SWMPQIC

Southwest Michigan Perinatal Quality Improvement Collaborative

Southwest Michigan Perinatal Quality Improvement Collaborative

NEEDS ASSESSMENT AND RECOMMENDATION REPORT

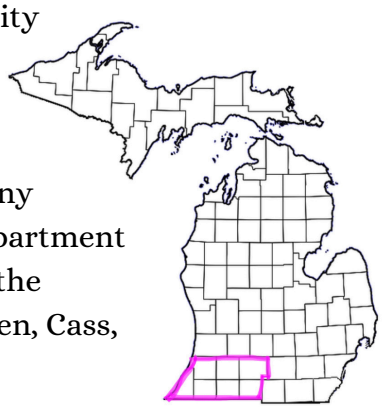
Report Created By

MPHI®

Center for Healthy Communities

INTRODUCTION

The Southwest Michigan Perinatal Quality Improvement Collaborative (SWMPQIC) is a regional perinatal collaborative with the goal to improve maternal and infant health outcomes. The collaborative membership is made up of community members, representatives from both local and state public health agencies, educators, and health care workers including physicians, nurses, community health workers, doulas, lactation consultants, mental health professionals, social workers, and many others. SWMPQIC works under the guidance of the Michigan Department of Health and Human Services (MDHHS) and with support from the Michigan Public Health Institute (MPHI). SWMPQIC serves Berrien, Cass, St. Joseph, Branch, Calhoun, Kalamazoo and Van Buren counties.



In August 2023, SWMPQIC's steering committee came together to participate in strategic planning. Through this process, the group decided to focus on three priority areas. 1. Continue to build a representative council of engaged partners that intentionally uplifts marginalized voices. 2. Intentionally investigate needs, barriers and gaps experienced by the community; and 3. Increase awareness and familiarity with existing resources available to the community.

To investigate community needs, barriers, and gaps in the region, SWMPQIC partnered with MPHI to conduct a needs assessment scan, town hall facilitated discussions, interviews with key partners, and listening sessions with community members.

PROCESS DESCRIPTION

Community health needs assessments are conducted on a regular basis by the various hospitals, health departments, regional agencies and state agencies throughout the region. Twenty needs assessments were scanned for components that were specific to or were applicable to the maternal and infant population using the qualitative analysis software, NVIVO. Themes across the various needs assessments were highlighted in this report.

Additionally, notes from a community town hall event which included several small group facilitated discussions on community health needs and strengths were reviewed. Transcripts from ten key partner interviews and five listening sessions were included in qualitative analysis as well. All three modalities, the town hall event, listening sessions and key partners interviews, asked participants what a healthy pregnancy and healthy baby meant to them, things in the community that helps families be and stay healthy, things in the community which keep families from being healthy, suggestions for improvement and

potential root causes to the region's high rate of late entry to prenatal care. These transcripts and notes were added into the qualitative analysis software, NVIVO. A coding structure was used to review content and categorize into the following groups- healthy pregnancy, healthy babies, challenges, supports, and recommendations. A summary of the findings is shared in this report.

DEFINING A HEALTHY PREGNANCY AND BABY

A healthy pregnancy was defined by participants as one with no or minimal complications or medical interventions. A large part of preventing complications meant moms ate foods to get the necessary amount of nutrition and calories for mom and baby to stay healthy during pregnancy. As well as drinking enough water and avoiding foods that would have a negative effect on the pregnancy. Participants also mentioned staying active. These are simple ways for a mom to maintain a healthy pregnancy and avoid preventable complications. However, a few participants discussed how built environment can impact a person's pregnancy and how they have little to no control over such things. For example, it is difficult to ensure adequate housing if one is homeless or renting since it is up to the landlord to maintain the integrity of the home.

Safe housing is also important for keeping babies healthy after birth. When houseless mothers get discharged, they may end up taking their newborns back to live in their cars, participants noted. A healthy baby is the result of living in a healthy environment. That includes a home without lead, asbestos or mold. It also includes safe sleep, physical activity, good nutrition, and ensuring all baby's needs are met. Participants mentioned the importance of proper breastfeeding techniques or ensuring that baby's formula has enough nutrients. A healthy baby was described as born anywhere between 37 and 41 weeks, with no complications or interventions, genetically and physically appropriate within their guidelines. Parents nurture a healthy baby by ensuring that their child is meeting development milestones and receiving support or having access to resources when they have difficulties meeting those milestones. Participants believed a healthy baby is a happy and thriving baby, meaning that children feel safe and loved, having formed a healthy attachment to their parents.

Additionally, participants noted the importance of mental health during and after pregnancy. Many moms in the listening sessions shared stories of worrying if they were doing enough for their baby and for themselves to stay healthy. It helped to have a good support system to lean on in the form of partners, friends, and family members. Being educated and prepared for pregnancy and baby were also shared as a part of the definition

of a healthy pregnancy and baby. This included preparing to get pregnant, preparing for baby, and being prepared for the postpartum experience. Being aware and knowledgeable is important for understanding when things are going right or wrong pre- and post-partum for either mom or baby. This leads to the final point participants mentioned, which was entering prenatal care as early as possible. A healthy pregnancy and a healthy baby were defined as receiving proper care from a team that understands, respects and helps the mother care for both themself and their baby. Mothers having access to care and resources to maintain a healthy pregnancy and healthy baby by being able to ask questions without fear of being labeled as “sensitive” or “anxious” leads to a healthier pregnancy and thriving babies.

COMMUNITY SUPPORTS

Interviewees identified many programs and agencies serving as community supports for maternal and infant health in the region. The identified local social services, hospital systems and medical groups, and community-based organizations extended material assistance, perinatal education, supportive medical care, and peer support to parents. Access to community supports was reported as a major problem for the region, as rural counties lack nearby programs and services, thereby necessitating long-distance travel for assistance. Free transportation services are available in some areas, however many noted that the services are understaffed and unreliable. Additionally, interviewees emphasized a need for more programming aimed at supporting parents through the postpartum period; social isolation, parental skill support, food and formula costs, and work-life balance were identified as key areas of concern.

Organizations that distributed material necessities and financial incentives, were celebrated for helping to address the significant cost of living burdens that parents are facing in the region. The distribution of resources like baby clothes, formula, diapers and wipes, coupons, baby books, car seats and strollers, were identified as particularly helpful. Nutrition and food assistance programs, such as WIC and SNAP, eased the cost burden of food and formula for families. However, many noted that the income eligibility limits of these programs restricted their broader accessibility, excluding those facing significant financial challenges but earning just above the income threshold.

Local hospital systems were highlighted as offering a wide range of educational programming and supportive services that uplift maternal infant health. Breastfeeding and birthing classes were mentioned frequently as offering needed community support. Bronson, in particular, was spotlighted among interviewees for providing education on

infant health and safety, as well as supporting the transition to parenthood with lactation resources and breastfeeding peer support groups. Home-visiting services, such as the Nurse Family Partnership program, Healthy Babies Healthy Start and 20 Hands, were identified as providing critical healthcare services to the region. Interviewees emphasized that expanding home visiting service coverage would be of great benefit to the region. A common issue identified with home-visiting programs was insufficient staffing despite community need; home-visiting services often have one staff member tasked with covering multiple counties.

Hospital-affiliated and community-based breastfeeding support groups (e.g. Baby Café's, Cradle) were praised for their positive community impacts, doubling as spaces for education and socializing. Many identified the postpartum period as needing more supportive programming, especially regarding postpartum mental health, parenting skills and infant health and safety. Peer support groups offered relief to those feeling isolated while parenting their newborns. Several participants noted that there is a lack of these supportive groups in counties beyond the larger cities in the region.

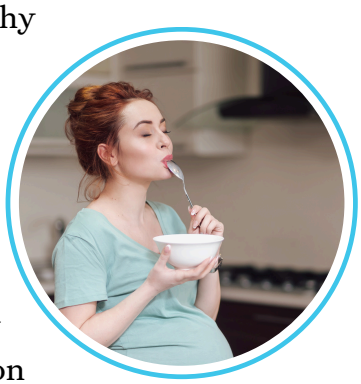
Doula services were spotlighted throughout interviews for offering a broad range of essential supports to the community, from affirming healthcare support throughout the perinatal period, to home visiting services, to parental education and emotional support. Doulas were noted to improve maternal-infant health outcomes, reduce the incidence of C-sections and aid with medical advocacy. Hospitals that collaborated effectively with doulas and included them on the birthing team were positively recognized by participants. Interviewees recommended that access to doula care be expanded to rural areas that lack sufficient service coverage. Interviewees recommended increased hiring and expanded collaboration between hospitals and doulas, while others emphasized increasing the quality of doula services through training, education and certification.

See Appendix A for a list of programs and agencies identified by interviewees.

CHALLENGES

Throughout this information gathering process of reviewing existing needs assessments and gathering input from the community, challenges experienced by the perinatal population were top of mind. Upon reviewing input ten themes of common challenges experienced were most evident.

Physical Health: Women are experiencing challenges staying healthy during pregnancy and after birth. Some of those challenges were within their control like eating healthily, exercising, staying hydrated and avoiding substances like marijuana. While other physical challenges experienced were more outside of their control like nausea, high blood pressure, gestational diabetes, pelvic floor weakness, prolapse, and miscarriages. Participants shared that they wanted more knowledge on how to make healthy choices on their own while pregnant but didn't feel this information was adequately addressed by provider offices.



Another physical challenge identified was that postpartum checkups are typically 6 weeks following birth which participants felt is too far out and too infrequent to catch problems as they arise or connect people to needed resources.

Additionally, birthing persons who use substances during pregnancy can be more reluctant to trust and share this information with providers or have in-home services like home visiting programs. Participants noted that the fear of tests coming back positive for substances or the fear of a partner's retaliation for someone experiencing domestic abuse could be contributing factors to birthing people waiting to seek prenatal care until their third trimester which impacts physical health.

Mental Health: Pregnancy and the birth of a baby are high stress life events that require additional support for moms and babies to stay healthy. Participants shared that work life balance and the pressure to meet societal norms are particularly challenging during pregnancy, birth and the postpartum period. Exacerbating this is the lack of, or perceived lack of, mental health resources available like support groups or other services in the region for those experiencing mild to moderate postpartum mood disorders.

Many participants shared their experiences or experiences of people close to them who did not receive mental health services when they were needed. This was due to irregular or no screening for mental health disorders at provider offices or other places where postpartum persons receive services, referrals to services not being provided or referred service agencies not connecting to the postpartum person. One factor that can be contributing to women not receiving the mental health services they need is that, according to interviewees, many mental health services are operating at or near capacity.

Access to Care: Birthing people are experiencing challenges getting to their provider and having enough time in the appointment to feel adequately cared for. Since provider offices have limited appointments, participants shared that those appointments don't meet the

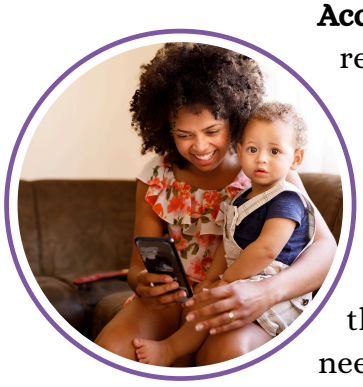
needs of families in a timely manner. Wait times are long, especially for first appointments. Establishing the needed trust with an OB provider is challenging when appointments are fast, and patients typically see a nurse for their first appointment.

An added layer of gaining trust is that patients are often seeing providers who do not look like them. Black and Brown women have personal and historical experience with healthcare negligence and systemic racism in the medical field. Women of color's experiences of pain and concerns being dismissed, along with higher rates of maternal mortality, lead to not being comfortable with White doctors or White medical industry. This mistrust of healthcare providers was elevated as a contributing factor to the high rate of late entry into prenatal care in the region.

With the vast majority of appointments during the day when families are at work, patients struggle to take time off or find childcare. Participants shared that most provider offices do not welcome children to attend appointments with the birthing or postpartum person, so childcare is required and can be a barrier to find or pay for. Another challenge is the geographic proximity to provider offices is far for some parts of the region. Added distance traveled requires more time off work and/or added transportation challenges like getting a ride or gas money.

Lack of insurance or the type of insurance someone has also leads to disparities in the quality and access to care one receives. Participants mention that the out-of-pocket cost of seeing a doctor is often very expensive without "good" insurance. People shared stories of their own/acquaintances who lost Medicaid around the time they found out they were pregnant. Lack of insurance was also uplifted as a reason why some may seek prenatal care late in their pregnancy.

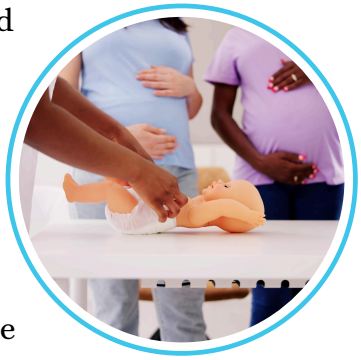
Another challenge is access to a doula which is limited by cost, availability, geographic location and sometimes policy. Doulas are not always seen by healthcare providers as a member of the care team which can prohibit their ability to care and advocate for their patient.



Access to Resources: Beyond access to quality care, access to resources impacts the ability of a birthing person to be and stay healthy. According to interviewees, agencies are experiencing challenges getting information to those who need it and those who need resources are having trouble getting those services. Awareness of available community resources is not consistent and there is no centralized location to identify services when they are needed. Agencies struggle to get information to those who need it in a way that they trust the message. Additionally, eligibility

requirements to access services can be restrictive. This leaves out individuals who may need the services but are ineligible and causes a stigma for those who do qualify. Even if eligibility is not an issue, overall availability of resources can be a challenge especially in rural communities who often have less resources available to residents.

Health Literacy and Advocacy: Birthing people need more understandable information to make appropriate choices during their pregnancy, birth and after the baby is born. Participants shared that they felt providers are generally not sharing information in a way that is easily understandable and respectful. The "why" is important and the full range of options available to the birthing person were often left out in communication. Participants also shared that they felt dismissed, ignored, or minimized when asking questions or raising concerns with their healthcare providers. Women of color are experiencing this even more frequently and some shared that their interactions with their healthcare providers are different depending on who is with them at their appointment, like doulas or home visitors.



Participants shared they want more information on what is needed to keep their families healthy, like car seat safety, development of baby in pregnancy and after birth, infant CPR, Heimlich maneuver, when/how/what to feed baby, how to prepare your body for labor, pumping at work, navigating insurance, what is adequate prenatal care, where to find needed resources, how to advocate when faced with racism or provider bias with their care, etc. but don't feel it is covered by providers and do not know where else to get this information.

Social Determinants of Health: It is very evident that families in the region are experiencing factors beyond their health that have huge impacts on the health outcomes of themselves and their babies. One highlighted factor is that the cost of things like medical care, essential baby items (e.g., diapers, wipes, or formula), food for the family and housing has stressed families' budgets. Healthy food is also expensive, and access is limited in some areas. Many interviewees shared the need for food assistance services but do not qualify, and for those that do qualify, they have challenges finding the food approved by the program.

Transportation is a significant barrier. There is a lack of public transportation or ride share services in the region, especially rural areas. Participants felt transportation services are not family friendly and rarely reliable. Finding a ride to appointments prevents pregnant people from entering prenatal care sooner or attending appointments throughout pregnancy. Some share a car with their partner which means coordinating work schedules

with the appointment. Others try to get a ride from a family member which then are faced with the same problems. Some participants also shared that they could not drive themselves because of pregnancy sickness. Another noted issue was the cost of gas.

Another factor impacting health outcomes is housing. Safe, affordable housing free from bugs, mice, lead, mold, crime and other conditions is sparce. Landlords abide by laxed or flawed policies and regulations leading to poor housing conditions. Homeless shelters are at capacity. Interviewees mentioned anecdotally that many of the patients they see that enter prenatal care late (in the 2nd or 3rd trimester) is because the patients are homeless.

Safe childcare is hard to find and is even harder to afford. Hospitals do not want young kids or babies at the prenatal appointments, nor do they have childcare options like daycare at the facilities. Finding someone to watch kids during the workday is a big issue. This is a challenge for pregnant and postpartum families but was specifically noted when participants were asked what causes late entry into prenatal care.

Another factor that impacts health outcomes is language accessibility. Birthing people who speak languages other than English have added complexity to understanding forms, materials and interactions with their healthcare providers. Agencies struggle to provide individualized care and establish trusting relationships without speaking the same language. Interviewees said that it is difficult to get Hispanic and other non-English speaking pregnant people into the doctors because they don't have the resources to translate their services and spread awareness to non-English speakers about the importance of prenatal care and how to find services.

Provider Supports: Interviewees felt they needed additional support to provide optimal care to birthing people and their families. Specifically, participants mentioned the need for healthcare provider education and training in areas like health literacy, active listening, biases, and common complications like pre-eclampsia, including how to catch it much earlier. Interviewees shared that training opportunities are not equitable across hospital systems or roles within the hospital. There was a call for more systemwide training for all roles, including residents. Beyond training, interviewees noted a need for accountability for healthcare providers to practice sensitivity, remove biases and engage in proper bedside manner.

Interviewees highlighted the need for more time with their patients overall. Additionally, it was noted that providers are limited in their knowledge and ability to connect birthing

persons directly to needed community resources. Supportive roles like community health workers or care coordinators who could make those connections should be leveraged more.

Provider Shortage: A contributing factor to providers needing additional support is the shortage of providers in the region. There are not enough providers in the region to get quality care to birthing people in a timely manner. Interviewees noted that health systems are short staffed. Specifically, there are shortages for doctors, nurses, midwives, lactation consultants, childbirth educators, and physical therapists. Due to this and cost saving measures, roles in provider offices have shifted to try to accommodate additional patients with less hands-on time with doctors and nurses.

Since a birthing hospital in the region closed, there are more birthing persons seeking care at surrounding practices increasing demand for providers. Provider shortages and less areas to access care are contributing factors to long wait times for appointments and short appointment times. Additionally, in rural areas the geographic span of service providers who go into the home, like home visitors, are stretched thin.

Support for Families: Families need social support systems and paid family leave to care for themselves and their families. Participants shared they are leaning on their "village" or support systems, like family, to keep themselves and their babies healthy for things like childcare, transportation, housing, food, and information. Advocacy from their support system was particularly important during birth since it is a time when lots of decisions are being made and the birthing person is sometimes unable to advocate for themselves.

Additionally, families without paid parental leave are experiencing high stress. Families are having to use limited sick days or go unpaid for things like prenatal care appointments and during postpartum recovery. Participants shared that those who do have sick days often don't have any left for things like future doctors' appointments and if people go unpaid to attend their appointments that is an added financial stress. Participants feel, regardless of having the ability to use sick days or not, their employers do not appreciate them taking so much time away from work. For many, time off work is time without pay and they believe that sacrificing pay is worse for baby than missing doctor appointments. Having to take time from work for appointments was identified as a contributing factor to late entry to prenatal care.

Coordination of Care: It is apparent that despite best efforts, there are gaps to connecting

birthing people to care, community resources and other referrals. Participants shared stories of experiences where referrals to services were not being made or referral loops were not closed/followed up on. Additionally, when patients are referred to a service, they often don't know who the referral is being made to, so they are unable to follow up themselves. These issues are leading to people not getting needed services. Furthermore, there was an identified gap in provider and community knowledge of what community programs exist and their eligibility requirements.

Another identified challenge to coordination of care is that positions who are responsible for coordinating referrals like nurse navigators, community health workers, and care coordinators, etc. are not consistently a part of the care team who see all birthing people. It was shared that when these roles are unable to meet with all birthing people who need additional services or community resources, it removes the opportunity to create a warm point of contact. Some families do not answer calls from unknown numbers, or their phone numbers change, making them hard to reach once they leave the office. An additional challenge is in areas where more than one provider or health system is available, some birthing people bounce between systems and there is little coordination of care.

LATE ENTRY TO PRENATAL CARE

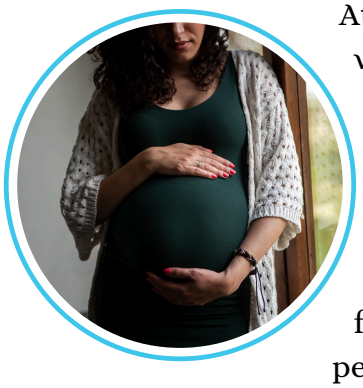
Late entry to prenatal care is defined as the first prenatal appointment between a pregnant person and a healthcare provider occurring during the 7th, 8th or 9th month of pregnancy. Data shows that Southwest Michigan has more women who enter prenatal care in their third trimester, or 7th - 9th months of pregnancy, compared to the rest of the state. Southwest Michigan has a late entry to prenatal care rate of 6.2% and the state of Michigan overall has an average of 4.1%.

When asked why pregnant people in Southwest Michigan might have a higher rate of late entry to prenatal care, participants suggested a number of challenges hindering people from seeking care. Many of these challenges aligned directly with what participants noted as challenges to keeping themselves and their babies healthy like mistrust of the healthcare system and providers, substance use and domestic abuse creating fear with seeking prenatal care, transportation barriers, homelessness, not having childcare, language barriers, not having insurance or having to take time off work. However, there were several additional barriers to seeking adequate prenatal care that were shared by participants and interviewees.

Lack of awareness of the importance: Interviewees said they thought there should be more education around the importance of getting prenatal care as soon as possible. New moms and/or young moms especially may not be aware of the importance for babies' development. As for those with subsequent pregnancies, some may feel as though they already understand the experience of pregnancy and emphasize less importance of seeking prenatal care unless something feels wrong.

Cultural and generational differences: Participants confirmed that their elder family members were surprised that they were receiving prenatal care in the first trimester and going to appointments so often. Participants shared that their family elders only believed in seeing a doctor when something felt wrong with baby, which is what they did in their youth. These generational practices are often shared with birthing people today.

Newcomers: many professionals interviewed were surprised by the high percentage of late entry to prenatal care and did not have any anecdotal experience. Those that did see new pregnant patients in their 2nd or 3rd trimester said it was usually due to them seeing a previous provider. They had moved recently (usually for work) and were looking for care closer to their new residence. These patients would likely not be included in the statistics of late entry to prenatal care since they had been seen elsewhere.



At the end of the day, pregnant people have to weigh their options while facing these barriers to decide if attending prenatal appointments are worth their time. Some believe that prenatal appointments that don't include an ultrasound or other testing are not worth the time and effort. Combined with the feeling that the appointments are very short, especially compared to the amount time it takes to drive there and wait to be seen, as well as feeling dismissed when they have questions or concerns leads people to skip or delay prenatal care.

COMMUNITY HEALTH NEEDS ASSESSMENT CHALLENGES

Challenges were pulled from a scan of existing Community Health Needs Assessments (CHNAs) from the hospitals and counties in Southwest Michigan. Themes that emerged included access to care, improving diversity, equity and inclusion (DEI) practices, addressing mental health, and specific populations to prioritize. While these themes focus on the maternal and infant population, they also apply to the general population.

The theme of access to care outlined barriers that people face when trying to get care, like a lack of available resources, people without insurance coverage, challenges getting to

appointments and services due to transportation, and a lack of preventive care. These barriers were also highlighted through the listening sessions, key partner interviews and the community town hall. Furthermore, each of these barriers to access care impacts a person's ability to begin prenatal care with a healthcare provider in their first trimester.

Community Health Needs Assessments also demonstrated mental health issues across the counties in the region. The assessments showed an increase in isolation, depression, and substance misuse. Some focus group participants in select CHNAs' primary data collection attributed this increase in diagnoses and concern to the COVID-19 pandemic. New mothers especially felt isolated and depressed during this time because they did not have community or family support to fall back on for help with their babies. Although the COVID-19 pandemic has passed, mental health still remains a challenge for birthing people in the region as outlined in the information gathering during the listening sessions, key partner interviews and community town hall event.

Improving DEI (diversity, equity, and inclusion) practices entails cultural competency, implicit bias, and accountability training. All the CHNAs detailed how systemic racism was adversely affecting Black, Indigenous, and people of color, resulting in poor health outcomes for mothers and infants. Understanding and/or acceptance of cultural differences plays a role in provider patient trust and ultimately outcomes which was also shown in the challenges that were gathered during the listening sessions, key partner interviews and the community town hall.

A number of CHNAs highlighted specifically focusing on women of color when it came to maternal and infant health, in order to decrease the adverse effects of medical and environmental racism. Generally, the needs assessments from the Southwest Michigan counties included pregnant women as a priority population. Among pregnant women, they included a need for improving maternal care for incarcerated women.

RECOMMENDATIONS

This section highlights the recurring themes in interviewee's recommendations for improving maternal and infant health outcomes in Southwest Michigan. Suggested changes centered around addressing the quality of maternal infant health programs, improving the community's social supports, and changing policy to help families meet their material needs. This section groups the most frequent suggestions into broad areas for improvement, then summarizes the key recommendations reflected in multiple interviews.

THEME	KEY RECOMMENDATION
Enhancing Quality of Maternal Infant Healthcare (MIH)	• Increase language accessibility • Invest in staff education and training • Improve procedures and practice • Expand home visiting service coverage • Increase doula services • Improve appointment availability and access • Increase collaboration between MIH programs and agencies
Improvements to Community Supports	• Reduce resource gaps in rural counties • Centralize MIH information and resources • Support family's material necessities • Increase community outreach • Broaden the types of education resources • Expand home-visit services • Increase the availability and accessibility of peer support groups • Generate educational resources on the transition to parenthood
Policy Changes & Advocacy	• Support advocacy for housing and transportation improvements • Support policies that address systematic barriers to maternal-infant health • Advocate for family-friendly work policies • Amend restrictive financial eligibility requirements for MIH programs and services • Expand childcare options and availability for the region • Support community-based organizations

ENHANCING QUALITY OF MATERNAL INFANT HEALTHCARE (MIH)

Language accessibility: Hire translators or community members to serve as translators for patients during health appointments. Translate existing MIH resources into the different languages spoken in the region.

Staff education and training: Fund training on respectful communication and responsive healthcare practices to reduce poor relationships between patients and providers. Invest in training programs aimed at improving birth outcomes (e.g. Spinning Babies, maternal care patient simulators). Increase the availability of Maternal Infant Health Program (MIHP) and change policies hindering the accessibility of the MIHP certification (e.g. missing the once annual orientation seminar means you can't become a MIHP provider that year).

Require training for all healthcare providers, including medical assistants and community health workers, on social determinants of health, implicit bias, health literacy and active listening to improve quality of care.

Procedures and practice: Local hospitals should adopt and implement the Michigan Alliance for Innovation on Maternal Health (MI AIM) patient safety bundles to improve perinatal health outcomes. Train medical professionals on identifying risk-factors and warning sides of hypertensive disorders and the main causes of maternal death. Standardize evaluations of pregnant persons in hospitals to more quickly identify perinatal risk factors and health complications. Develop education initiatives for medical professionals to identify maternal mental health needs and support maternal mental wellness.

Expand areas of service provision: Invest in hiring and well-compensate home-visiting staff; increase hiring of home visiting nurses and counselors as they are routinely made to cover multiple counties. Fund doula training and certification programs to improve the availability and quality of doula services in the region. Increase the accessibility of doulas for perinatal care. Include doulas on birthing team. Expand healthcare access in rural counties; rural areas lack birthing hospitals and must travel long distances for specialized care and sometimes even basic perinatal care.

Increase appointment accessibility by reducing wait times for appointments. Offer appointments at various times allowing more availability for different schedules. Develop child friendly spaces or childcare options at doctors' offices to reduce barriers to parents attending MIH programs, services, and appointments.

IMPROVEMENTS TO COMMUNITY SUPPORTS

Resource availability and accessibility: Reduce resource gaps in rural counties: Increase the number and quality of supportive services and programs available in rural counties. Program availability varies by county, internet accessibility; there is a lack in consistency in the availability of services across the region, particularly in less densely populated areas.

Centralize maternal infant health information and resources: Develop a centralized hub to house information about local maternal infant health educational resources, programs and services.

Support family's material necessities: Increase the availability of physical incentives and increase distribution of material necessities to families (i.e. baby clothes, baby food and formula, diapers, wipes, pack and plays, car seats, gas cards, coupons, and vouchers).

Increase community outreach for available programs and resources: Enlist trusted community members to engage the community and disseminate information to members of the community most in need of resources.

Increase the types of educational resources available: Offer a wider variety of educational information and courses (e.g. car seat modeling, fatherhood programs, patient self-advocacy, parenting skills, infant milestones, CPR courses, nutrition, physical and mental health and wellness). Offer courses at different times and in different modes to make attendance easier for people with multiple children or work commitments. Offer courses in multiple languages or with translators available for non-English speakers. Increase lactation support and education in hospitals.

Greater support for the postpartum period: Offer home visits by nurses especially after a c-section, birth complications, families with significant time burdens/scheduling difficulties. Increase the number of peer support groups to support postpartum needs (i.e. infant milestones, parenting skills, lactation support, mental health and wellness). Create resources that set new parents up for success in the postpartum period, that specifically focus on parent-child postpartum needs.

Educate on postpartum depression and anxiety (including the differences between postpartum and general depression) and offer behavioral health support around postpartum mental health. Develop lactation resources specific to pumping: Offer more information about when and how much to pump, as well as how much baby should eat. Provide resources on how to manage pumping when going back to work, education on how to request accommodations at work; and how to advocate for workplaces to have more family inclusive practices (i.e. pumping rooms, pumping breaks).

POLICY CHANGES & ADVOCACY

Address living conditions that contribute to health outcomes
Support access to safe, affordable housing and reliable transportation (i.e. a county wide bus program). Hold landlords accountable for clean and safe living spaces. Invest in reducing homelessness; fund more family-friendly shelters, invest in affordable housing efforts. Support policies that address upstream barriers to maternal infant health.

Advocate for policies that alleviate cost of living burdens on families; support guaranteed income for parents of infants; advocate for public transportation improvements for the region. Amend restrictive financial eligibility requirements for supportive social programs to increase the families who need but aren't eligible for programs like Early On, WIC, Medicaid.

Advocate for child-friendly work policies such as flexibility in work scheduling for parents. Advocate for policies that support breastfeeding / pumping in the workplace. Support paid parental leave advocacy efforts. Expand childcare options for the region; local childcare options are slim and expensive.

Support the work of grassroots and community-based organizations. Hire staff from the local community to carry out community work.

RECOMMENDATION CROSSWALK

A crosswalk of the challenges identified through data collection connected to recommendations outlined in this report was created and can be found in Appendix B. Challenges that frequently arose over various data collection methods are highlighted in a darker shade of purple. This crosswalk is a tool that can be used to help SWMPQIC consider recommendations from the community when tackling regional challenges.

In August, SWMPQIC held a quarterly collaborative meeting where the challenges identified from the various forms of data collection were shared with collaborative members. Collaborative members separated into facilitated breakout groups and provided reactions and recommendations to the challenges shared. Those recommendations are also included in the crosswalk of the challenges and specific solutions that could be done to address those challenges.

CONCLUSION

The Southwest Michigan Perinatal Quality Improvement Collaborative has a unique opportunity to use the information gathered through the community health needs assessment scan, listening sessions, key partner interviews, and community town hall event to leverage existing community supports and create innovative solutions to address challenges leading to poor maternal and infant health outcomes. Using the information in this report will help the collaborative address the needs that are most important to the community, help establish partnerships with agencies in the region who are also closely tied to the work, and to improve outcomes for birthing people and families throughout Southwest Michigan.

Appendix A

List of supportive community programs and agencies identified through data collection.

- 20 Hands
- 2-1-1
- Ascension
- Baby Café
- BCGo Transit, Battle Creek
- Beginning of Care life Center
- Berrien County Health Department
- Berrien Regional Education Service Agency (RESA)
- Birth Kalamazoo
- Birth Queens
- Branch County Maternal Infant Health programs
- Breastfeeding Peers (part of WIC)
- Bronson Programs
- Burma Center in Calhoun County
- Calhoun County Playgroups
- Calhoun County Public Health Department
- Cass Family Clinic
- Centering Pregnancy
- Children Special Healthcare Services
- Children's Special Health Care Services
- CHIP-Kellog Community Foundation
- Cradle
- DHHS programs
- Double Up
- Dreamer
- Early Head Start
- Early On
- Family Links
- Feeding America
- Fetal Infant Mortality Review (FIMR)
- Food Bucks
- Fruitful Lactation
- Go Dan Cab
- Great Start Collaborative
- Healthy Babies, Healthy Start
- Healthy Families America (HFA)
- Healthy Starts

- Helping Hands
- InterCare
- International Board-Certified Lactation Consultants (IBCLC)
- Kalamazoo County Health and Community Services
- Life Plan
- Linked
- Loaves and Fishes (formerly Friday Groceries)
- Maternal Infant Health Program (MIHP)
- Medicaid
- Meridian
- MI AIM Safety Bundles
- MI Bridges
- Milk Like Mine
- Milk Queens
- Mothers of Preschoolers (MOPS)
- Nook Like Mine
- Nurse Family Partnership (NFP)
- Oaklawn Medical group
- Parents as Teachers
- Parents as Teachers Program
- Pokagon Health Services - Healthy Start Home Visiting
- Pokagon Health Services- Food Pharmacy.
- Project Access
- Reproductive Health Fund
- Rooted
- Rx Kids
- Seeds 4 Success
- Senior Project Fresh
- Silver Linings MIHP
- Similac Coupon Rewards
- SNAP (food stamps)
- Supplemental Nutrition Assistance Program (SNAP)
- SWMPQIC
- Teen Hope Parent Resource Center
- The Burma Center
- Title X program
- Van Buren County Programs
- Voces
- WIC (Special Supplemental Nutrition Program for Women Infants & Children)
- Women's Life Recovery program (the Haven)
- YWCA

Appendix B

CHALLENGES	RECOMMENDATIONS
Women experience physical challenges staying healthy some within their control like eating healthy, exercising and avoiding substances while other challenges are more outside of their control. Participants wanted more knowledge to make their own healthy choices in pregnancy and parenthood.	Improvements to Community Supports • **Centralize maternal infant health information and resources**: Develop a centralized hub to house information about local maternal infant health educational resources, programs and services. • **Increase the types of educational resources available**: Offer a wider variety of educational information and courses (e.g. car seat modeling, fatherhood programs, patient self-advocacy, parenting skills, infant milestones, CPR courses, nutrition, physical and mental health and wellness) at different times and in different modes to make attendance easier for people with multiple children or work commitments. • **Greater support for the postpartum period:** Increase the number of peer support groups to support pregnancy and postpartum needs. • **Greater support for the postpartum period:** Develop lactation resources specific to pumping: Offer more information about when and how much to pump, as well as how much baby should eat. Recommendations from SWMPQIC Quarterly Collaborative Meeting • Provide content on SWMPQIC's social media and/or website on topics identified as important by those in the region.
Birthing persons who use substances during pregnancy can be more reluctant to trust and share this information with providers or home visitors.	Quality of Maternal Infant Healthcare • **Procedures and practice**: Develop education initiatives for medical professionals to identify maternal mental health needs and support maternal mental wellness. Improvements to Community Supports • **Increase community outreach for available programs and resources:** Enlist trusted community members to engage the community and disseminate information to members of the community most in need of resources. Recommendations from SWMPQIC Quarterly Collaborative Meeting • Address the root causes that lead pregnant and postpartum people to self-medicate with substances. • Promote harm reduction approaches to substance use, specifically cannabis.

CHALLENGES	RECOMMENDATIONS
Postpartum checkups are typically 6 weeks following birth which is too far and infrequent to catch problems as they arise or connect to resources.	Enhancing Quality of Maternal Infant Healthcare (MIH) • **Foster collaboration and improve communication between MIH agencies and services:** Improve care coordination between and within healthcare organizations and MIH programs. • **Foster collaboration and improve communication between MIH agencies and services:** Increase follow-ups with patients between appointments. • **Foster collaboration and improve communication between MIH agencies and services:** Improve communication between home visiting services and medical provider to more quickly coordinate healthcare concerns. • **Staff education and training:** Increase the availability of the Maternal Infant Health Program (MIHP) and increase hiring of home visiting nurses and counselors. Improvements to Community Supports • **Greater support for the postpartum period:** Offer home visit services, a doula, a nurse or a visit from a community health worker to check in on and connect people to needed resources prior to the 6 week postpartum appointment, especially for families who experience c-section, birth complications, families with significant time burdens or scheduling difficulties. • **Greater support for the postpartum period:** Increase the number of peer support groups to support postpartum needs (i.e. infant milestones, parenting skills, lactation support, mental health and wellness). • **Greater support for the postpartum period:** Create resources that set new parents up for success in the postpartum period, that specifically focus on parent-child postpartum needs. • **Greater support for the postpartum period:** Educate on postpartum depression and anxiety (including the differences between postpartum and general depression) and offer behavioral health support around postpartum mental health. Recommendations from SWMPQIC Quarterly Collaborative Meeting • Advocate for policy changes to reduce the time between birth and the postpartum check up. • Create and test out innovative strategies to get postpartum patients to care prior to 6 weeks. • Establish a community advocate, that is not tied to the hospital system, who connects with moms after giving birth on their emotional, mental, and physical health. • Create a system where mom and baby are seen by a health care provider together during the postpartum period. • Expand training opportunities aimed at catching perinatal complications earlier beyond healthcare provider offices to community agencies.

CHALLENGES	RECOMMENDATIONS
There is a lack or perceived lack of mental health resources like support groups or services and existing mental health services are at capacity.	Improvements to Community Supports • **Centralize maternal infant health information and resources:** Develop a centralized hub to house information about local maternal infant health educational resources, programs and services. • **Greater support for the postpartum period:** Increase the number of peer support groups to support postpartum needs (i.e. infant milestones, parenting skills, lactation support, mental health and wellness). • **Greater support for the postpartum period:** Create resources that set new parents up for success in the postpartum period, that specifically focus on parent-child postpartum needs. • **Greater support for the postpartum period:** Educate on postpartum depression and anxiety (including the differences between postpartum and general depression) and offer behavioral health support around postpartum mental health.
The process of screening mental health during the pregnancy and postpartum period and connecting people to needed services needs improvement.	Enhancing Quality of Maternal Infant Healthcare (MIH) • **Procedures and practice:** Standardize evaluations of pregnant persons in hospitals to more quickly identify perinatal risk factors and health complications. • **Procedures and practice:** Develop education initiatives for medical professionals to identify maternal mental health needs and support maternal mental wellness. • **Procedures and practice:** Conduct mental health screening at other service touch points and improve care coordination between and within healthcare organizations and MIH programs. • **Expand areas of service provision:** Offer home visit services or a visit from a community health worker to connect people to needed resources prior to the 6 week postpartum appointment. Improvements to Community Supports • **Greater support for the postpartum period:** Create resources that set new parents up for success in the postpartum period, that specifically focus on parent-child postpartum needs. • **Greater support for the postpartum period:** Educate on postpartum depression and anxiety (including the differences between postpartum and general depression) and offer behavioral health support around postpartum mental health. Recommendations from SWMPQIC Quarterly Collaborative Meeting • Establish a community advocate, that is not tied to the hospital system, who connects with moms after giving birth on their emotional, mental, and physical health. • Screen the birthing person for mental health and check their blood pressure at every pediatrician appointment.

CHALLENGES	RECOMMENDATIONS
Provider offices have limited appointments and wait times are long, especially for first appointments.	Enhancing Quality of Maternal Infant Healthcare (MIH) • **Expand areas of service provision:** Increase appointment accessibility by reducing wait times for appointments. • **Expand areas of service provision:** Offer appointments at various times allowing more availability for different schedules. • **Foster collaboration and improve communication between MIH agencies and services:** Increase follow-ups with patients between appointments. Recommendations from SWMPQIC Quarterly Collaborative Meeting • Create a system where mom and baby are seen by a health care provider together during the postpartum period. • Provide access to a doula and/or home visitor for every perinatal person in the region. • Expand hours of providers offices or offer after hours walk in clinics. • Provide education to explain the different roles and abilities in pregnancy and birth work to allow people to make the choices of who they want to see for their care (e.g. Obstetrician (OB), Midwife, Doula, etc.)
Geographic proximity to provider offices is poor for some part of the region. Added distance traveled requires more time off work and added transportation issues.	Enhancing Quality of Maternal Infant Healthcare (MIH) • **Staff education and training:** Increase the availability of the Maternal Infant Health Program (MIHP) and increase hiring of home visiting nurses and counselors. • **Expand areas of service provision:** Increase the accessibility of doulas for perinatal care. Improvements to Community Supports • **Resource availability and accessibility:** Expand healthcare access in rural counties; rural areas lack birthing hospitals and must travel long distances for specialized care and sometimes even basic perinatal care. • **Resource availability and accessibility:** Increase the number and quality of supportive services and programs available in rural counties. • **Resource availability and accessibility:** Expand internet access in rural communities and leverage telehealth appointments. Recommendations from SWMPQIC Quarterly Collaborative Meeting • Work with agencies who provide transportation services directly to connect patients or clients with transportation barriers preventing them from attending appointments. • Provide access to a doula and/or home visitor for every perinatal person in the region. • Create a system where mom and baby are seen by a health care provider together during the postpartum period.

CHALLENGES	RECOMMENDATIONS
Access to a doula is limited be cost, availability, geographic location, and policy.	Quality of Maternal Infant Healthcare • **Expand areas of service provision:** Fund doula training and certification programs to improve the availability and quality of doula services in the region. • **Expand areas of service provision:** Increase the accessibility of doulas for perinatal care. • **Expand areas of service provision:** Include doulas on birthing team. • **Expand areas of service provision:** Expand healthcare access in rural counties; rural areas lack birthing hospitals and must travel long distances for specialized care and sometimes even basic perinatal care. Policy Changes & Advocacy • **Address living conditions that contribute to health outcomes:** Support the work of grassroots and community-based organizations. Recommendations from SWMPQIC Quarterly Collaborative Meeting • Expand insurance coverage for doulas to allow them to remain independent from the hospital systems.
Healthcare providers need greater awareness of common complications like preeclampsia or postpartum depression and how to catch it earlier.	Enhancing Quality of Maternal Infant Healthcare (MIH) • **Procedures and practice:** Local hospitals should adopt and implement the Michigan Alliance for Innovation on Maternal Health (MI AIM) patient safety bundles to improve perinatal health outcomes. • **Procedures and practice:** Train medical professionals on identifying risk-factors and warning sides of hypertensive disorders and the main causes of maternal death. • **Procedures and practice:** Standardize evaluations of pregnant persons in hospitals to more quickly identify perinatal risk factors and health complications. Recommendations from SWMPQIC Quarterly Collaborative Meeting • Continue to provide space for engagement and dialogue between MIH agencies, healthcare organizations and the community. • Expand training opportunities aimed at catching perinatal complications earlier beyond healthcare provider offices to community agencies.
Establishing trust with a provider is challenging when appointments are fast and patients aren't seeing providers who look like them.	Enhancing Quality of Maternal Infant Healthcare (MIH) • **Expand areas of service provision:** Invest in the workforce pipeline and hiring of diverse health care providers in the region. • **Expand areas of service provision:** Compensate diverse health care providers appropriately and create environments where providers want to remain.

CHALLENGES	RECOMMENDATIONS
Health systems are short staffed. Provider shortages are a contributing factor to long wait times for appointments and short appointment times.	Enhancing Quality of Maternal Infant Healthcare (MIH) • **Expand areas of service provision:** Invest in the workforce pipeline and hiring of diverse health care providers in the region. • **Expand areas of service provision:** Compensate diverse health care providers appropriately and create environments where providers want to remain.
Providers need more time with their patients. Roles in providers offices have shifted to try to accommodate additional patients with less hands on time with doctors and nurses.	Enhancing Quality of Maternal Infant Healthcare (MIH) • **Foster collaboration and improve communication between MIH agencies and services:** Improve care coordination between and within healthcare organizations and MIH programs. Recommendations from SWMPQIC Quarterly Collaborative Meeting • Provide access to a doula and/or home visitor for every perinatal person in the region. • Explore and advocate for strategies that reduce the fiscal and administrative burden that more time with patients causes.
Since a birthing hospital closed in the region, there are more birthing people seeking care at surrounding practices.	Improvements to Community Supports • **Resource availability and accessibility:** Increase the number and quality of supportive services and programs available in rural counties.
Birthing people often feel dismissed, ignored, or minimized when asking questions or raising concerns, especially people of color.	Enhancing Quality of Maternal Infant Healthcare (MIH) • **Staff education and training:** Offer/fund training on respectful communication and responsive healthcare practices to reduce poor relationships between patients and providers. Recommendations from SWMPQIC Quarterly Collaborative Meeting • SWMPQIC should continue to be a bridge between the community, MIH agencies and healthcare organizations through information sharing opportunities (e.g. listening sessions, town hall). • Create mechanisms for birthing people to share their experiences, good and bad, and have those experiences be validated and acted upon by the health care system. • Create health literacy and advocacy materials and incorporate those for materials into the existing Birth and Beyond educational classes and on the website. • Share the process for filing a complaint at each of the birthing hospitals in the region. • Explore the complaint process with each of the birthing hospitals to identify how the complaint is reviewed, how actions are taken, and how that information is shared back with whomever filed the complaint. • Provide education to explain the different roles and abilities in pregnancy and birth work to allow people to make the choices of who they want to see for their care (e.g. Obstetrician (OB), Midwife, Doula, etc.)

CHALLENGES	RECOMMENDATIONS
Providers are not sharing information in a way that is easily understood and respectful. The "why" something is important and available options is often missing from provider communication.	Enhancing Quality of Maternal Infant Healthcare (MIH) • **Staff education and training:** Offer/fund training on respectful communication and responsive healthcare practices to reduce poor relationships between patients and providers. • **Staff education and training:** Offer/fund provider training on strategies for shared decision making and health literacy.
Providers are not receiving adequate education and training on health literacy, active listening, bedside manner, sensitivity, and implicit biases with accountability to practice those concepts. Current training opportunities are not equitable across hospital systems and roles within the hospital.	Enhancing Quality of Maternal Infant Healthcare (MIH) • **Staff education and training:** Encourage training for all healthcare providers, including medical assistants, community health workers and residents, on the social determinants of health, implicit bias, strategies for shared decision making, health literacy and active listening to improve quality of care. Recommendations from SWMPQIC Quarterly Collaborative Meeting • Offer training to providers on the value added and improved outcomes when patients having an advocate, like a doula, present.
Awareness of available community resources and their eligibility requirements is not consistent and there is no centralized location to identify services. Agencies struggle to get information to those who need it in a way that they trust the message.	Enhancing Quality of Maternal Infant Healthcare (MIH) • **Foster collaboration and improve communication between MIH agencies and services:** Increase coordination of care between MIH organizations. Improvements to Community Supports • **Centralize maternal infant health information and resources:** Develop a centralized hub to house information about local maternal infant health educational resources, programs and services. • **Increase community outreach for available programs and resources:** Enlist trusted community members to engage the community and disseminate information to members of the community most in need of resources. Recommendations from SWMPQIC Quarterly Collaborative Meeting • Provide more information and resources online, where young people often look. • Offer home visit services or a visit from a community health worker to connect people to needed resources prior to the 6 week postpartum appointment. • Continue to share county specific resources on the SWMPQIC website.

CHALLENGES	RECOMMENDATIONS
Providers are limited in their knowledge and ability to connect birthing persons to needed resources in the community.	Enhancing Quality of Maternal Infant Healthcare (MIH) • **Foster collaboration and improve communication between MIH agencies and services:** Use discharge instructions to connect parents to resources. • **Foster collaboration and improve communication between MIH agencies and services:** Improve care coordination between and within healthcare organizations and MIH programs. Improvements to Community Supports • **Centralize maternal infant health information and resources:** Develop a centralized hub to house information about local maternal infant health educational resources, programs and services. • **Increase community outreach for available programs and resources:** Enlist trusted community members to engage the community and disseminate information to members of the community most in need of resources. Recommendations from SWMPQIC Quarterly Collaborative Meeting • Offer home visit services, a doula, or a visit from a community health worker to connect people to needed resources prior to the 6 week postpartum appointment. • Embed community health workers and doulas into hospitals and provider offices. • Provide access to a doula and/or home visitor for every perinatal person in the region. • A mechanism at birthing hospitals and provider offices that identify what needs to be in place before a pregnant or postpartum person can return home safely. • Continue to share county specific resources on the SWMPQIC website. • Offer training to providers on the value added and improved outcomes when patients having an advocate, like a doula, present.
Roles who are responsible for making referrals and closing the referral loops are not seen as a part of the care team for all birthing people or providing warm handoffs.	Enhancing Quality of Maternal Infant Healthcare (MIH) • **Foster collaboration and improve communication between MIH agencies and services:** Improve care coordination between and within healthcare organizations and MIH programs. • **Foster collaboration and improve communication between MIH agencies and services:** Increase follow-ups with patients between appointments. • **Foster collaboration and improve communication between MIH agencies and services:** Improve communication between home visiting services and medical provider to more quickly coordinate healthcare concerns.

CHALLENGES	RECOMMENDATION
Eligibility requirements to access services can be restricting. This leaves out individuals who may need the services but are ineligible which causes stigma for those who do qualify.	Improvements to Community Supports • **Support family's material necessities:** Increase the availability of physical incentives and increase distribution of material necessities to families (i.e. baby clothes, baby food and formula, diapers, wipes, pack and plays, car seats, gas cards, coupons, and vouchers). Policy Changes & Advocacy • **Address living conditions that contribute to health outcomes:** Amend restrictive financial eligibility requirements for supportive social programs to increase the families who need but aren't eligible for programs like Early On, WIC, Medicaid. Recommendations from SWMPQIC Quarterly Collaborative Meeting • Provide access to a doula and/or home visitor for every perinatal person in the region.
Lack of insurance or the type of insurance lead to disparities in quality and access to care.	Recommendations from SWMPQIC Quarterly Collaborative Meeting • Remove barriers and red tape that make public insurance less desirable for providers/ health systems. • Educate provider offices and patients on their changing insurance while advocating for consistency.
People who speak languages other than English have added complexity navigating healthcare services and communicating with providers.	Enhancing Quality of Maternal Infant Healthcare (MIH) • **Language Accessibility:** Hire translators or community members to serve as translators for patients during health appointments. • **Language Accessibility:** Translate existing MIH resources into the different languages spoken in the region. Improvements to Community Supports • **Increase Community Outreach for Available Programs and Resources:** Enlist trusted community members to engage the community and disseminate information to members of the community most in need of resources. • Offer a wider variety of educational information and courses (e.g. car seat modeling, fatherhood programs, patient self-advocacy, parenting skills, infant milestones, CPR courses, nutrition, physical and mental health and wellness) in multiple languages or with translators available for non-English speakers. Recommendations from SWMPQIC Quarterly Collaborative Meeting • Identify ways to get After Visit Summaries in languages other than English.

CHALLENGES	RECOMMENDATION
Geographic span of service provision leaves home visitors and other providers who visit the home stretched thin.	Enhancing Quality of Maternal Infant Healthcare (MIH) • **Staff education and training:** Increase the availability of Maternal Infant Health Program (MIHP) and change policies hindering the accessibility of the MIHP certification (e.g. missing the once annual orientation seminar means you can't become a MIHP provider that year). • **Expand areas of service provision:** Invest in hiring and well-compensate home-visiting staff; increase hiring of home visiting nurses and counselors as they are routinely made to cover multiple counties. Improvements to Community Supports • **Resource availability and accessibility:** Increase the number and quality of supportive services and programs available in rural counties. • **Resource availability and accessibility:** Expand internet access in rural communities and leverage telehealth appointments. • **Increase community outreach for available programs and resources:** Enlist trusted community members to engage the community and disseminate information to members of the community most in need of resources.
Rural communities have less resources available to residents.	Improvements to Community Supports • **Resource availability and accessibility:** Increase the number and quality of supportive services and programs available in rural counties. Recommendations from SWMPQIC Quarterly Collaborative Meeting • Provide access to a doula and/or home visitor for every perinatal person in the region.
Costs of things like medical care, essential baby items, food for the family and housing is stressing families budgets.	Improvements to Community Supports • **Support family's material necessities:** Increase the availability of physical incentives and increase distribution of material necessities to families (i.e. baby clothes, baby food and formula, diapers, wipes, pack and plays, car seats, gas cards, coupons, and vouchers). Policy Changes & Advocacy • **Address living conditions that contribute to health outcomes:** Advocate for policies that alleviate cost of living burdens on families, like guaranteed income for parents of infants. • **Address living conditions that contribute to health outcomes:** Support the work of grassroots and community-based organizations working to improve this challenge. Recommendations from SWMPQIC Quarterly Collaborative Meeting • Connect families to formula companies who offer free formula, like Abbott.

CHALLENGES	RECOMMENDATION
Families without paid parental leave are experiencing high stress having to use sick time or go unpaid for appointments or postpartum.	Policy Changes & Advocacy • **Address living conditions that contribute to health outcomes:** Advocate for policies that alleviate cost of living burdens on families, like guaranteed income for parents of infants. • **Address living conditions that contribute to health outcomes:** Advocate for child-friendly work policies such as flexibility in work scheduling for parents. • **Address living conditions that contribute to health outcomes:** Support paid parental leave advocacy efforts. Recommendations from SWMPQIC Quarterly Collaborative Meeting • Create a system where mom and baby are clinically seen together during the postpartum period.
Employers don't always offer the time off needed to adequately recover from birth or provide the needed supports, like time and places to pump.	Improvements to Community Supports • **Greater support for the postpartum period:** Provide resources on how to manage pumping when going back to work, education on how to request accommodations at work; and how to advocate for workplaces to have more family inclusive practices (i.e. pumping rooms, pumping breaks). Policy Changes & Advocacy • **Address living conditions that contribute to health outcomes:** Advocate for policies that alleviate cost of living burdens on families, like guaranteed income for parents of infants. • **Address living conditions that contribute to health outcomes:** Advocate for policies that support breastfeeding / pumping in the workplace.
Public transportation or ride share services are sparce or unreliable.	Improvements to Community Supports • **Resource availability and accessibility:** Increase the number and quality of supportive services and programs available in rural counties. Policy Changes & Advocacy • **Address living conditions that contribute to health outcomes:** Support access to safe, affordable housing and reliable transportation (i.e. a county wide bus program). • **Address living conditions that contribute to health outcomes:** Advocate for public transportation improvements for the region. • **Address living conditions that contribute to health outcomes:** Support the work of grassroots and community-based organizations working to improve this challenge. Recommendations from SWMPQIC Quarterly Collaborative Meeting • Review policies to address inequities, like late policies for patients who rely on public transit and which have restrictive times and bus lines.

CHALLENGES	RECOMMENDATION
Healthy food is expensive and inaccessible in some areas in the region. Many people who need them don't qualify for food assistance programs or those who participate in the programs have trouble finding foods approved by the program.	Improvements to Community Supports • **Support family's material necessities:** Increase the availability of physical incentives and increase distribution of material necessities to families (i.e. baby clothes, baby food and formula, diapers, wipes, pack and plays, car seats, gas cards, coupons, and vouchers). • **Greater support for the postpartum period:** Develop lactation resources specific to pumping: Offer more information about when and how much to pump, as well as how much baby should eat. Policy Changes & Advocacy • **Address living conditions that contribute to health outcomes:** Amend restrictive financial eligibility requirements for supportive social programs to increase the families who need but aren't eligible for programs like Early On, WIC, Medicaid. • **Address living conditions that contribute to health outcomes:** Support the work of grassroots and community-based organizations working to improve this challenge. Recommendations from SWMPQIC Quarterly Collaborative Meeting • Connect families to formula companies who offer free formula, like Abbott. • Explore strategies to connect all families to lactation support.
Safe, affordable housing free from hazards is sparce. Landlords are not held accountable and shelters are at capacity.	Policy Changes & Advocacy • **Address living conditions that contribute to health outcomes:** Support access to safe, affordable housing and reliable transportation (i.e. a county wide bus program). • **Address living conditions that contribute to health outcomes:** Hold landlords accountable for clean and safe living spaces. • **Address living conditions that contribute to health outcomes:** Invest in reducing homelessness; fund more family-friendly shelters, invest in affordable housing efforts. • **Address living conditions that contribute to health outcomes:** Support the work of grassroots and community-based organizations working to improve this challenge. Recommendations from SWMPQIC Quarterly Collaborative Meeting • Increase partnerships between SWMPQIC and agencies in the region working on housing, both homelessness and substandard housing.

CHALLENGES	RECOMMENDATION
Safe childcare is hard to find and is even harder to afford. Children are not welcomed at appointments so childcare is needed to attend.	Enhancing Quality of Maternal Infant Healthcare (MIH) • **Expand areas of service provision:** Develop child friendly spaces or childcare options at doctors' offices to reduce barriers to parents attending MIH programs, services, and appointments. Policy Changes & Advocacy • **Address living conditions that contribute to health outcomes:** Expand childcare options for the region. • **Address living conditions that contribute to health outcomes:** Support the work of grassroots and community-based organizations working to improve this challenge. Recommendations from SWMPQIC Quarterly Collaborative Meeting • Revise agency policy to welcome children at appointments with the birthing/postpartum person.