thank you so much. Brittany, any last comments from you?

Brittany: I just really appreciate the opportunity. Thank you all so much for your time today.

Nancy: Thank you so much. All right. Then I'm going to turn it back over to you, Nydia.

Ndyia: Thank you. Thank you so much to our speakers, Khadija. Thank you to Brittany and to Nancy. Thank you for all this important information. If you have more questions, you can go to my peers or write to health@ecetta.info. The evaluation, you are well remembered that it will appear when the webinar ends. Do not close the Zoom platform or you won't see the evaluation pop up. Remember, that after submitting the evaluation you will see a new URL and this link will allow you to access, download, save, and print your certificates.

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