Care during Pregnancy and Delivery

ACCESSIBLE, QUALITY HEALTH CARE DURING PREGNANCY AND DELIVERY

Minnesota acknowledges that systemic racism and generational structural (social, economic, political and environmental) inequities result in poor health outcomes. These inequities have a greater influence on health outcomes than individual choices or one's ability to access health care, and not all communities are impacted the same way. All people living in Minnesota benefit when we reduce health disparities and advance racial equity.

We recognize that not all people who get pregnant in Minnesota identify as women or may not identify as a mother or father after the birth of the child. In order to honor all those in our communities who experience pregnancy, we will incorporate gender inclusive language such as pregnant person throughout this document. 'Mother' or 'Women' may still be used when referring to statistics in order to accurately reflect collected data.

Current Landscape of Care during Pregnancy and Delivery in Minnesota

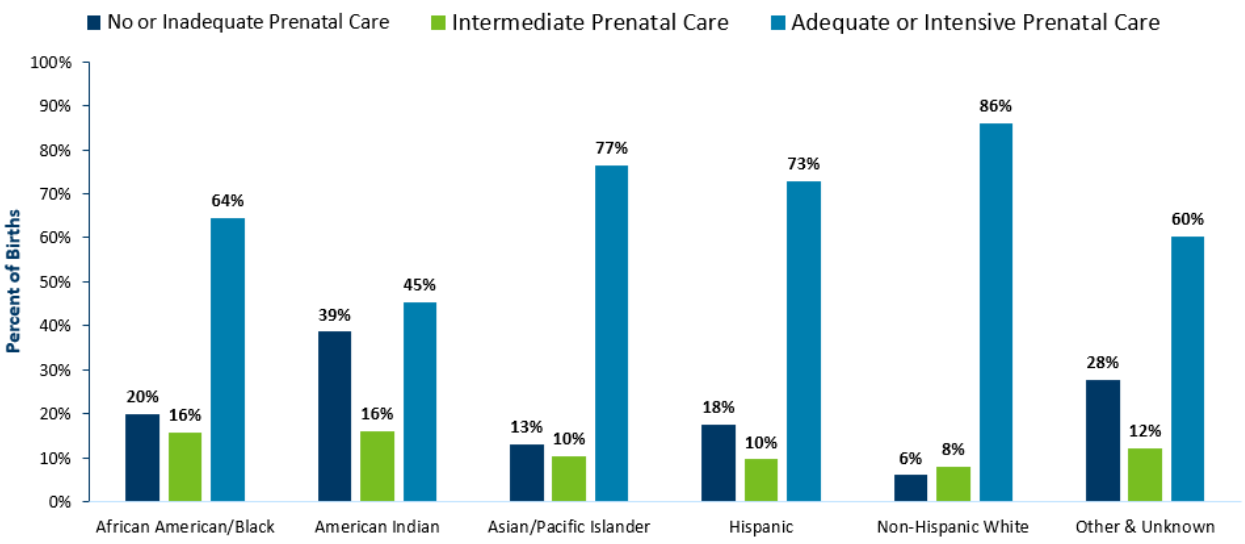
Having a healthy pregnancy and access to quality birth facilities are the best ways to promote a healthy birth and have a thriving newborn. Getting quality, early, and regular prenatal care is vital for both the pregnant person and baby. Prenatal care is the health care that pregnant people receive during their pregnancy. Prenatal care is more than doctor's visits and ultrasounds; it is an opportunity to improve the overall well-being and health of the pregnant person which directly affects the health of their baby.

It's important that pregnant people receive both early prenatal care, starting in the first trimester, and adequate prenatal care, having the appropriate number of prenatal care visits at the appropriate intervals throughout the pregnancy. Babies of pregnant people who are exposed to systemic barriers that prohibit them from getting care are born with low birthweight at rates three times greater and die at rates five times greater than babies born to pregnant people who are not exposed to these systemic barriers and do receive prenatal care.[1]

In 2019 in Minnesota, 82.4 percent of pregnant people received prenatal care within their first trimester of pregnancy. Approximately 1 in 30 or 2,138 infants were born to a parent who received late (started in the third trimester) or no prenatal care at all. Systemic racism creates barriers to accessing quality care throughout pregnancy and delivery. This also results in unfair and unjust treatment of women and pregnant people of color and their families in the healthcare system. As a result of structural racism, disparities are seen in the adequacy of prenatal care utilization across race/ethnicity (Figure 1). Less than half of births to American Indian mothers receive the recommended adequate/intensive prenatal care utilization.

Prenatal care is critical as pregnant people can be screened for common complications during pregnancy, such as preeclampsia and gestational diabetes, and receive timely, appropriate care to treat these conditions. Screening for infections during pregnancy, such as cytomegalovirus (CMV) and syphilis, is important as well as these infections left untreated could lead to numerous congenital health effects for the baby including vision loss, brain malformations, miscarriage, or stillbirth. Appropriate treatment of health conditions can improve the chance of giving birth to babies that are full term and a healthy weight. Prenatal health includes the birthing experience, such as selecting the best birthing environment and doula support for a pregnant person's needs, whether it be a birthing center for low-risk pregnancies or a hospital with obstetric services.

Figure 1. Prenatal Care Utilization by Race/Ethnicity, Minnesota Mothers, 2019



Data Source: Minnesota Final Resident Birth File

COVID-19 Pandemic: Impact on Care during Pregnancy and Delivery

Pregnant individuals are at higher risk for both death and severe illness from COVID-19, and their infants may also be at increased risk for preterm birth and stillbirth.[2] Given this increased risk, the COVID-19 pandemic has significantly affected the lives of pregnant people and the care they receive throughout pregnancy and delivery.

The impact of the COVID-19 pandemic on access to care during pregnancy and delivery must be considered within a broader context. Recommendations to reduce the risk of COVID-19 transmission during pregnancy include not taking public transportation, working from home if possible, and avoiding spaces where large numbers of people may be congregated.[3] Due to structural inequities, these recommendations are much easier and more realistic for some pregnant people to follow than for others. As a result of these systemic inequities, pregnant people with jobs that do not allow for work from home, without access to other transportation options aside from public transit, and without a safe and stable home to be socially distant may be exposed to greater harm from COVID-19. All of these systemic factors intersect to affect pregnant people's experiences with health and health care during pregnancy and delivery throughout the course of this pandemic.

Finally, in Minnesota, and across the U.S., health care providers, women, pregnant people, and their families have had to adapt to changes in the nature of pregnancy and delivery care in order to reduce the risk of COVID-19 transmission. For example, many hospitals and delivery/birth centers now only allow one support person to be present for a birth and during any related hospital stays.[4]

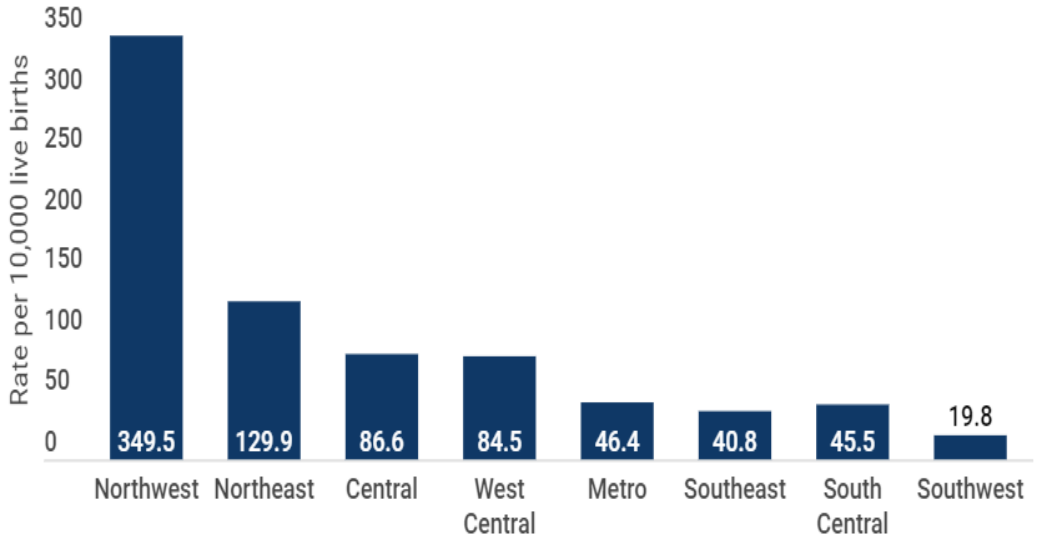
Substance Use and Pregnancy

Many families and individuals are experiencing stress and strain from the COVID-19 pandemic that has negatively affected their mental health and well-being. According to a Kaiser Family Foundation poll, 12 percent of U.S. adults say their alcohol consumption and substance use has increased because of pandemic-related stress.[5] Addressing substance use is a critical issue for pregnant people and their families in many parts of the state, and this care should be provided alongside wellness visits, pre-conception, pregnancy, and postpartum care. This issue has been exacerbated by the COVID-19 pandemic. Even before the start of the COVID-19 pandemic, maternal opioid use and infant neonatal

abstinence syndrome (NAS) diagnoses more than doubled from 2012 to 2019 according to Minnesota Medicaid claims data. Northern Minnesota endures the highest rates of prenatal opiate use. Within these northern rural communities, the average rate of prenatal opiate use is 9.8 percent, compared to the statewide average of 1.5 percent for all Medicaid-covered births.

Within the eight Emergency Medical Services (EMS) regions in Minnesota the highest rate of NAS was found in the Northwest EMS region of the state (Figure 3). Although the rate of the Metro region was the fifth highest among the EMS regions, the largest portion of the total number of NAS cases occurred in the Metro region (39% or 1,312 of the total 3,354 cases).

Figure 3. Neonatal Abstinence Syndrome Rate, by Minnesota EMS Region, 2012 - 2019



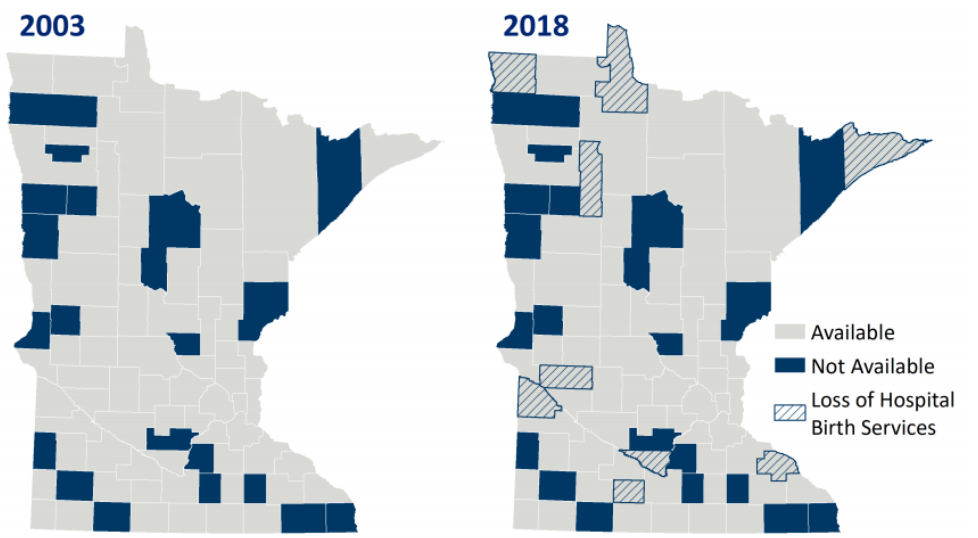
Data Source: Minnesota Hospital Discharge data

Efforts to address care during pregnancy and delivery are imperative to improve health for pregnant people over the next 5 years. For people of childbearing age, having access to age and culturally appropriate, quality health care is imperative for themselves and for their families. Maternal health is a cornerstone to population health. Enhancing prenatal and postnatal care for this population will elevate the chance of healthy birth outcomes for women, pregnant people, and infants.

Rural Access to Care during Pregnancy

When it is time for people to give birth, having access to safe, high quality birth facilities is critical. The Rural Health Research Center at the University of Minnesota published a comprehensive rural hospital study and found pregnant people living in rural areas are exposed to more pregnancy complications including preterm birth, out of hospital birth, and giving birth in a hospital without obstetric services.[10] Giving birth in a hospital without obstetric services can lead to higher rates of hemorrhage, emergency surgery, and maternal death.[6] Between 2003 and 2018, nine Minnesota counties lost community hospitals offering birth services, a reduction of 13.6 percent. Seven of the nine counties that lost these services were rural counties (see figure 4).[7] There was an increase in anxiety among expectant birthing parents when the Grand Marais and Ely hospitals stopped providing labor and delivery services in the summer of 2015.[8]

Figure 4. Hospital Birth Services Availability by County, 2003 and 2018



Source: Minnesota Health Economics Program Analysis of Hospital Annual reports; U.S. Census Bureau (County Designations)

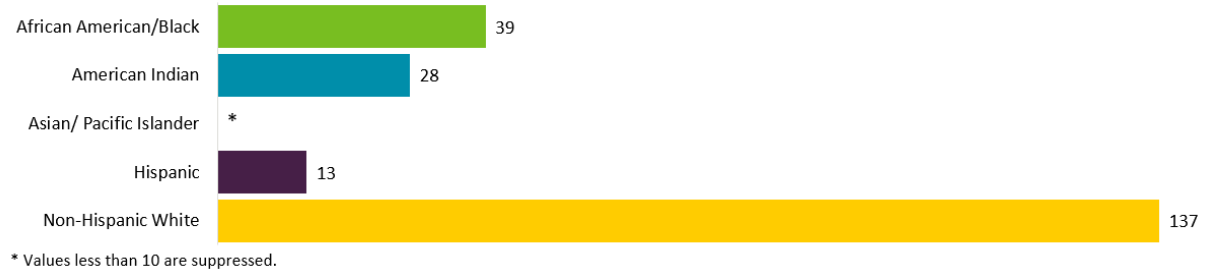
Among birthing parents living in Greater Minnesota, 44 percent experienced at least one barrier to prenatal care.[9] Barriers can be related to finances, transportation, health insurance, and ability to take time off work. Pregnant people with lower incomes are often simultaneously exposed to multiple, intersecting barriers to care. Additionally, systemic educational inequities can affect access to reproductive and pregnancy care. As a result of these structural inequities, pregnant people who have lower levels of education are systematically less likely to be able to initiate prenatal care in the first trimester and receive adequate prenatal care compared to pregnant people with higher levels of education and fewer barriers to prenatal treatment access.[10]

Racial Justice and Care during Pregnancy and Delivery

Systemic racism is at the root of the significant disparities in reproductive health care access, quality, and outcomes by race/ethnicity that exist in Minnesota. As a result of structural racism, Black, Indigenous, and people of color (BIPOC) pregnant people and their families experience significant barriers to accessing high quality care during pregnancy and delivery and to receiving fair treatment within the healthcare system. Ultimately, structural racism leads to worse pregnancy and birth outcomes among BIPOC pregnant people and their families. As a result of structural racism, American Indian pregnant people, for example, systematically experience the lowest rates of prenatal care and the highest rates of giving birth prematurely to a baby with low birthweight in Minnesota.[11]

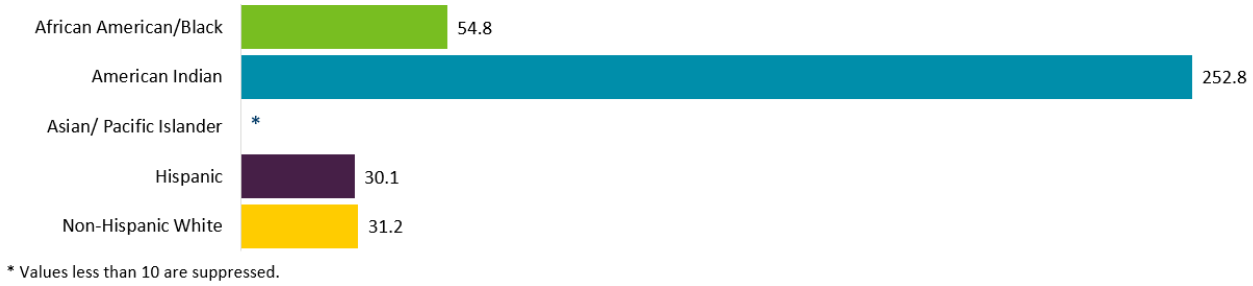
Quality care during pregnancy and delivery is essential for preventing maternal and infant deaths. Tracking systemic inequities across populations in Minnesota for maternal mortality is difficult as there are few deaths each year. When we combine data from multiple years, we are able to see significant systemic disparities in maternal mortality rates across different race and ethnicity groups. As a result of systemic racism, preliminary data from Minnesota Vital Records, 2011-2019, shows African American/Black pregnant people and American Indian pregnant people die during pregnancy, delivery, or the year post-delivery at rates 1.8 times and 8.1 times higher respectively than non-Hispanic White people. When breaking down the African American/Black population further, the data shows U.S. born African American/Black pregnant people systematically die during pregnancy, delivery, or the year post-delivery at rates 2.8 times higher than non-Hispanic White pregnant people.

Figure 5. Total Count of Maternal Deaths, 2011-2019



Data Source: Minnesota Department of Health, Minnesota Resident Maternal Mortality File

Figure 6. Maternal Death Rate (per 100,000 Live Births), 2011-2019



Data Source: Minnesota Department of Health, Minnesota Resident Maternal Mortality File

In the United States, severe maternal morbidity is 50 to 100 times more common than maternal death and increases systematically among ethnic/racial minority pregnant people.[12] However, specific knowledge about how the types and timing of severe maternal morbidities affect ethnic/racial minority women is poorly understood. In Minnesota, maternal morbidity data reported on the birth record shows disparities by race/ethnicity. From a study on Californian births from 1997-2014, the prevalence of severe maternal morbidity was highest in non-Hispanic Black pregnant people and lowest in non-Hispanic White pregnant people but increased by approximately 170 percent in each racial/ethnic group.[13] Experiencing complications such as preeclampsia and gestational diabetes during pregnancy can place pregnant people at increased risk for maternal morbidity conditions like difficult deliveries and postpartum recovery challenges.[13,14] Barriers to care differ systematically by race and ethnicity and include health insurance coverage, cost, convenience, discrimination and racism, fear, and lack of information on how to address postpartum health issues. All of these barriers can perpetuate maternal morbidity.

Strategic Planning

The Division of Child and Family Health (CFH) in partnership with stakeholders conducted a comprehensive assessment of the health and well-being of Minnesota's maternal and child health populations – including women, mothers, fathers, caregivers, children and youth (including those with special health needs), families, and communities. Following the prioritization of unmet needs, Care during Pregnancy and Delivery was selected as a top priority for Minnesota.

In order to advance maternal and child health outcomes and health equity, CFH acknowledges that we need to work together in authentic, collaborative, and innovative ways. CFH continued to engage stakeholders by implementing a community-focused process to set and implement strategies to address the priority needs using Strategy Teams. We have only begun this work and know there is still much

work to do. The outcome of this process helped form a statewide strategic plan that guides work on improving maternal and child health systems going forward.

Vision for the Future

We strive for a Minnesota where communities receive the support they need, and where all families, children, and communities of all races and ethnicities have access to holistic, culturally responsive care and services during pregnancy and delivery. We envision a shift in policy and funding priorities in order to reduce systemic barriers across the state. In the future, we aim for a Minnesota with well-equipped providers, improved pregnancy and delivery outcomes, and headlines that highlight our state's successes.

Strategies to Address Care during Pregnancy and Delivery

A Strategy Team was assembled to identify a set of strategies and activities for the Minnesota Title V program to help ensure pregnant people have accessible, quality health care during pregnancy and delivery. This Strategy Team was comprised of a diverse group of statewide stakeholders and included recipients and providers of reproductive services, such as pregnancy and postpartum support, birth doula services, representatives from local public health (LPH) from regions across Minnesota (representing large, small, rural and urban communities), Title V staff, professionals serving Minnesota's American Indian populations, and other communities of color, and academia.

The discussion below is a brief summary of CFH strategies for improving care during pregnancy and delivery. To learn more see the entire Minnesota Title V Maternal and Child Block Grant Application and Annual Report.

Strategy A. Expand Family-Focused, Community-Based Policy and Funding

Addressing care during pregnancy and delivery from a population health lens focuses on expanding the immediate family's role in care and the birthing process. This also involves the evolution of funding and policy to be reflective of the communities they are intended to serve. Over the next five years, statewide initiatives will focus on addressing foundational changes to delivery structure for maternal health and improving/expanding the workforce to reflect our communities by:

- Collaborating across government agencies, including participating on the Children's Cabinet Healthy Beginnings Work Group and working with Family Home Visitors.
- Establishing an interdisciplinary Learning Collaborative to build a culture of health equity as a foundation for our work across disciplines and promote workforce development.

Strategy B. Integrate Services and Optimize Cross-Sector Collaboration

The second strategy for improving care during pregnancy and delivery is to integrate health and social services and optimize cross-sector collaboration to benefit birthing parents and infants. Care for birthing parents is often delivered by health specialties and is not holistic. By integrating existing services, promotion of preventative health becomes an option for pregnant people and babies and allows families to work with a care team. Connecting families with health resources and groups is at the core of our work. Over the next five years, CFH will integrate services and optimize cross-sector collaboration by:

- Adapting and implementing the evidence-based IMPLICIT (Interventions to Minimize Preterm and Low birth weight Infants using Continuous Improvement Techniques) Model in well-child visits to improve care and health outcomes during the 4th trimester for birthing parents and babies.

- Strengthening and expanding the Minnesota Perinatal Quality Collaborative (MNPQC) using community and stakeholder feedback through the Community Advisory Committee.
- Addressing maternal opioid misuse through collaborative interventions with the MNPQC neonatal abstinence syndrome/opioid use disorder (NAS/OUD) work group and its stakeholders, including provider trainings and protocol implementation.

Strategy C. Strengthen and Expand Culturally Responsive, Trauma-Informed Care

The third strategy is to work with partners and decision makers to strengthen and expand culturally responsive, trauma-informed care, among people with uteruses who are of childbearing age. In discussions with partners, it is evident that changes need to occur in training, locations of delivery services, and funding sources for this population. Increasing access to respectful care, will allow pregnant people to have more autonomy while seeking services with the intention to build a trusting relationship with their health provider. Using public health surveillance programs such as evaluating maternal mortality, has allowed collaboration across sectors to identify where population health can be improved to allow birthing parents to thrive during and after their pregnancies.

Over the next 5 years, CFH will partner across sectors to encourage providers and maternal health partners to participate, complete, and continue education on implicit bias and trauma-informed care throughout pregnancy and delivery by:

- Expanding and improving the Minnesota Maternal Mortality Review Project by measuring and analyzing maternal morbidity, discrimination, interpersonal racism, and structural racism as factors contributing to maternal and carrier deaths.

Highlighting Success

While there are many challenges to achieving our vision for care during pregnancy and delivery in Minnesota, communities across the state remain strong and resilient. Community-based organizations have been successful in filling gaps in care resulting from systemic racism. One example of a community-based organization doing phenomenal work in this area is Roots Community Birth Center in North Minneapolis. Roots is a Black-owned birth center that is integrated within the community it serves. It specializes in culturally-congruent, anti-racist, anti-oppression, and trauma-informed care. Roots makes prenatal care, birth, and well person care accessible for all people and their families.[15]

Image Source: Becca Fruncillo (Roots Community Birth Center)

Midwives at Roots focus on high quality, whole-person care, and their center reduces access barriers for pregnant people in the North Minneapolis area. The success of the Roots model is evident in their preterm birth outcomes: none of the almost 300 families who have gone through Roots have experienced a preterm birth.[16] Roots is an example of what equitable care during pregnancy and delivery should look like in Minnesota, and how such care can begin to address racial disparities in pregnancy and birth outcomes that stem from systemic racism.

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Division of Child and Family Health
Minnesota Department of Health
PO Box 64975
St. Paul, MN 55164-0975
651-201-3589
health.cfhcommunications@state.mn.us
www.health.state.mn.us

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