The Role of Title X and TPP in Maternal Morbidity and Mortality Prevention: Retrofit, Reform or Reimagine
May 10, 2021
Transcript

Slide 1

Jennifer Kawatu: Okay. I think we're going to get started. Hello everyone, this is Jennifer Kawatu from the Title X Reproductive Health National Training Center. I'd like to welcome you all to today's webinar, The Role of Title X and TPP in Maternal Morbidity and Mortality Prevention: Retrofit, Reform or Reimagine. So just a few quick housekeeping items before we begin, everyone on the webinar today is muted, but we'll have time for question and answers. So you can ask questions at any point during the webinar, you can use the chat at any point, and we'll answer those at the end. The recording and the slides for today's webinar will be available on rhntc.org, within just a few days after today's webinar. This presentation was supported by the Office of Population Affairs and the Office on Women's Health. Its contents are solely the responsibility of the authors and do not necessarily represent the official views of OPA, OWH or HHS.

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Jennifer Kawatu: But before we get started today, we are excited to have our project officer with us from the Office on Women's Health. So I'd like to introduce Keiva Nelson from the Office on Women's Health to get us started. Keiva.

Keiva Nelson: Hello. Thank you, Jennifer. Again, my name is Keiva Nelson. I'm a lead public health advisor with the HHS, Office on Women's Health. The Office on Women's Health

provides national leadership and coordination to improve the health of women and girls through policy, education and innovative programs. We'd like to thank you for attending today's webinar. As OWH celebrates its 30th year, we'd like to welcome you to join us as we celebrate our office's most exciting annual observances, National Women's Health Week, May 9th through 15th, which serves as a reminder to women and girls of the importance of making their health a priority, and to take care of themselves, especially during the COVID-19 outbreak. The theme for this year's National Women's Health Week is ending the pandemic and elevating women's health. It is extremely important for all women and girls, especially those with underlying health conditions such as hypertension, diabetes, obesity, cardiovascular and respiratory conditions, and older adults to take care of their health. To learn more, visit us at www.womenshealth.gov. Thank you.

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Jennifer Kawatu: Thank you so much Keiva. Now we're excited to have as our speaker today, Dr. Monica McLemore. Dr. McLemore is a tenured associate professor in the Family Health Care Nursing Department, an affiliated scientist with Advancing New Standards in Reproductive Health, a member of the Bixby Center for Global Reproductive Health, a board member for Black Mamas Matter, and a well known and nationally recognized advocate for reproductive justice. With that, I will turn it over with great excitement to Dr. McLemore.

Dr. Monica McLemore: Thank you so much, Jennifer. I appreciate the invitation. I appreciate being here. Keiva, it is so good, thank you so much for not only the sponsorship, but I can't believe it's 30 years for the Office on Women's Health. It's 50 years for Title X. Oh my goodness, I'm going to talk so much about this. We're coming off of Mother's Day in addition to the fact that it's National Nurses Week, Florence Nightingale's birthday will be celebrated on Wednesday. So, to any and all nurses who are on this webinar, I hope you're having a good National Nurses Day and Nurses Week. I'm so excited to be with you during the week of women's health. It's just so important and so exciting to be here. We also got exciting news this morning that Jessica Marcella is now being named as the Deputy Assistant Secretary for Population Affairs. I look very forward to supporting her work and the transformative opportunity that we have to just rebuild so many incredibly important things. Before I begin, I want to tell everyone that you have my affirmative consent to screenshot, to tweet, to really share this work. I think one of the things that we don't do well is disseminate our work in ways that I think are digestible to the public. So you have my affirmative consent to do those things.

I also want to thank everyone who has been doing the hard work of reproductive health services provision, of family planning services, of birth services during this pandemic. As a nurse, as a public health person, thank you, it has been a very, very hard and difficult time, and it would be really, really inappropriate for me not to mention that. We think of our friends and our colleagues in India, we think of our friends and our colleagues around the world who are still wrestling with the implications of the COVID-19 pandemic.

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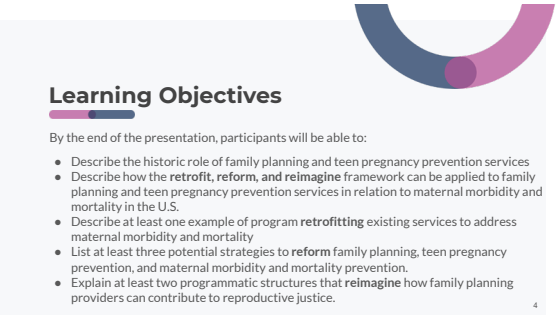

So with that, I have a lot I want to talk to you about, oh, my goodness, there's so many opportunities for us to really think about the important work that we do every day. I want to be very clear in how I start this talk. It is not about stigma, shame, judgment or blame. We are evolving and growing into a network, and I really think understanding retrofit, reform, reimagine, will be very helpful to you as you think about your place in the continuum of all the important work that we have to do across the life course, and how we can do that together.

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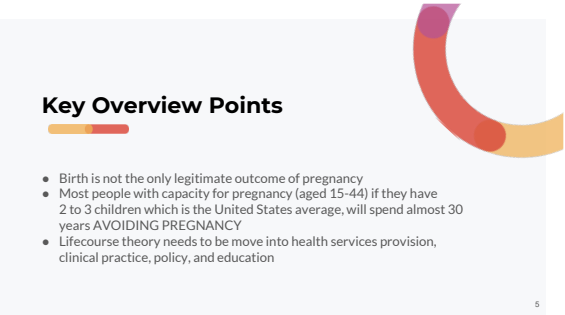

Couple of things I should ... I probably don't have to say this to this audience, but let's remember pregnancy or capacity for pregnancy, is what we really study. Birth isn't the only legitimate option. We think about contraception, we think about surrogacy, we think about infertility, we think about abortion, we think about all these other outcomes. But let's remember that reproductive capacity is really, really the thing that we're trying to reimagine, retrofit and reform. Right? Trying to really think about that in a bigger way.

Also, this probably won't be news to anyone on this webinar, but most people, if you have capacity for pregnancy, you are probably going to spend more years of your life avoiding pregnancy than actually being pregnant. We just saw data that came out of the CDC, showing

that this was the lowest birth rates that we've had in decades. Right? If everyone has their two to three children, and you have almost 30 years of fertility, you're probably going to spend more time in your life avoiding pregnancy than actually being pregnant, and that's why your programmatic view is so important. Right? But it should be a cluster of things in terms of how we think about pregnant capable people.

I'm going to talk about a lot about life course. Right? We know that the reproductive decisions capacities and actualities, they have intergenerational impacts. Right? So, I don't understand why we don't think about clinical health services provision and policy and education and how we think about the workforce, like why we don't use a life course perspective.

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With that, let's dive right in. Right? It is really important for us to understand the historical role of family planning services and Teen Pregnancy Prevention Programs. I will put out a very personal caveat. I spend a lot of time with teen moms, both as collaborators, as colleagues, as co researchers. I have a deep amount of respect for teen parents. Right? I have members who have defended master's theses, I have people who have gone on to become midwives, I have a person who became a faculty member with us after being a postdoc. So, my take home message is that if we create the necessary investments that people need to be successful, then actually we can reframe how we think about all of our work.

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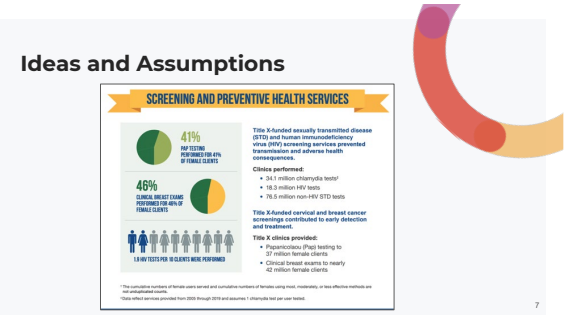

That said, if you haven't seen these beautiful infographics from the Department of Health and Human Services, and OPA in particular, to really show like, there has been a lot of work this network has done in the last 50 years. When you think about access for poor people, for just general basic reproductive health services, we've done really, really well. When you think about

sexually transmitted infection screening, when you think about breast cancer, and early detection and treatment for cervical cancer, we've done some good work. It's hard to feel the work that we do is constantly under scrutiny, or discussed in context of abortion only, when the truth of the matter is we've done some really important, I think, essential public health work that has been invisible to a lot of people. So this is where the retrofit, reform piece comes forward. That's why infographics like this are so helpful, and so necessary, it helps to educate the public about the work that we've been doing.

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We've had a lot of successes, we've had a lot of very interesting ways to think about providing contraceptive services to people with capacity for pregnancy. Everything across the FDA-approved methods to really teaching people how to use fertility-based awareness methods and thinking about condoms and pills and patch and ring, all of the different devices. Right? These are things that have been successful. And knowing that we've been providing these essential services, especially to low-income individuals and communities, since 1970 is something really to be celebrated. I think the more that we can utilize beautiful, simple translative data visualizations like these, it will help people to understand that behind-the-scenes work that we've all been doing.

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So, after we've thought so much about contraception and family planning and teen pregnancy prevention, let's think about the theoretical frameworks that underpin that, because there's been so much revelation we've all had once in a lifetime pandemic. Right?

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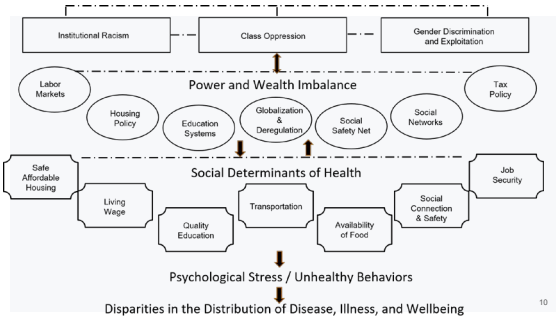

For those of us who are clinicians, we've been through HIV and zika, and H1N1, MERS and SARS and ebola, and we can keep going. Right? We've been through these. But for the public, let's remember, for a lot of folks, this has been a once in a lifetime pandemic that has personally and professionally affected them. So when we talk about revamping, reimagining, rethinking, reforming, or even retrofitting, what we're currently doing, let's tell the truth. The social determinants of health, generally are neutral. A lot of people think about them as negative things because we've seen what happens when the social determinants of health are not addressed. But in my opinion, many of them are actually quite neutral, and if you don't think about power, wealth and balance, and if you don't think about the drivers of social determinants, then in my view, you're having an incomplete conversation. The social determinants of health are not born out of thin air, they actually come from policy decisions. Right? We make a decision to invest in health services, we make a decision to divest from the social safety net, we make decisions to be able to make sure that people have a living wage, we make decisions that folks should be paid to stay home during pandemic. These are all decisions and the policy decisions that have huge influence over how social determinants of health manifest. This is a slide, I really love it. It comes from my good friend Dr. Joia Crear-Perry from an incredible book, really looking at the social determinants of health. We have to start being really real, around the discussions that we're having when we start to talk about individually experienced health conditions, because they don't just come out of thin air.

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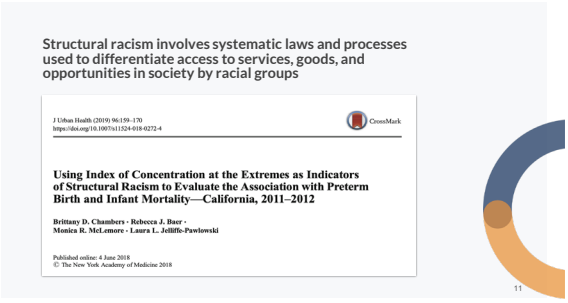

When I use the language of structural racism, and I mostly talk about structural racism, if you want a great background on this, you want to go to whatever video displaying services you use, and you want to write in Dr. Camara Jones, who used to run the American Public Health

Association, is lucky enough to be the chair of Sexual and Reproductive Health of APHA, she talks about the gardener's tale, and she talks about levels of racism. Right? There's intermediary and individually mediated, and then there's institutional. I talk about structural racism, and this comes from a paper that Dr. Brittany Chambers who's that team mama I talked about, who finished her Ph.D. before 30. This is the definition that we use, that "Structural racism involves systemic laws and processes and policies and procedures to differentiate access to goods and services and opportunities in society by racial groups." Right? It's a very, in my opinion, parsimonious or very elegant way of stating that we organize our society to benefit some people, and not to benefit all. And I would like to make the argument that as we retrofit, reform and reimagine, that we have an opportunity to do all of those things.

Resource:

[Allegories on race and racism | Camara Jones | TEDxEmory – YouTube](https://youtu.be/GNhcY6fTyBM)
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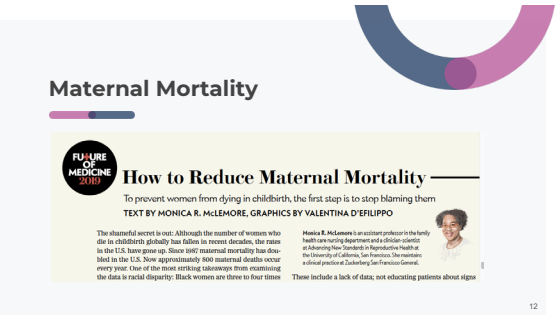

For those of you who haven't been paying attention, we have a Black maternal health crisis in the United States, we have a maternal health crisis, period. But maternal morbidity and mortality has been on the rise in the United States. That's people dying from pregnancy-related, pregnancy-associated conditions. I got asked to write this by the editors at Scientific American, which is the oldest nationally published periodical, and it was a real honor to be able to do a data visualization project again, getting at these infographics and pictures that you can use to explain things to the public. It was very important that I really lay out. This is not an impossible thing that we can do nothing about.

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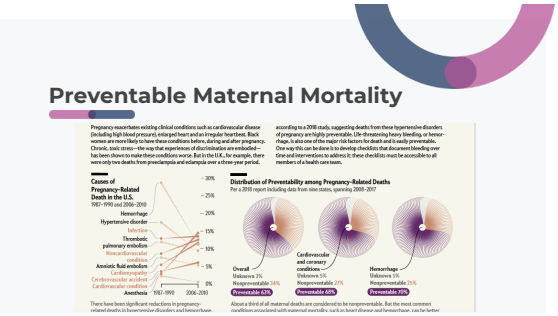

I fought for this panel, and this is where our work comes in. Right? If you believe nothing I say, if you don't pick up any of the learning objectives, hear me on this. We estimate that between 60 and 70% of maternal deaths are preventable. Right? That means we can do something about it. That means if we are brave enough and courageous enough, that we will think through new and uncanny partnerships, and new and uncanny ways to think about where we fall in the prevention spectrum. You can see this data visualization for free if you go to Black Mamas Matter Alliance website, you go under resources, you click literature, the legacy link for the data visualization project, which is free, and open source lives on the Black Mamas Matter Alliance website. I did that on purpose, because in order for people to be able to see it, I wanted you to have to go through Black women in order to understand what the path is to turning this around.

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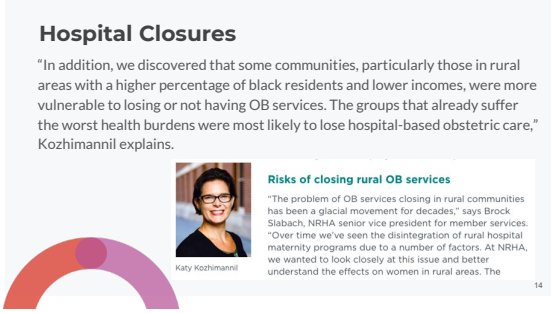

For those of you who are not familiar with health services researchers or the incredible team at University of Minnesota, this is Katy Kozhimannil. She is a vanguard researcher in health services research, and she's done a lot of work looking at doulas and workforce and Medicaid and maternal health. One of the things that she pointed out, and I want all of the Title X providers to hear me clearly on this, that obstetric hospital closures just don't result in the loss of that obstetric expertise, because most of those units, like many OB units, have specific OB triage. One of the reasons why I recorded a webinar with Dr. Lisa Wolf, who's a colleague of mine, and she is the nurse researcher who leads the Emergency Nurses Association, because I asked her one day, I said, "Lisa, with all these obstetrical hospital closures going on around the country, where does that OB triage expertise go?" She said, "Wherever those nurses go." She said, "But I can tell you one thing, it's not going in the emergency departments." So we need to

be doing some updating of the education of emergency room nurses to be able to recognize the signs and symptoms of deterioration because when we lose an OB triage unit, we've lost that obstetrical nurse expertise. So that's why we did a freely available webinar looking at the triage of pregnant capable people in emergency departments. Because hospital closures and obstetric closures are not isolated events,. They impact the rest of the hospital and the health care institution.

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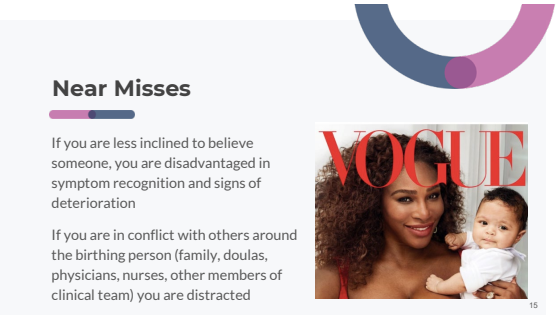

Again, near misses—I showed you the preventable maternal deaths. I didn't talk about what we estimate to be nearly 50,000 near misses. Serena Williams was just one of them, who told her story, not only in Vogue, but wrote a first person op-ed in CNN, about the importance of team. If there is anything I know Title X grantees do really, really well, along with abortion care providers is team-based care. We know how to be in community with each other, and how to make a day work. This is something we have to teach the rest of health care. I have said this for years, and people looked at me like I'm crazy. But if your care team is in conflict, then you're distracted, and you're less likely to recognize signs and symptoms of deterioration, because you are all fighting, we fight amongst each other, but we don't have our eye on the person who we should have our eye on, and that's either the birthing person or the person who is seeking care in front of us. You'll see later on why I will talk about doulas as a potential intervention to assist us in helping to bridge some of these gaps.

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Please, please, please, please, please check your own institutional websites for disinformation and misinformation. This came about when Beyoncé said, nine months after Serena Williams told her story to Vogue, she told her birthing story in Vogue and she talked about toxemia in pregnancy. The Google searches went through the roof when that happened because a lot of

people missed that she was talking about preeclampsia, and there were so many university and well-trusted websites that had dated and old information on their websites. This lists Mayo Clinic and Harvard. Even my own institution had dated information. So if your home websites are going to be a landing general information page, but you're going to drive people to your social media for more up-to-date or more accurate, rapidly changing site, you need to tell people that. Right? I was stunned by the number of people who had inaccurate information, the most important one being that preeclampsia resolved after the birth of the fetus. Right? You can have preeclampsia in postpartum period. So, this whole notion that because information is moving so fast and we can't keep it updated, we should be communicating, and again, this is where infographics are really important and can be, put skeleton bare bones on your website but then drive people to some place where your information is more rapidly being updated.

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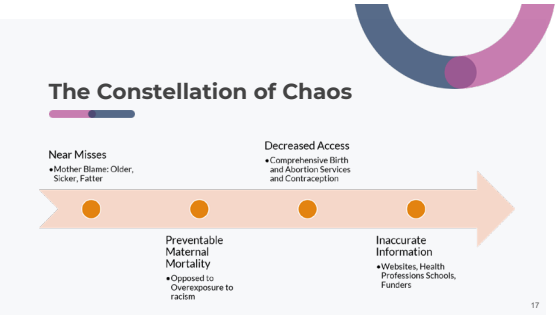

Let's talk about what I call the constellation of chaos, because that's where we're at right now. That's what happens when scientific, in my opinion, revolutions happen. You're in a situation where you have all these factors that are competing with each other. You've got inaccurate information, you've got decreased access, you've got preventable conditions, but it requires everybody's senses to be working.

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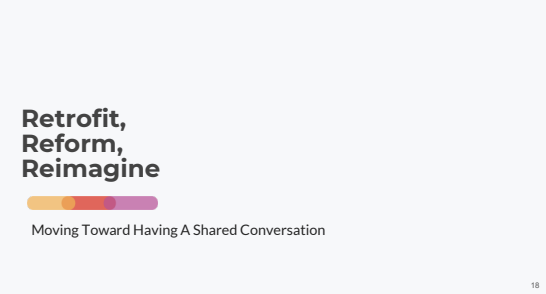

Then you have near misses, and what you end up with is not all having the same discussion about how to fix it. So, I want to introduce you to something I've been playing around with for a while, I'm currently writing this up, because I think it might be helpful to get everybody all on the same page, so that we can all be having the same discussion around interventions, around touchpoints for partnership, around what we should be investing, human, money and time resources. So that way, everybody's not all doing the same thing, and nothing's getting done.

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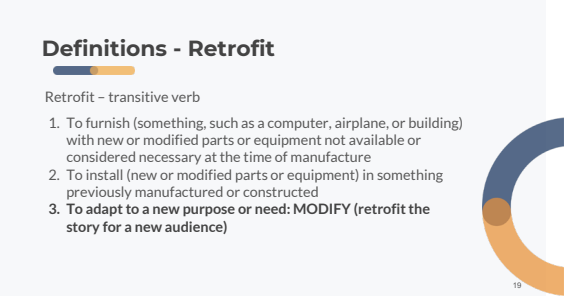

So, these definitions come from Merriam-Webster, I am a new scientist by training. So I go to the source. How do you define retrofit? These are the three definitions you will find in Merriam-Webster online. I like the bottom. It says, "To adapt to a new purpose or need, or to modify." So you retrofit the story for a new audience. Now, the important thing I want to point out about retrofit is, it assumes that the inherent structure as it exists will continue to exist. You want to tweak it, make some modifications. Right? We need retrofitters, reformers, and reimaginers, but here's the rub. You can't be all three at the same time.

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Reform, again, Merriam-Webster. Right? I like the number one definition here, which is “To put or change into an improved form or condition, or you can amend or remove faults or abuses.” That means the primary structure that you start off with might stay there, but it might change. This definition also allows you to do something that a lot of times in health services we don't want to do, which is to take something off of somebody's plate. We always add stuff. But we never have real discussions about, "Okay, well, what can we take off our plate?" Right?

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Then when you think about reimagine, this is where I spend a lot of my time although recently, I've been really trying to do a lot of retrofits because I feel that that work is really important. Reimagination means you get to imagine it all over again, and you get to create something new. Right? It's a new conception of something. Here's the rub that I want reimaginers like me to sit with, and that's this. Right? We cannot abandon the people in the now for the utopia we all dream of. Right? I'm going to say that you can't abandon the people in the now for the utopia, to go build utopia we all want to exist. So for me, that's why I always get pulled back into retrofit and reform, because I know that the people in the now also need our help.

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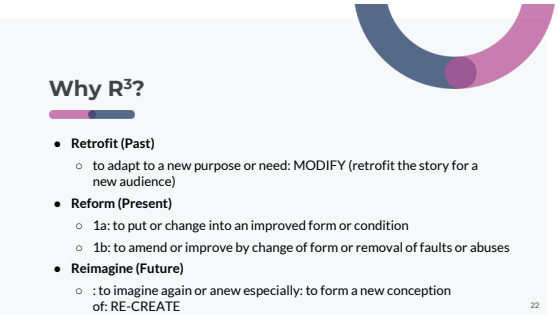

Another way to think about the three Rs is to the past, present, future. Right? It's one way to think about when we're having discussions. "Okay, Dr. McLemore, what does all of this mean? How are you thinking about this in the context of teen pregnancy prevention and family planning?"

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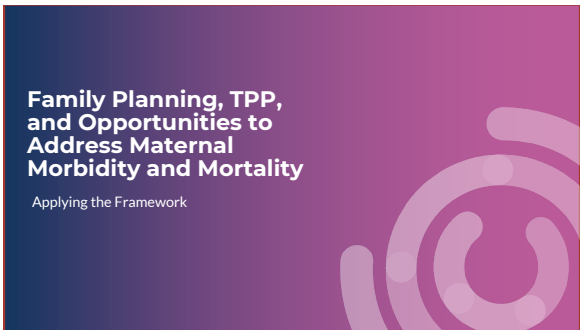

Okay, let's go there. Okay? Because I think it's really important to get concrete about this. Right?

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When we screen for social determinants of health, there's a new curriculum that Dr. Zoë Julian and collaborators put together, we published this in "The Green Journal," of how we think about community engagement when we're talking about sexual and reproductive health, and developing a curriculum. Right? One of the things that we did in this work is we went to a community advisory board, individuals who were using or utilizing our services, and we asked

them, "Where and when, if you would like for us to screen for these different determinants of health, for the purposes of either making a referral"—and we were very upfront and honest about this—"or for the purposes of receiving treatment, or for the purposes of being able to help you advocate for a better thing?" So let me give you a perfect example: transportation. Right? For a lot of people, transportation is an issue, especially public transportation, especially during a pandemic. One of the things that we always want to work with people around is, do they even want us to be screening for their transportation needs? Because for some people that becomes either racial profiling or surveillance. Right? What they want to know is if there is a taxi voucher or if there is some support for them to get to and from their visits, they don't want you to know all the different levers that they're going to pull in order to be able to get to that appointment. Right? To me, I would ask you to retrofit whatever screening you're doing for social determinants of health, to examine whether or not they have the potential to be viewed either as racial profiling or as unnecessary surveillance. Right? The best way you do that is to ask the people you're serving. This can be a simple three- to four-question either iPad survey, or fill out a card, or send them a text. There are ways to figure out how people are perceiving the screening for social determinants of health in the health care visit, because we haven't been clear, reform, in explaining why we're doing it. That's concrete example number one.

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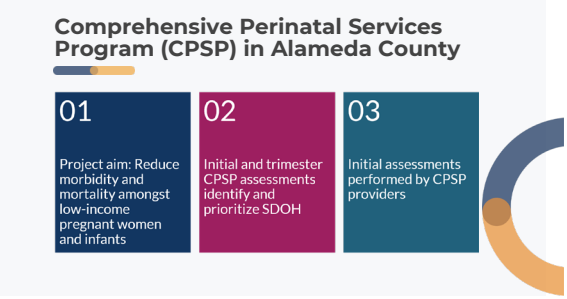

Concrete example number two comes from some work I did with a master's thesis student to really look at and evaluate...okay, we have a comprehensive perinatal services program here in Alameda County in California, where during prenatal care, social workers or community health workers will talk with pregnant people about what their social determinants of health needs are. And one of the things that we really wanted to do was we wanted to reduce maternal morbidity and mortality. We figured if we screen for these social determinants of health, that we would maybe be able to provide the resources and be able to assist them in accessing different referrals. The CPSP providers, or the Comprehensive Perinatal Services Providers, in Alameda County are community health workers, and the community health workers are community members who have been trained to be able to work with pregnant capable people to come in and assess their needs, and to be able to connect them with services that are based in the community.

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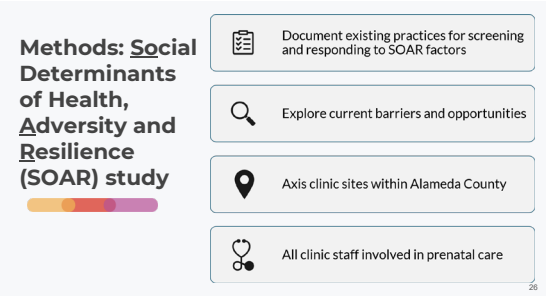

We wanted to really look at the social determinants of health, adversity, and resilience. We wanted to really document some practices, we wanted to look at facilitators and barriers, we wanted to look at all the safety net clinics in Alameda County, and we really wanted to talk to the staff who were screening for social determinants to find out what was important, what was the barrier, what was the facilitator, how do you do this in your clinic time, how do you get the information back to providers? Right?

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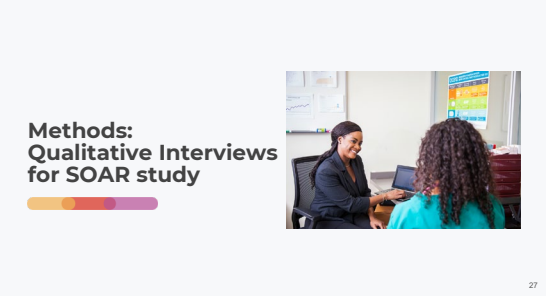
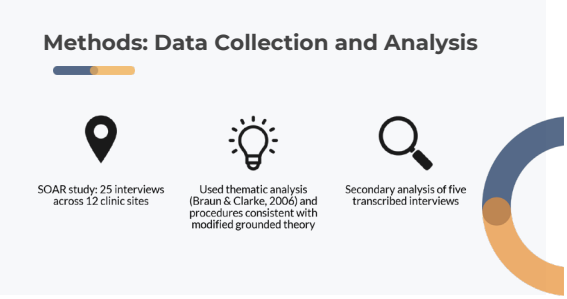


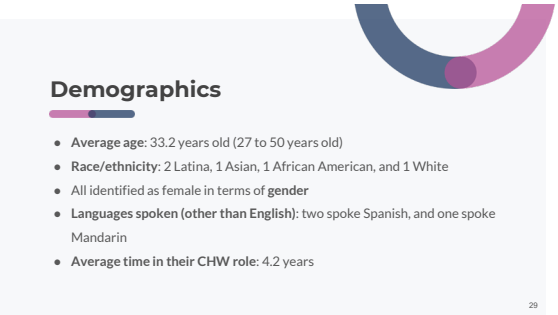
So, what we did was we qualitatively interviewed them, and we talked to those community health workers to find out how well is this working in your setting? Are you thinking about using this for family planning or for teen moms, or potentially teen moms? How is this working for you? And can we use this in our family planning and contraceptive services? Can you make that adaptation?

Slide 28



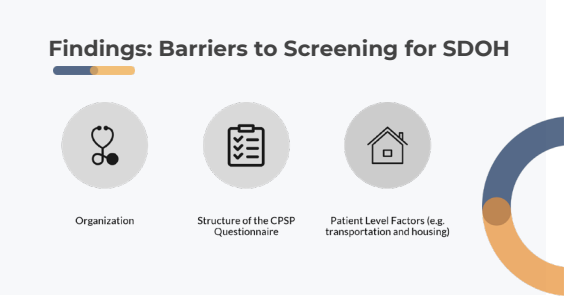
We conducted 25 interviews across 12 sites. We used thematic analysis across those interviews. This is a secondary analysis of five transcribed interviews, it really got at components of life course, family planning, contraception, as well as teen pregnancy prevention.

Slide 29



The community health workers range from 27 to 50 years old, and this is really important. Because if you're going to do life course work, your community health workers should match to people you're serving. Right? So I already talked about that pregnancy window being from 15 to 44. We really need to start paying some attention to our mid-life or later-life pregnant capable people, because I can just tell you, they are not getting the comprehensive information that they need. And we've got some data, I think, it's in the slide set that I'll show you where, that's a potential opportunity of us to get some real focus to it. You can see this was a small sample, but we tried to represent all the major racial and ethnic groups here in Alameda County. This average time of community health worker is really important, which is 4.2 years. We get many of our community health workers from people who we've previously served as patients. So it's a big deal to know that we're not getting rapid turnover if you invest in the community members as your future employees, that you're not finding that you're getting to cycling in and out of your workforce. I know a lot of times people will use med students and public health students and nursing students and people on the way to school. So it feels like you're spending all this time, every two to three years training folks, I'm telling you, one of the most basic investments that you can do is to encourage the people that you serve to become your future workforce. You will get longevity in your workforce.

Slide 30



One of the biggest barriers we found in screening for social determinants of health, especially how to marry a life course perspective to family planning and to really have that be informed by the best science that we have, is the organization in and of itself. The structure of the way the questionnaire is delivered here in California, we made some suggestions to public policymakers to fix that. But then there's some patient-level factors as well that we thought were really, really important that I want to share with you all.

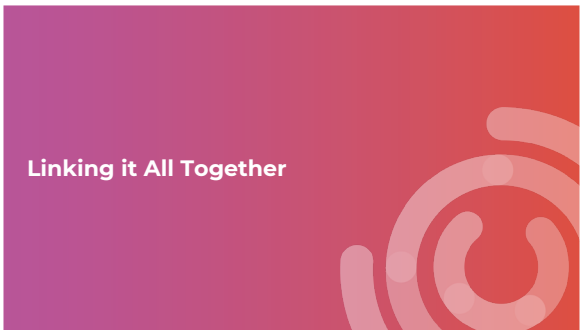
Slide 31

If you're really trying to think about how to reduce maternal morbidity and mortality and what your role is in that as a family planning provider, it can't just be long acting reversible contraception, "don't let those people get pregnant." That's not helpful nor is it going to get you the results that you need. It's really modeling the team-based care that you're already expert at. There are people on the prenatal care side who don't even have any sense of how team-based care is in Title X clinics. I would love for more people to do demonstration projects, where you're videoing your process, or you're doing some kind of infographic around how you do your flow. Because I'm telling you, there are other aspects of the health care services provision, especially on the prenatal care side, that could really learn from some of the innovations that we've developed. I also think that how we've organized our services can be very helpful. So what I'm going to push a lot of you to do is to think about speed dating, either with the prenatal providers in your area, speed dating with the midwives, and the doulas, and yes, it's going to be controversial, but maybe even speed dating with some of the pregnancy help and more social support organizations, because we have a lot to teach them, and I would love for us to stand in that expertise.

Slide 32

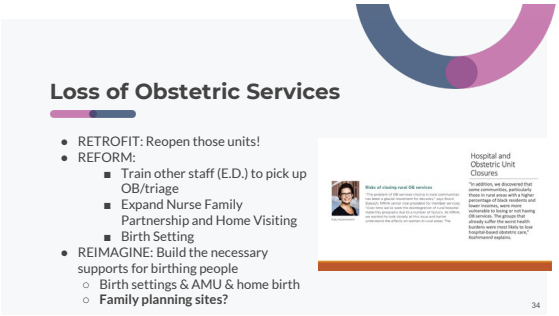
One of the things I'm not going to talk about is the CPSP questionnaire, because it's very California specific, and there were a lot of details. I can go into a deeper dive, if you either send me a tweet or send me an email. I do want to get into this greater clinician involvement in these appointments. So, one of the things that qualitatively came out was, people we serve, the patients, they didn't understand why they filled out the questionnaire, they talked to the community health worker, and then they also had to talk to the clinician. It was almost like we weren't explaining to the patients that there was a conversation that happened between the community health worker and the clinician. So on the clinician side, it's tricky, right, because on the one hand, you don't want patients to feel like we're talking about them behind their back. But at the same time, it was very helpful to know from a continuity standpoint that the clinician was very clear and transparent, and said, "I talked to Cynthia ..." This is a pseudonym. "The community health worker, and she reviewed everything about what's going on with you." This was the line that was most effective with the clinicians after they said, "Which of these, if any, would you like to discuss or address today?" They left it to the patients to make a determination about which, if any, and that if any is really important, because sometimes patients told us in our interviews, that they weren't interested in addressing those things today, but they were interested in addressing them at another time. Right? So this whole other piece about how we manage time in our clinical environments, is also something I think that's ripe for a reform or a retrofit.

Slide 33



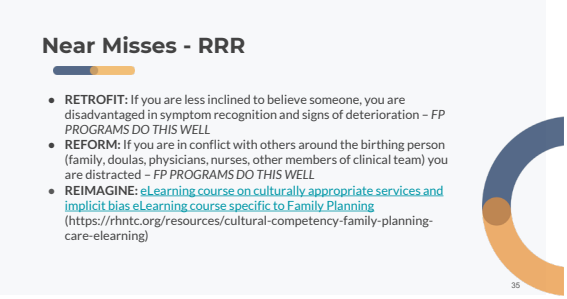
Using that as just one example, let me link it all together for you. Because I know I've said a lot and I know fitting in ... I left tons of time for questions because people ask me all the time, "Monica, there are concrete ways in my specific clinic or my specific clinics, can I really, really use this framework?" The answer to that question is yes.

Slide 34



And it also depends on how you want to approach these things. Right? I already showed you this slide. If we really wanted to retrofit the loss of rural and obstetric services, we could retrofit--it would just be reopen those units. Right? A reform would be, "Let's train other staff to be able to pick up those OB triage skills. Let's expand nurse family partnership to allow for some of that surveillance, especially in the postpartum period, to know that home visiting can have a role in helping us to get that information back to people, even their family planning providers. Or let's build relationships with the home visiting program, especially for the shared people that we're taking care of." But a reimagine, a complete reimagination was afforded to us by the COVID-19 pandemic. Let's change where birthing people birth. Let's think about auxiliary maternity units. Let's think about the drive-thru baby showers that can happen and the drive-thru prenatal care visits and how people were doing home monitoring, and let's think about using telehealth differently. Right? Maybe we need to have some more virtual family planning sites that aren't just Nurx and other kinds of like contraception providers. Maybe we need to have a drop-in on Instagram for 15 minutes on Friday to talk through contraceptive questions. Maybe those are the kinds of things that if you're not just having a retrofit discussion or reform discussion, you can think about things that you can pilot.

Slide 35

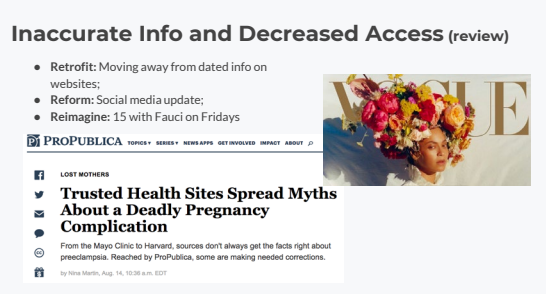


For the near misses, right, if you're less inclined to believe somebody because your team is in conflict, you're going to miss signs and symptoms of deterioration, or you might miss important signs about where people aren't in their contraceptive lives. I think we do this really well in family planning programs. I think we're good with retrofit. I think with the reform, really bringing in that whole-team perspective, some places you have, maybe that can be further from a reimagine. There are so many cool classes out right now specific to implicit bias, specific to understanding what our clinics look like and what imagery people want, specific to the mixing of both tele and in-person visits, specific to how to date a doula in your clinic. Right? There's so many good trainings. Ancient Song Doulas in New York City has done a whole training for nurses around our different roles, but our common goals and how to get there. So, I actually think family planning providers have a huge role to play in surveillance around the potential for near misses. We have a way to think about our telephone triage and what people are really telling us, "There's just something not right." There are ways for us to think about being that netting, that retrofit weaving. I actually think that full-spectrum doulas can help us with this. I would love to be thinking through with folks if and how you're utilizing full-spectrum doulas and communicating with them to be able to be that glue between, especially for postpartum people, or people who have yet to come back around their reproductive health equity goals, or for the language some people will use as their preconception goals, will that clock reset? I would love for us to think about that period in terms of how we can get some innovative and uncanny partnerships.

Resource:

Cultural Competency in Family Planning Care eLearning (https://rhntc.org/resources/cultural-competency-family-planning-care-elearning)

Slide 36



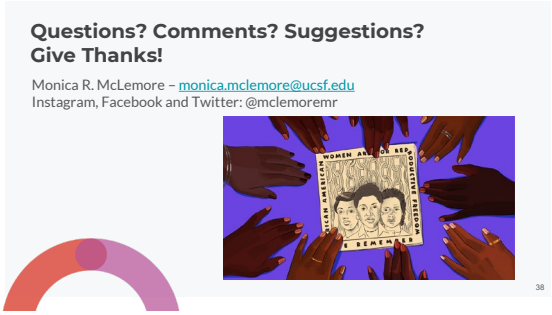
I talked about this. Again, we've got to move away from dated information on websites, we've got to move away from dated information on mobilely-accessed websites. We got to think about, do we have social media updates? Or are there trusted places where we want to direct people to? Right? The OPA website is really tricky. So are there ways for us to think about what would be more mobile friendly? Or can we do a "15 with Fauci on Fridays?" That was my fancy name for why didn't we have Dr. Fauci come out during COVID-19 every Friday for 15 minutes to answer the public's questions on Instagram Live? Why can't we be thinking about some of these more innovative uses of technology to ask people's questions or to ask doulas to host different conversations about contraception and lactation, right, to really be doing some relatively low cost, but high touch opportunities to build trust with the public. I want us to have this conversation, right, because I think it's really, really important that we start to really think about what are the retrofits that we could be doing? What's the reforms that we can be doing to ... and what's the community based organizations that other group of people haven't talked about? Right? Which community based organizations in your environment, whether it's WIC or it's ... For us in California, we have Black Infant Health, but if there are community based doula organizations, there are community based Black women or Black focused organizations, the National Birth Equity Collaborative, or SisterSong, SisterReach, or SisterLove, what are the best practices? Having a real learning community of sharing with those retrofit, those reforms, and that reimaginings.

Slide 37

Finally, I will tell you, one of the things that I've figured out, and if the COVID-19 pandemic didn't teach us anything is this, we have to start distributing resources based on need. This is so important, especially as we start to think about retrofitting our services, thinking about what

we can ask for in a new administration, really knowing that we all can't do it all. That's what this divide and success approach means. Right? I'm trying to move away from war metaphors. So it's not divide and conquer, it's divide and success. If you know clinic A is doing something really, really well, let clinic A do that thing really, really well, you don't have to retrofit your environment to do what clinic A is doing really, really well. But maybe you all partner so that when you're doing some projects and you want to reform, you're sharing and co-allowing for these things to happen, whether they're in the network or not. Retrofit, reform and reimagine also really makes you hone down on the need for clear communication. People need to know which option you're talking about. Because if you're really talking about, "Hey, we don't even have doulas in our Title X Clinic," maybe you need to retrofit to figure out a simple infographic around where doulas could be useful and helpful, and maybe to send that to the local doula collective. Right? Even if it's just coming to talk with patients in your waiting room." Right? There are ways to think about utilization, or "Hey, these are the good doulas producing content on Instagram," you can go watch their Instagram videos. Right? Or bringing them in to talk with your staff about the work that they do. Right? Everybody thinks that it has to be some big thing, and it really, really doesn't. I also would push, and I'm going to be doing this both externally and from my position as an educator and a faculty member, to think about, we have to, we have to start community engagement at all levels. I think in Title X, we've not really had a conducive environment that's been curated to allow us to do that ethically and to allow us to do that well, given the confidentiality issues around some of our work, but I do think what the pandemic has taught us is that there are innovations that we should continue to riff on and adopt, that we continue fighting to make sure that telehealth visits will be compensated appropriately as in-person visits. I'm really pushing folks on the birth and prenatal side to really, really make sure they are using the language of, also, family planning and preconception and reproductive life course, to be using that language as well. I'm really pushing our professional organizations. That's the other thing I've been really happy to see the Society of Family Planning partnering with the Society of Maternal and Fetal Medicine, and seeing the American College of Obstetrics and Gynecology working with the Association of Women's Health, Obstetric and Neonatal Nursing. So we need to continue at all levels those retrofits and those reforms. Then at some point, maybe we all will be realizing that reimagine is what happens when you go through the cycle of retrofit and reform. Right? That's the thing I didn't tell you. It's not a linear process, it's a circle. Because if we're all really trying to grow together and really have one piece inform the next piece, and you might be somewhere on the continuum of the circle, but you're somewhere else on the circle elsewhere, this will help us to share resources to really ask for what we deserve, and to fully integrate what I believe our reproductive justice principle into retrofit reproductive justice principles on to our existing work. I think collectively, we can get there, if we are all driving towards using skills that have the same conversation.

Slide 38



I want to be very clear as I end, you can contact me by email, you can contact me on any social media. But I will also say this, right, that as we think through what we really see as the future of family planning, what we see as the future of the Teen Pregnancy Prevention Program, what we see as the future of reproductive justice, we want to be very, very clear about what services we need, what policies we need. I also want us to all be intentional around realizing that resources have three aspects to it, humans, money, and time. I think too often we talk about resources as if it's just money. But I don't think we've done enough work, looking at human resources and time resources, and I can tell you, people in the birth space and in the infertility space and in the surrogacy space, we're all trying to figure this out, and I really believe if we all teamed up using a retrofit, reform and reimagine framework, then we can actually create the transformation that we're looking for in health services provision, health education, policy, research, and practice.

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Resources:

Innovating Education in Reproductive Health. Structures & Self: Advancing Equity and Justice eLearning (https://rhntc.org/resources/innovating-education-reproductive-health-structures-self-advancing-equity-and-justice)

Think Cultural Health. Culturally Competent Nursing Care: A Cornerstone of Caring eLearning

(https://rhntc.org/resources/think-cultural-health-culturally-competent-nursing-care-cornerstone-caring)

Cultural Competency in Family Planning Care eLearning (https://rhntc.org/resources/cultural-competency-family-planning-care-elearning)

Title X: Celebrating 50 Years of Family Planning Services Delivery (infographics) (https://opa.hhs.gov/sites/default/files/2020-11/title-x-50-years-infographic.pdf)

Michael C. Lu, MD, MS, MPH – selected publications (https://pubmed.ncbi.nlm.nih.gov/?term=Lu%2C%20Michael%20C%5BFull%20Author%20Name%5D%20OR%20Lu%2C%20Michael%20C%5BFull%20Investigator%20Name%5D&cmd=DetailsSearch)

Slide 39

RHNTC email: rhntc@jsi.com

Dr. Monica McLemore: So with that, I'm going to stop sharing my screen. Actually, I'm not going to stop sharing my screen, because I know we have one last slide for evals, but I see there's tons of stuff in the chat and I'm dying to get to it. Should I leave this slide up, Jennifer? Would that make sense? Okay?

Jennifer Kawatu: Sure. You can leave that.

Dr. Monica McLemore: Let me move over. I've got two devices up. So, if you have questions, if you have comments, if you have stuff that you tweeted me, I'm going to go ... Oh, and it's so good to see folks making comments. Okay. "Where can we access the infographics?" This is a very important question. So if you go to the OPA website, there is a 50 year anniversary of Title X. What I did was I screenshot them and I broke them up, and they're built out as PDFs. So they're purposely designed, so that you can use them in a variety of ways. They can be blown

up as posters to be laminated in your clinic. One of the things I love about those infographics, most of them are gender neutral. Most of them don't actually have pictures of anybody in terms of race, ethnicity, it has a historical timeline, and it can be used in whatever size is appropriate for your clinical area. So even if you just want the club card or cut out, or if you want it on the back of your business card, they are on the Office of Population Affairs websites as downloadable PDFs and JPEGs that you can use that I find to be very, very helpful. We should take good credit for the work that we've done. Jennifer has put that in the chat, so that you can directly go and find those infographics. "Can Monica increase her volume?" Oh, I'm so sorry. I'm sorry that my volume wasn't consistent to Mary Rogers. Apologies for that. "Second time watching this presentation, it just gets better." Thank you so much. I mean, one of the things I'm trying to do is to write this up, so we can all be good partners to each other. Right? We've all been home for a year. Right? Some of us more than that, and if we can't figure out how to work together as a health system, to make sure that no one again is ever vulnerable again. We're in trouble. Right? I mean, COVID-19 has taught you nothing, the misinformation, the attacks, the politicization of science, that's not unique to us. We were the canaries in the coal mine. Right? We also have been combating this for years, we have really good skills, we know how to take care of ourselves and each other, and it's time for us to stand in that rightness to be able to say, "This isn't right. We stand with the people that we serve." It is very important for us to read, to curate a new narrative about what we've all been through, I want to see some grief, I want to see some loss, I want to see some acknowledgement at least in the community setting, that what we've been through this last year is not normal, and we are all committed to making sure that it doesn't happen again, that we want to reimagine what health services looks like for them, and we want their input and their insights to be able to help us to do that. I also really, really think that one of the most important things that we can do right now is to continue to high quality services we're providing. One interesting thing about retrofit is this, you're doing good work right now. Right? Let's own that. Right? That's the thing that I don't like about everyone wanting to throw the baby out with the bathwater. Right? That's a horrible analogy. If somebody has a better one, can you put it in the chat, but like we are doing good work right now, and that good work needs to continue to happen. That's why I keep saying that those infographics make visible, the important public health work that you all, and we all have been doing.

It's very, very important that we think about that, that it shouldn't just go away because it's been seamless and invisible to folk. That's what happened in COVID-19. We let our public health infrastructure go away and look what we got. Right? Look what happens when essential public health doesn't function. So, we need to make the argument that public health and that reproductive health are public goods, and they need to be funded like other public goods, not a luxury, not something, if your insurance is lucky enough to cover that, you can get. Those are the kinds of discussions that I think we need to be having. Yes, I tweeted earlier today that OPA needs to change its name and its focus. What do I recommend? I think we need Office of Sexual and Reproductive Health and Wellbeing as Dr. Joia Crear-Perry has called for. I think that our language of our offices and I think our language at the federal level really needs to reflect the transformational changes that are going on in a lot of your clinics, and in a lot of your service areas and a lot of your research. Right? I think the language of Population Affairs has some

harmful impacts to communities, where they've been the burdened population. If we're really trying to center the margins, what's wrong with the Office of Sexual and Reproductive Health and Wellbeing? The radical in me wants the Office of Reproductive Justice, Health Rights and Justice, but I think we can all crowdsource and brainstorm a better way to think about reproductive life course. Why can't we have an office of reproductive life course? Right? That includes gender justice, that includes sexual and reproductive health, and talk about healthy consent and pleasure? Right? Comprehensive sex education. Right? Why can't we have those things? Right? It's one thing to want to be aspirational, it's another thing to want to retrofit. In my mind, changing the name is a retrofit that we can do quite easily, because it's not the first time the office's name hasn't changed. Because there's been other things before in the past, and I'll let you go look it up to see what it used to be. Right? So we can think about that. Right? I like to remind people, the Department of Homeland Security was developing in my lifetime, and people act like stuff's always been around, and it's always going to be there. It's not true. So again, are we going to retrofit some stuff, are we going to reimagine some stuff, are we going to reform on some stuff? A name change would be a reform, and I think it would be a welcomed one by many people. "Will this webinar be available to watch after today?" I hope so.

Jennifer Kawatu: Yeah.

Dr. Monica McLemore: Maybe somebody else can answer that for me. Yeah, you can have my slides. Yes, absolutely. Thank you for the kind words, yes, you can have my slides, if as long as Jennifer and the team say that's okay. One another thing that was discussed was the closure of obstetric services at hospitals. I live in a state where a number of closures have occurred over the last 10 years, mostly due to the decrease in birth rates and inability of hospitals to have enough deliveries, for providers to keep up their skills to provide safe deliveries and care. What's the solution to this issue? The birth rate has once again gone to its lowest rate since 1979. The issue is we shouldn't tie the value of birthing services to the population rate, propagation of our species is a sacred act. Right? People forget I'm a laboratory trained person. Some of my research skills are grounded in evolutionary biology, propagation of our human species is an existential act. If we didn't learn that last year, when a microbe almost took most of us out, some of us should really think of how this notion that we accept, that we tie resources that are necessary for birthing people to shepherd new humans to the world to the number of birthing people that exist. Right? It'll be our environmental justice people who will make this clearer to us, that the planet is good at recycling things that we need, and reusing things that we need and reducing use of things that we don't need. But the truth of the matter is, we never should have tied the human money and time resources to run hospitals, to the propagation of the human species. That's a public good, and it should be funded as such. Right? That's how I see it. Right? In the same way that a lot of people are making the argument about a basic minimum income, that people shouldn't have to die because they're poor. Whether you shouldn't be able to parent because you're poor. Right? To not experience one of the most ... What people tell me, I've never birthed, I've never been pregnant, what people tell me it was one of the most satisfying existential experiences that one could have, that you have the courage to parent, we can't do so because our social determinants of health are messed up. If that's a thing, we've lost our way. I'm grateful for the people who have the courage to create

the future physicians who will care for me when I'm an old girl, who will create the tech that I will use when I'm an old girl, who will create the policies that are necessary to have a more just world when I'm an old girl. I thank those parents, because your children will move the world, I hope, to a better place than it is now, and I'm grateful for that. For me, I think we should fund birthing spaces as if it was a public good.

For people who celebrated Mother's Day yesterday, we should act like they're revered year round as opposed to just one day out of the year. I'm not making the perfect the enemy of the good. Yes, that is a bit ... Thank you, Rachel for that. Yes, that making perfect the enemy of the good, that is a much better way to say that. I see a lot of people wanting to change the name of programs. I didn't answer the question about the focus. Right? We should retrofit and continue to fund programs that receive Title X dollars. We should reform and add new money to the pot to restore what we've lost over the last couple of years. Then we should reimagine, we should actually provide joint funding for institutions that provide prenatal care and life course and cancer care and infertility care, we should have some badass DARPA grants for the teams that come together to design reproductive life course well, including infertility. That should be new money that we think about to incentivize them, to catalyze new ways of thinking about not only health care services provision, but health care finance. For me, it's a retrofit we should keep the dollars that the Title X program has, and should restore it to what it was under the Obama administration? But a retrofit is to give it more money, so that they can actually be amortized for cost of living increases, and we should stop criminalizing poor people and policing their reproduction. But then reimagine should, we should have a grand challenge to figure out what infertility service, what cancer service, what birthing service, what family planning ... who will team up and create a life course model? That's the kind of stuff that we should be reimagining. Right? The reimagine can't just stop it getting what the Title X network needs or what the Teen Pregnancy Prevention Programs need, we can't stop there. That's a retrofit. I want us to think bigger about what's possible. Right? Maybe we need to talk to our philanthropic friends, while our federal friends try to get it together, because they really showed up during COVID-19. Let's be clear. Right? There were three sectors that have one job to do during a global pandemic. Right? We had the for profit sector, the business sector, we had federal government, and we had philanthropy, and in my view, only one stepped up, and that would be philanthropy.

So, we need to start thinking differently around how those three sectors that control pots of money in our environment are going to function, they need to team up too. That's the other thing. Right? If we really want to reimagine we will see the catalyzation of ... If you just look at what's going on with NFTs and cryptocurrency, that's like a whole other discussion that other people are having, that people in the regular economy aren't even dealing with. That's what I mean when I say we want to reimagine, let's reimagine. Right? The retrofit is keeping my doors open. The reform is giving us the resources that we need in order to not only continue to provide high quality services, but to integrate them with other high quality services, so that people we serve get an opportunity to have a one stop shop if that's what they want. Reimagine is a whole other beast. Right? That's where I think the framework is helpful in terms of at least how I think about these things. Can I talk a little bit more about what I mean by applying life course approach? Absolutely. So Michael Lu, who's the current dean of the School of Public Health at UC Berkeley. He was an obstetrician gynecologist trained at UCLA, and he

ran the maternal child health branch at HRSA for years, he wrote a ton of papers about life course, and basically it goes a little something like this, right, from womb to tomb, we care about you, and all those activities, all those environments, all of the factors are related in terms of predictors that help to understand how you will have a dignified and whole life. And that we can build a system around life course that will really, really allow people to get what they need, at whatever point in the care trajectory that they need it. That's the simplest way for me to be able to say what life course theory is, and you can read a whole ton of it in Michael Lu's work, some of it's been very, very public. Some of it's behind paywalls. But I'm telling you, they are some of the best papers. There's two books. Now to remember that there is a life course theory book that you can also get, and I think it's just super, super important. I'm grateful for the work that you all do. Thank you for taking good care of all the people that you take care of, and I look forward to hearing your comments, your questions and your feedback. Jennifer, let me pass it back to you.

Jennifer Kawatu: Thank you so much, so very, very much. You've given us so much to think about and we really appreciate it and appreciate you taking all of those questions as well. Thank you to everyone for joining us, please, please do fill out the feedback form. We take those very seriously, we look at every comment, and we really appreciate your feedback. That can help us to plan and design additional activities for the future. Make sure that you're signed up for our e-news, and you can find some of the resources that Dr. McLemore talked about today on our website, rhntc.org. Thank you very much and have a nice day. Thank you again, Dr. McLemore.

Dr. Monica McLemore: Thank you.