MAP to Action
Resources: Data

View Recording of This Session: https://youtu.be/d3LXydHqw8E

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NAACP Maternal Experience Survey

Pre-Reading Materials

MAP to Action Work Session
January 27, 2023 at 10:00AM

Survey Data: *1/26/2021 – 1/4/2023*

Implementation Activities: January 2020 – January 2023

Report Date:

1/19/2023

Most Recent Survey End Date:

1/4/2023

Statewide Data:
Live Births: Statewide & Essex County

2020 Statewide Live Births						
# Live Births, All Races/ Ethnicities	**# Live Births** Black, non-Hispanic	**% of Live Births** Black, non-Hispanic	**# Live Births** White, non-Hispanic	**% of Live Births** White, non-Hispanic	**# Live Births** Hispanic (of any race)	**% of Live Births** Hispanic (of any race)
97,146	12,587	**12.9%**	43,392	**44.6%**	27,074	**27.9%**

2020 Essex County Live Births						
# Live Births, All Races/ Ethnicities	**# Live Births** Black, non-Hispanic	**% of Live Births** Black, non-Hispanic	**# Live Births** White, non-Hispanic	**% of Live Births** White, non-Hispanic	**# Live Births** Hispanic (of any race)	**% of Live Births** Hispanic (of any race)
9,618	3,684	**38.3%**	2,091	**21.7%**	2,869	**29.8%**

Data Source: 2020 Birth Data from New Jersey Birth Certificate Database. Retrieved on Jul 5, 2022. Data Last Updated by NJSHAD May 2022 from New Jersey Department of Health, New Jersey State Health Assessment Data website: https://www-doh.state.nj.us/doh-shad/query/result/birth`/BirthBirthCnty/Count.html

Statewide Data:
Live Births: Atlantic County & Camden County

2020 Atlantic County Live Births						
# Live Births, All Races/ Ethnicities	**# Live Births** Black, non-Hispanic	**% of Live Births** Black, non-Hispanic	**# Live Births** White, non-Hispanic	**% of Live Births** White, non-Hispanic	**# Live Births** Hispanic (of any race)	**% of Live Births** Hispanic (of any race)
2,789	502	**18.0%**	1,172	**42.0%**	805	**28.9%**

2020 Camden County Live Births						
# Live Births, All Races/ Ethnicities	**# Live Births** Black, non-Hispanic	**% of Live Births** Black, non-Hispanic	**# Live Births** White, non-Hispanic	**% of Live Births** White, non-Hispanic	**# Live Births** Hispanic (of any race)	**% of Live Births** Hispanic (of any race)
5,716	1,142	**20.0%**	2,490	**43.6%**	1,494	**26.1%**

Data Source: 2020 Birth Data from New Jersey Birth Certificate Database. Retrieved on Jul 5, 2022. Data Last Updated by NJSHAD May 2022 from New Jersey Department of Health, New Jersey State Health Assessment Data website: https://www-doh.state.nj.us/doh-shad/query/result/birth`/BirthBirthCnty/Count.html

Why MES?

In Fall 2019, the Prematurity Prevention Initiative (PPI), a program of Family Health Initiatives, and NAACP Atlantic City Branch collaborated to form the Black Infant and Maternal Mortality (BIMM) task force.
A collaborative team of community members and leaders organized deliverables, such as the Maternal Experience Survey, to build a community-level action response to inequities and birthing injustices in New Jersey.

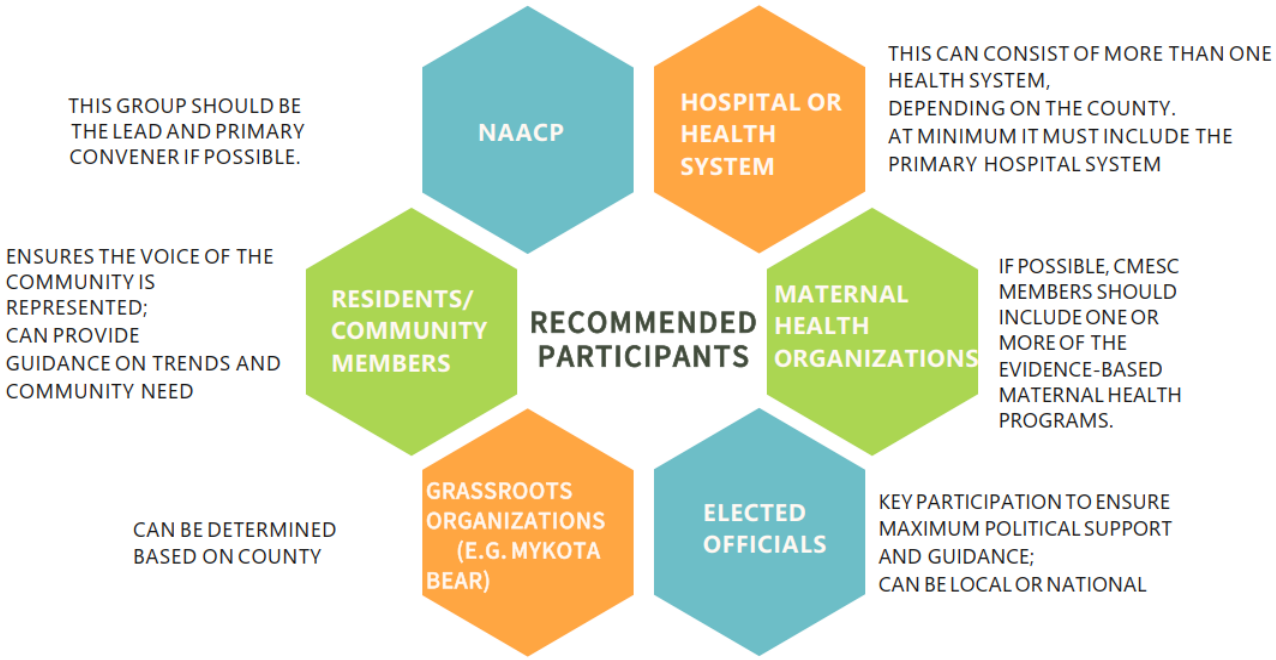
Tell Your Story

Thinking about the words you checked off in the last question, please use the box below if you would like to **tell your story about your labor, delivery, and birth experience.**

If you need support after answering any questions on this survey, please text NJ to 741741 for 24/7 crisis support.

In 2021, Prematurity Prevention Initiative and NAACP Black Infant and Maternal Mortality task force strategically launched the MES in 3 New Jersey counties that face the highest rates of Black maternal and infant mortality and prematurity- Atlantic (January 2021), Essex (August 2021), and Camden (December 2021) Counties.

Survey Implementation:
County MES Committee Membership



County MES Committee Membership

The participant categories above should be fully represented as part of the CMESC membership prior to launch. It will be at the discretion of the committee to determine roles and responsibilities.

Maternal Experience Survey Advisory Board

As the Maternal Experience Survey launches in New Jersey counties, advisory board members are identified to support outreach and advisement strategies. Maternal Experience Survey advisory boards include members of the NAACP, hospital and health systems, maternal health organizations, elected officials, grassroot organizations, and community members. Advisory board members meet quarterly to amplify efforts of the survey.

Survey Implementation:
Community Engagement

The Maternal Experience Survey has officially launched in 3 New Jersey Counties.

The MES launched in **Atlantic County** on January 26, 2021, **Essex County** on August 26, 2021, and in **Camden County** on December 7, 2021.

In June 2022, a **Central New Jersey** region MES Advisory Board was formed. The MES will launch in Central New Jersey in early 2023.

Successful Engagement Processes

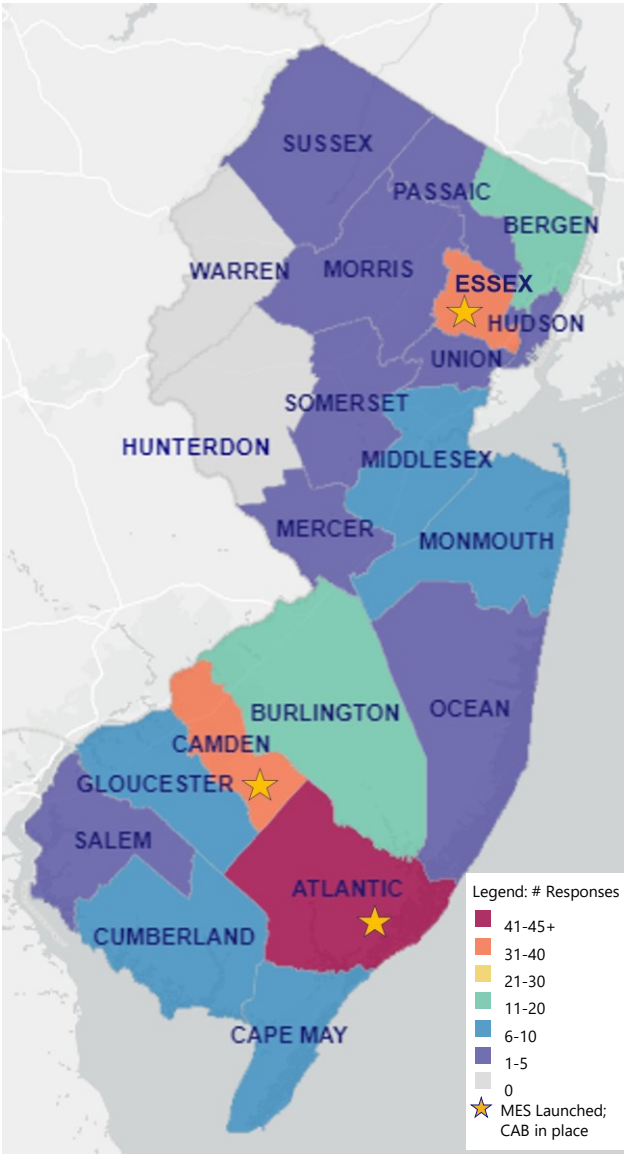
Key outreach successes toward Maternal Experience Survey completions consist of collaborative efforts among key partners and stakeholders.

The survey has been able to widen its reach with the help of Community Health Workers, nurses, hospital staff, healthcare providers and practitioners, elected officials, business owners, educators, and community leaders.

Outreach efforts through email, webinars and presentations, county survey launches, in-person events, and social media have been activated.

With support from Advocates for Children of New Jersey (ACNJ), a pilot MES ambassador program launched in Spring of 2022 to further support survey promotion efforts through women with birthing experience in Atlantic and Camden Counties. Ambassadors also shared pertinent health education with their communities pertaining to hypertension, preeclampsia, Covid-19 and pregnancy, diabetes, and smoking cessation.

Survey Implementation:
MES Responses by County through 1/19/2023



County	Total Complete
Atlantic	20%
Bergen	5%
Burlington	6%
Camden	18%
Cape May	3%
Cumberland	4%
Essex	17%
Gloucester	3%
Hudson	2%
Mercer	2%
Middlesex	5%
Monmouth	3%
Morris	2%
Ocean	1%
Passaic	2%
Salem	2%
Somerset	1%
Sussex	1%
Union	1%
Total	**100%**

As of January 19, 2023

There were **216 responses** across all counties.

55% (*n=118*) responses came from **counties with a County Advisory Board (CAB)** in place where the **MES has launched**.

20% of responses (*n=43*) came from **Atlantic County** residents.
18% of responses (*n=39*) came from **Camden County** residents.
17% *(n=37)* of responses came from **Essex County** residents.

Total Responses
216

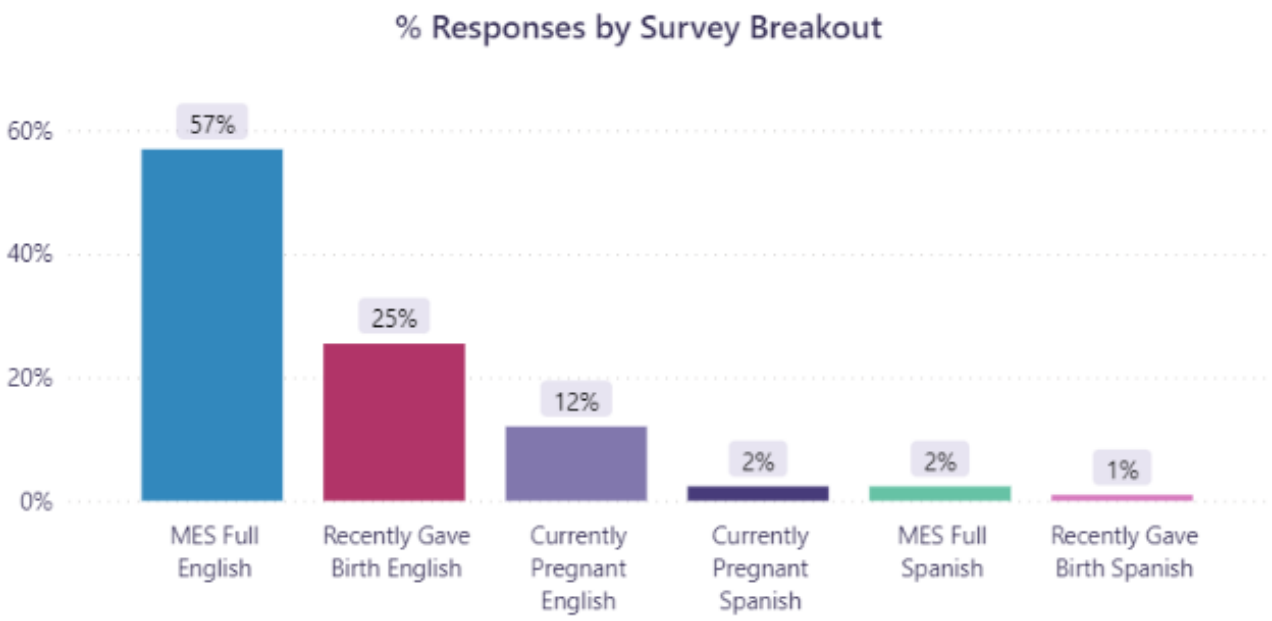
Most Recent Survey End Date:
1/4/2023

Survey Implementation:
MES Responses by Survey Breakout through 1/19/2023

As of **January 19, 2023** there were **216 responses** across all MES Breakouts.

59% (*n=128)* of responses came through the MES Full Survey- English or Spanish.

41% (*n=88)* of responses came through one of the MES Breakouts, English or Spanish.



Name of Survey Breakout (groups)	Total Complete
Currently Pregnant English	12%
Currently Pregnant Spanish	2%
MES Full English	56%
MES Full Spanish	2%
Recently Gave Birth English	26%
Recently Gave Birth Spanish	1%
Total	**100%**

Total Responses

216

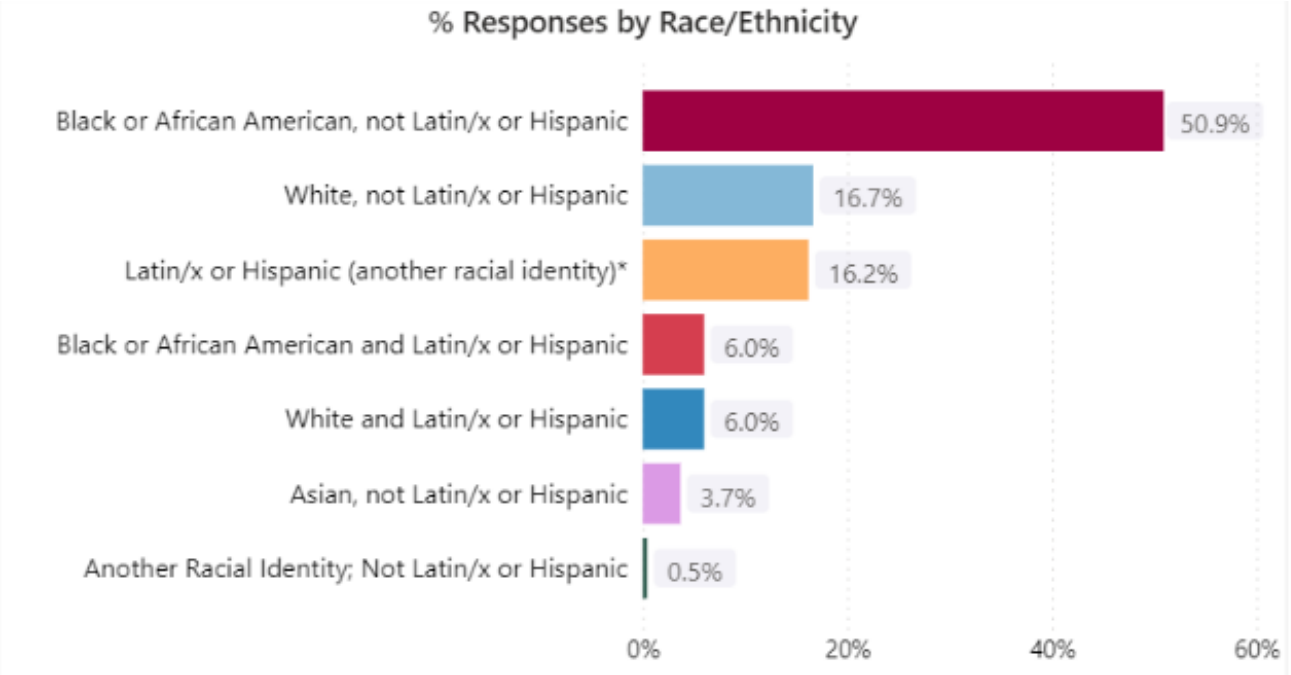
Most Recent Survey End Date:
1/4/2023

Survey Demographics:

Total Responses: 216

Most Recent Survey End Date: 1/4/2023

MES Responses by Race/Ethnicity Combined through 1/19/2023



As of January 19, 2023
57% of respondents (*n=123)*
identified as **Black or African American.**

57% of respondents (*n=123)* identified as **Black or African American** (of any ethnicity).

28% of respondents (*n=61)* identified as **Latin/x, Latina or Hispanic** (of any race).

23% of respondents (*n=49)* identified as **white** (of any ethnicity).

"Black or African American" includes respondents who chose "Another Racial Identity" and wrote in responses such as "Black" or "African American".

"**Latin/x, Latina, or Hispanic"** includes respondents who chose "Latin/x, Latina, or Hispanic," "Latino/a/x o hispano/a/x," and/or wrote in a response that fell in this category including "Mexican" or "Guatemalteca".

Racial/ethnic categories are not mutually exclusive.

Call to Action

Share the MES flyer with all NJ parents who have had a pregnancy or birthing experience.

Link to **complete or share** the MES survey:
https://www.njpreterm.org/mes

Share *this flyer with any New Jersey mothers who would like to take the survey*

Link to **browse** the MES:
https://bit.ly/MESBrowseSurvey

Healthcare providers and professionals can take a "test drive" to ***browse*** *the survey.*

The MES is available in English and Spanish. There are 3 survey options:

Currently Pregnant- Parents share their experiences during pregnancy
Recently Gave Birth- Parents share their experience after giving birth
Full Survey- Parents share their full journey

How to Access the Maternal Experience Survey

1

STEP 1

Visit
https://www.njpreterm.org/mes

2

STEP 2

Choose the survey breakout category and language type

3

STEP 3

Complete the Maternal Experience Survey

NOTE: The survey can be completed in multiple sittings
(must use the same device)

Acknowledgments

National Association for the Advancement of Colored People (NAACP)

NAACP vision is to ensure a society in which all individuals have equal rights and there is no racial hatred or racial discrimination.

Prematurity Prevention Initiative (PPI)

The Prematurity Prevention Initiative is a collaborative effort focused on reducing the number of early births in New Jersey.

The Prematurity Prevention Initiative is a program of Family Health Initiatives (FHI) supported by funding from the NJ Department of Health. FHI is a subsidiary agency of the Southern New Jersey Perinatal Cooperative 2022.

Maternal Experience Survey Advisory Boards

- Atlantic County
- Essex County
- Camden County
- Central New Jersey Region

Christine Ivery, MPH, CHES®

Family Health Initiatives would like to acknowledge the work of Christine Ivery as a leader of the Maternal Experience Survey initiative.

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Purpose of Document, Intended Audience, & Data Sharing

Purpose of MES Statewide Implementation Report

The purpose of the NAACP Maternal Experience Survey (MES) Statewide Implementation Report is to share initial survey implementation data, community engagement information, survey background, and purpose of use. This report refers to publicly available data and statewide reports.

Intended Audience

The intended audience of this MES Statewide Implementation Report is maternal and child health professionals, hospital or hospital system representatives, state representatives, grassroots organization representatives, and other stakeholders interested in MES implementation to date.

Data Sharing

MES responses are confidential and anonymous. The MES is intended to offer birthing people an opportunity to provide feedback on their birth experiences and to tell their stories. It is not intended to be a representative sample of women in New Jersey or the counties. To inquire about receiving this or related reports, or to find out more about the MES in your area, please visit this page of the PPI website.

MATERNAL EXPERIENCE SURVEY

COUNTY LAUNCH PACKET

WHAT IS THE PURPOSE OF THE MATERNAL EXPERIENCE SURVEY?

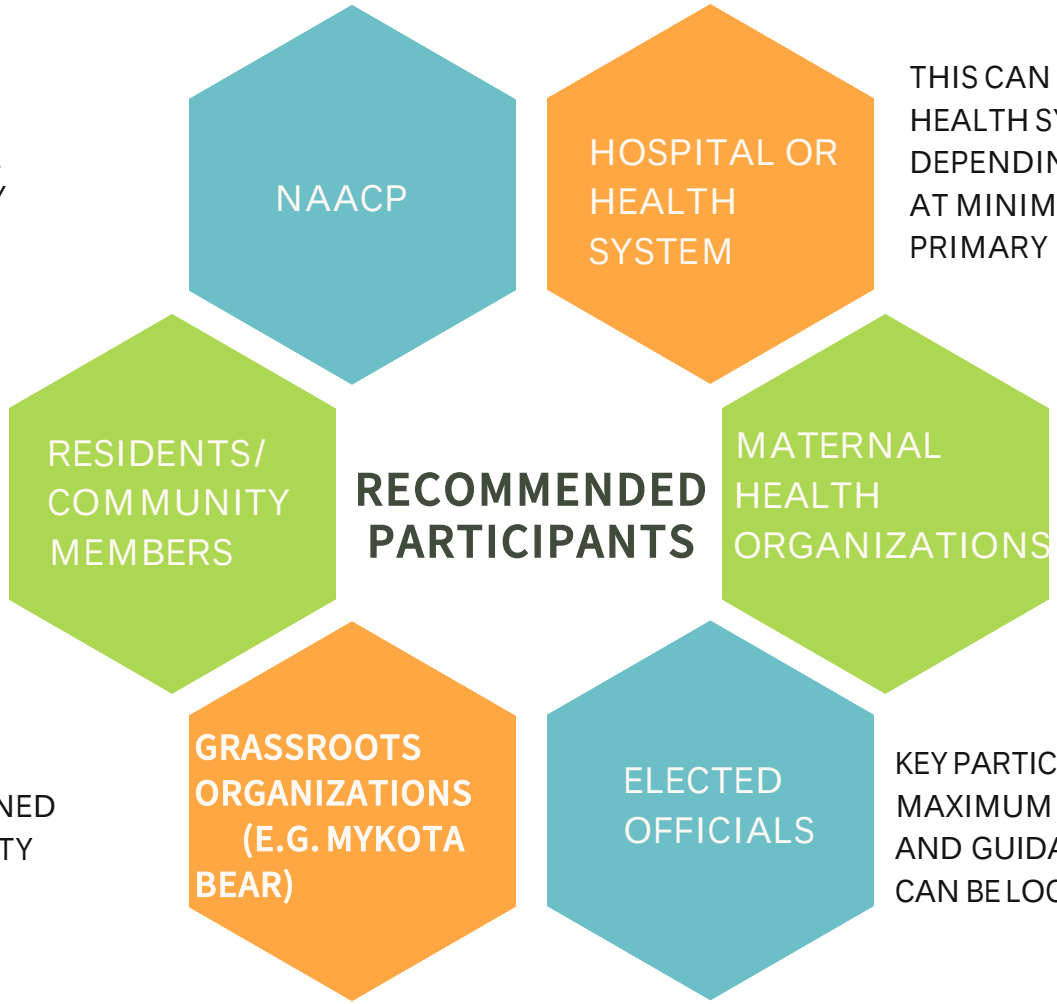
- To improve care and reduce childbirth-related disparities for women of color by providing a tool which records and reports their maternal care experiences
  - divided by prenatal, labor & delivery, postpartum
  - across multiple providers
  - flexible survey tool
  - user-friendly format; ease of use with any mobile device
  - available in English and Spanish

STEPS REQUIRED FOR COUNTY LAUNCH

These are the high-level steps required to help ensure a seamless county-level launch of the MES. Each member of the County MES Committee should sign a usage and confidentiality agreement prior to the launch meeting with the State MES Advisory Group.

1. County MES lead should assemble County MES Committee which is comprised of key participant stakeholders.
2. County MES Committee schedules launch meeting with State MES Advisory Group. (Invite template will be provided.)
3. County MES Committee establishes meeting schedule and key roles
4. County MES Committee implements Marketing/ Outreach Strategy

THIS GROUP SHOULD BE THE LEAD AND PRIMARY CONVENER IF POSSIBLE.



THIS CAN CONSIST OF MORE THAN ONE HEALTH SYSTEM, DEPENDING ON THE COUNTY. AT MINIMUM IT MUST INCLUDE THE PRIMARY HOSPITAL SYSTEM

ENSURES THE VOICE OF THE COMMUNITY IS REPRESENTED; CAN PROVIDE GUIDANCE ON TRENDS AND COMMUNITY NEED

IF POSSIBLE, CMESC MEMBERS SHOULD INCLUDE ONE OR MORE OF THE EVIDENCE-BASED MATERNAL HEALTH PROGRAMS.

CAN BE DETERMINED BASED ON COUNTY

KEY PARTICIPATION TO ENSURE MAXIMUM POLITICAL SUPPORT AND GUIDANCE; CAN BE LOCAL OR NATIONAL

County MES Committee Membership

The participant categories above should be fully represented as part of the CMESC membership prior to launch. It will be at the discretion of the committee to determine roles and responsibilities.

LAUNCH MEETING DISCUSSION ITEMS

01 Review of MES Purpose, Messaging and Strategy

02 Outreach and Marketing

02 Next steps, reporting, meeting structure and timeline

COMMUNICATION PLAN

	REACH	ACT	CONVERT	ENGAGE
Launch	Add link to survey on key websites (0-7 days of launch) Provide link and hard copies of survey to key community stakeholders (1-5 days of launch) Implement media campaign (1-14 days of launch) Implement social media campaign (1-14 days of launch) Create and distribute related press releases (within1-2 days of launch)	Design dashboard and reporting according to community and stakeholder needs Invite maternal health stakeholders to ongoing meetings	Monitor number of survey completions to ensure appropriate level of completion	
Implementation	Search engine optimization (as required) Ongoing social media presence (14+ days after launch) Replenish inventory of hard copy surveys and posters for community stakeholders (as needed) 120-day media campaign (survey update)	Conduct quarterly maternal health stakeholder meeting touchpoints Distribute and post reporting as required 'Periodically review stakeholder links to ensure they are operational	Monitor number of survey completions to ensure appropriate level of completion.	Post infographics and survey results for public review

PARTICIPATION IS KEY.

Monthly CMESC Meetings

Quarterly Statewide Meetings

Regular Results Reporting

Identify Community Insiders

Directions: Consider the following columns as you develop your community insider list and outreach methods

Column (1) lists diverse insider organizations; Column (2) are examples of key implementation qualities (3) demonstrates contact strategies for insider outreach

What Are Types of Assets The Community Possesses?	Key Qualities Needed for Project Implementation	Locate Name and Title Of Community Insiders
Artistic Groups: musical, theater, writing **Business Groups**: local chamber, local cooperatives; charitable/ philanthropic groups **Civic Event Groups:** fair, festivals **Educational/ Vocational Groups**: National Association of Hispanic Nurses, National Medical Association, university alumni groups **Ethnic/ Cultural Associations:** National Association for the Advancement of Colored People (NAACP), International Work Group for Indigenous Affairs **Professional Associations:** AMCHP, APHA, Sororities and Fraternities **Faith- Based Organizations:** Church committees (health, community development), First lady's committee **Interest Clubs**: books, recycling, birding, health & fitness, nutrition, gardening **Local Media:** commercial newspaper, radio, cable TV health Groups: cultural, political, social, educational, vocational, blogs, social media outlets **Neighborhood Groups:** crime watch, block clubs, neighborhood associations, collector groups, community building **Organization Support Groups:** environmental/ Conservation organizations, Political/Citizenship Parties, League of Women Voters **Youth and School Groups:** 4H clubs, Girl/ Boy Scouts, PTA, recreation services **Clubs:** Kiwanis, Rotary Social Cause Groups: peace, civil rights, advocacy sports leagues **Support/Self-Help Groups**: Postpartum Depression, Alcoholics Anonymous, La Leche League, empowerment	Examples • Mission aligns with project • Openly communicates • Interest in population • Track record of effective partnerships • Strong leadership • Strong informal relationships • Willingness to be a part of a collective group • Longstanding presence • Understands the importance of community to solve its own problems • Desire to avoid duplication of services in community • Willingness to work with experts • Strong community connections with political stakeholders • Influential community leader	List each Name Title Email Telephone **Outreach Tips:** • If you are unsure of title or name of the person you that will help your project, call the front desk staff or receptionist. This first response contact can serve as a valued gatekeeper in the outreach process • After making outreach to contact through phone, be sure to follow up on the same day by email with any next steps, confirmations, or deliverables

Community Plan Template	
List goals and objectives	
Describe the intended audience	
Purpose or Promotional Statement *Consider the cultural background, language type(s), literacy level and of your audience*	
Marketing Method *ie: flyers, social media, phone, in-person*	
Evaluation Plan	
Resources	
Timeframe of Activities *Sample Timeline* • *Develop list of potential stakeholders (Week 1-2)* • *Contact by phone five Insiders (Week 3-4)* • *Schedule Meeting (Virtual, Face-to-Face) (Week 3-4)* • *Prepare talking points for meeting (Week 4-5)*	

Evaluation Plan Reflection

Adapted from A Framework for Program Evaluation from the CDC

Steps & Summary Question	Reflection Questions
• **Engage stakeholders** *Who are community insiders and stakeholders who are already engaged around these issues within their community? Who is most affected by the issues?*	• Who are community insiders and stakeholders, and what are their diverse needs? • What are stakeholders' personal and community values, implicit and explicit? • What are ways of knowing that are specific to this community? • How are stakeholders overcoming challenges related to what the program is trying to accomplish? • How is your program ensuring everyone gets a seat at the table, particularly if their voice has been softened regarding this issue? • Who is missing from the table?
• **Describe the program** *How will you know your program was successful?*	• What are the environmental, cultural, political, and economic contexts in the community where the program will work? • What activities need to be considered to conduct evaluation throughout the program? • What are the program goals, according to various stakeholders? • How will you measure success? • How does the program's logic model apply to the sequence of events you hope will affect change?
• **Focus the evaluation design** *What are the diverse ways you can measure success based on stakeholder needs?*	• How will your evaluation meet stakeholder and program needs? • How will your program measure success? • How will your program measure change and program effectiveness? • How will the evaluation empower program participants and other stakeholders, particularly those who have been disempowered, especially as a result of issues around which the program is trying to affect change.
• **Gather credible evidence** *What diverse sources of evidence help tell the story?*	• How will your program consult diverse sources of evidence? • How will program and stakeholder goals be translated into indicators? • When considering sources of data that may illustrate community issues, consider national, statewide, and community-level data sources. • Are there other engaged communities who have looked at the issue such as a local university or taskforce? What stories are not being told within the evidence?
• **Justify conclusions** *What did you learn, and what does it mean?*	• How does what you learned throughout program implementation connect with the evidence and stakeholder views, experiences, and discussions? • How will you measure success within the designed indicators and measures? • What recommended actions may be considered as a result of the evaluation?
• **Ensure use and lessons learned** *How will the program and evaluation affect the community and surrounding communities?*	• How will you continuously engage diverse stakeholders throughout the program and evaluation processes? • How are you providing various opportunities for program participants and stakeholders to provide feedback? • How will you follow back up with participants? How will you reflect with stakeholders and participants?

Maternity Action Plan

Collect and Use Data to Improve Equity and Quality

Damali Campbell Oparaji MD

Ob / Gyn

Medical Director NJMCQC

Chair of MMRC

Associate Professor Rutgers, New Jersey Medical School

Disclosures

- I have no financial disclosures.
- I have the lived experience as a birthing person who gave birth to 3 living children in New Jersey- 1 born too soon, 2 remain living
- My work is often not valued as much as others because of my race and gender.

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New Jersey Maternal Data Center

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Home › Maternal Care Quality Collaborative

- Maternal Care Quality Collaborative
  - Public Meetings
  - Members
- Pregnancy During the

Maternal Care Quality Collaborative

The New Jersey Maternal Care Quality Collaborative (NJMCQC) serves as the state's legislated 34-member maternal health task force. The NJMCQC was formed to improve maternal health outcomes by catalyzing a multidisciplinary collaboration, analyzing maternal health data, and promoting timely innovation and education at the consumer, provider, and system levels. The collaborative will coordinate efforts and strategies aimed at reducing severe maternal morbidity (SMM) and mortality, and racial/ethnic disparities across the state.

NJMCQC New Jersey Maternal Care Quality Collaborative

Public Meeting Information

To health! NJHA New Jersey Hospital Association

Patient Safety | Harm Reduction | Neonatal Abstinence Syndrome | Health Equity | Shared Learning | COVID-19

NJ Perinatal Quality Collaborative

NJHAD New Jersey State Health Assessment Data
New Jersey's Public Health Data Resource
Path: NJSHAD » Home

Search this website...

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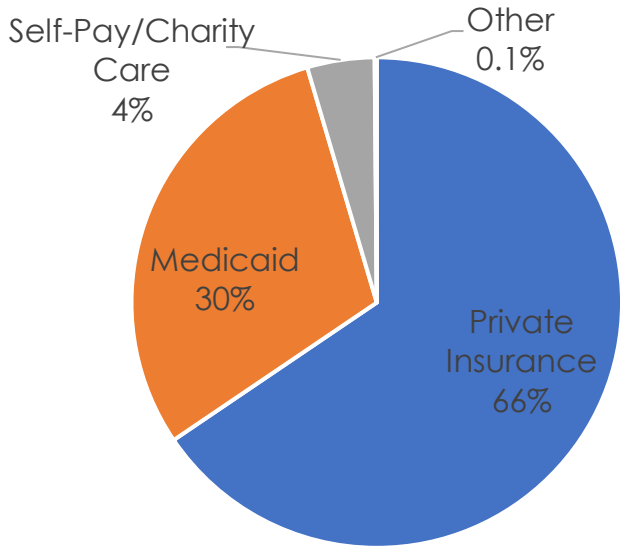
MORE NEW DATA AND REPORTS:

- 2021 STD Incidence Data (Jul 2022)
- 2020 Marriage Counts (June 2022)
- 2020 Behavioral Risk Factor Survey Data (May 2022)

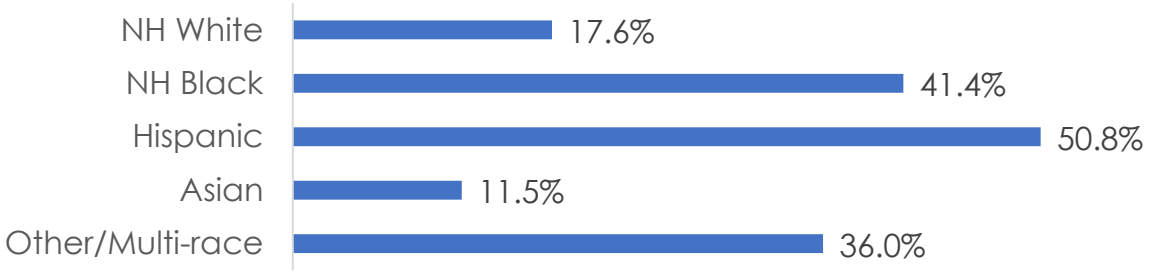
The New Jersey Department of Health's State Health Assessment Data (NJSHAD) System provides access to public health datasets, statistics, and information on the health status of New Jerseyans. **If you're new to NJSHAD, start here:**

Access to Care/ Health Insurance	Air Quality	Alcohol	Asthma/COPD	Births/Maternity
Brain and Nervous System	Cancer	Cardiovascular Disease	Child/Adolescent Health	Demographic Characteristics

Delivery Hospitalizations by Mother's Insurance Coverage
New Jersey, 2019



Medicaid Coverage Percentage in each Racial/Ethnic Group, 2019



Maternity Care in New Jersey

Births and Demographics

In 2019, 30% of delivery hospitalizations were to mothers on Medicaid, compared to 31% in 2018 (not shown) representing a 3% decrease.

In 2019, 66% of delivery hospitalizations were to mothers with private insurance compared to 65% in 2018 (not shown) representing a 2% increase.

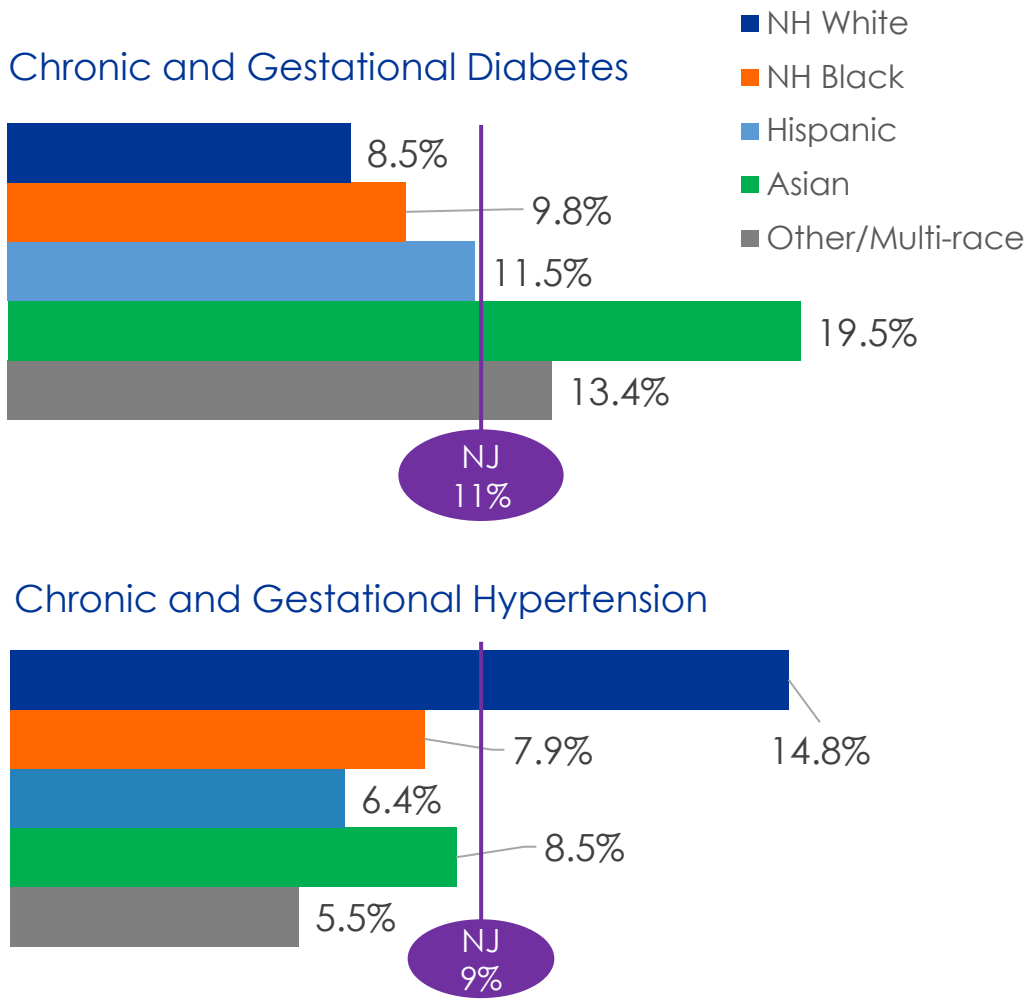
When looking at distribution of insurance coverage for delivery hospitalizations in each racial/ethnic group, in 2019, 50.8% of Hispanic women and 41.4% of Non-Hispanic Black women were covered by Medicaid compared to 11.5 % of Asian mothers and 17.6% of Non-Hispanic White mothers.

Data Source: 1. New Jersey Hospital Discharge Data Collection System, Health Care Quality Assessment, Healthcare Quality and Informatics, NJ Department of Health
2. Vital Information Platform (New Jersey Electronic Birth Certificate Database).

NJ Health NJMDC New Jersey Maternal Data Center

Maternal Medical Conditions, by Race/Ethnicity

New Jersey, 2019



Maternity Care in New Jersey

Risk Factors

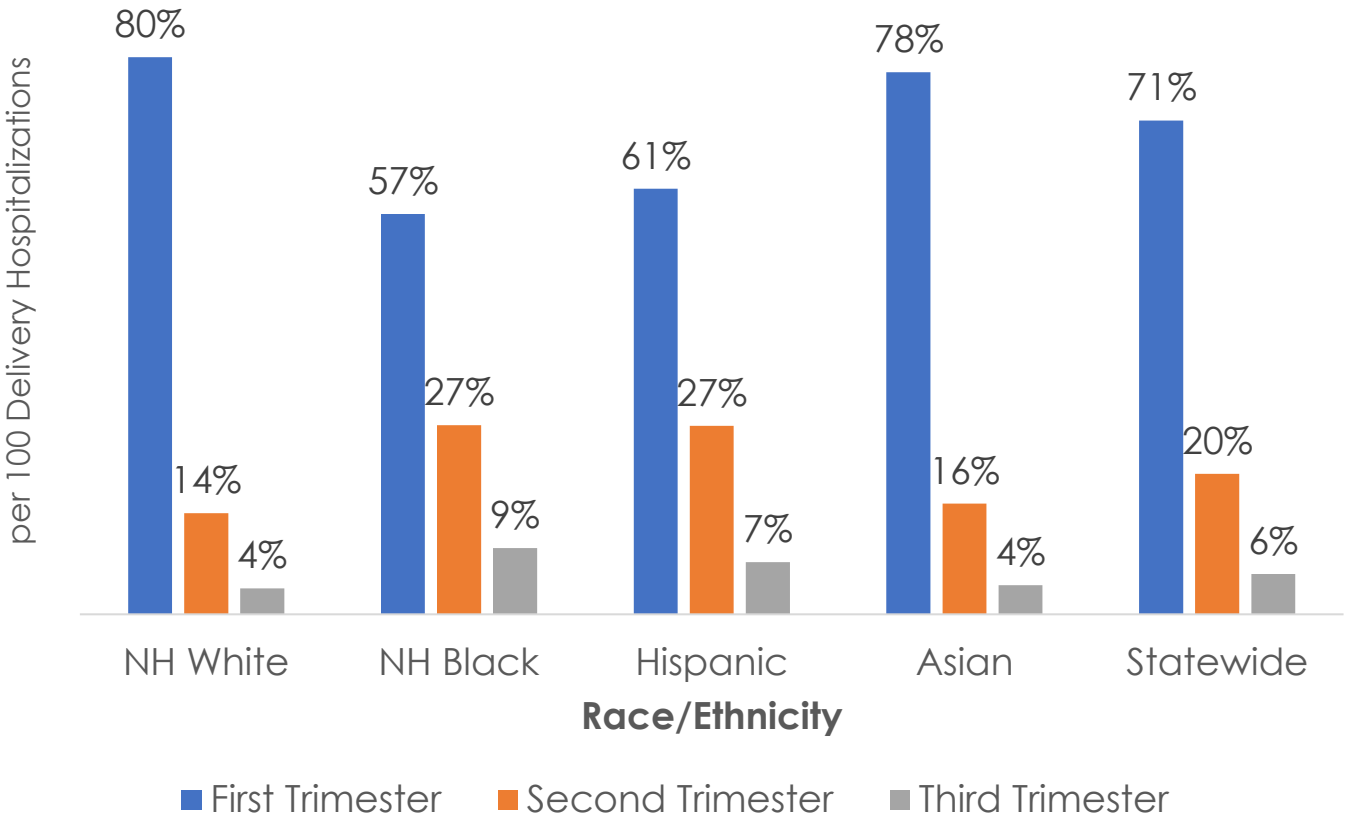
In 2019, 11% of mothers who gave birth at a hospital were diabetic. Racial and ethnic disparities were observed, with the highest rate of diabetes amongst Asian mothers at 19.5% compared to Non-Hispanic White mothers at 8.5%.

In 2019, 9% of mothers who gave birth at hospital were hypertensive. Similarly, racial and ethnic disparities were observed with the highest rate being amongst Non-Hispanic Black mothers (14.8%) and the lowest amongst Other/Multiracial mothers (5.5%).

Data Source: 1. New Jersey Hospital Discharge Data Collection System, Health Care Quality Assessment, Healthcare Quality and Informatics, NJ Department of Health
2. Vital Information Platform (New Jersey Electronic Birth Certificate Database).

NJ Health NJMDC New Jersey Maternal Data Center

Delivery Hospitalizations by Prenatal Care Initiation
New Jersey, 2019



In 2019, 71% of all mothers initiated prenatal care in the first trimester of their pregnancy. This was a minimal improvement over 2016, during which time 70% of mothers initiated prenatal care in their first trimester and no improvement at all over 2018 (not shown).

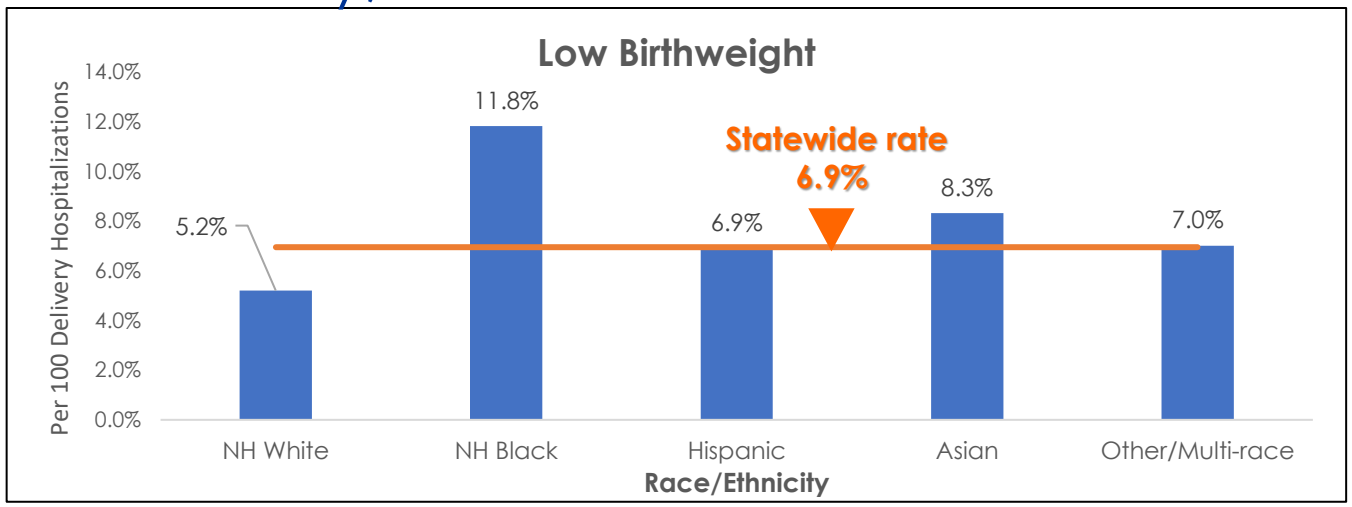
However, racial disparities in the timing of initiation of care were evident, with 80% of Non-Hispanic White mothers starting care in their first trimester, but only 57% of Non-Hispanic Black mothers doing so.

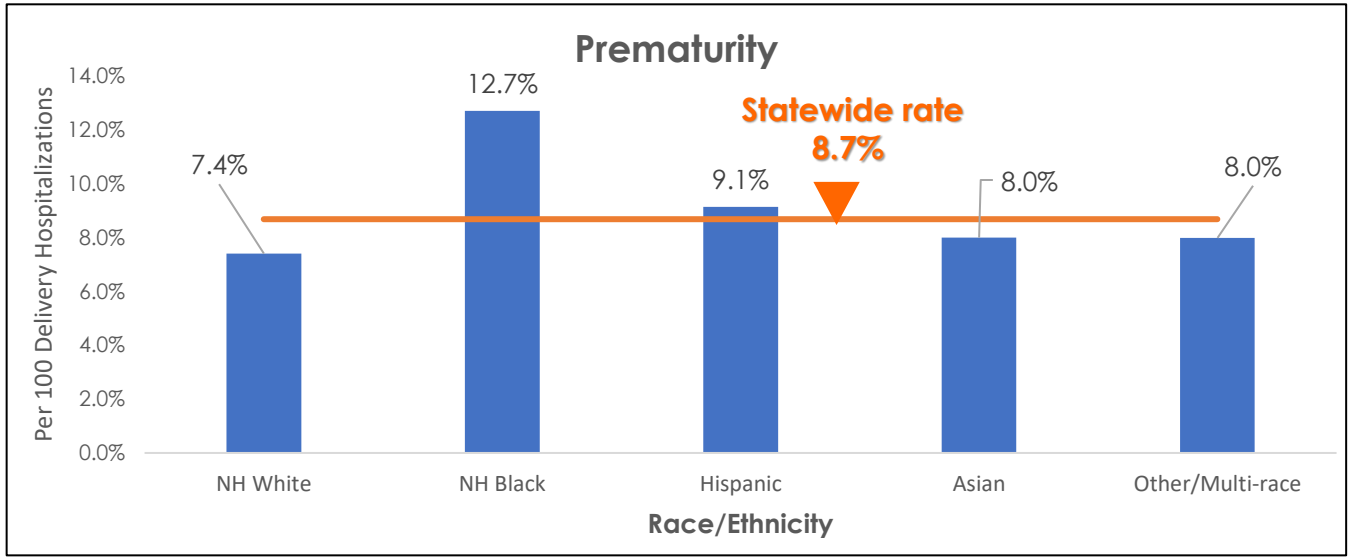
Data Source: 1. New Jersey Hospital Discharge Data Collection System, Health Care Quality Assessment, Healthcare Quality and Informatics, NJ Department of Health
2. Vital Information Platform (New Jersey Electronic Birth Certificate Database).

NJ Health NJMDC New Jersey Maternal Data Center

Childbirth-Related Quality Measures, by Race/Ethnicity

New Jersey, 2019





Data Source: 1. New Jersey Hospital Discharge Data Collection System, Health Care Quality Assessment, Healthcare Quality and Informatics, NJ Department of Health
2. Vital Information Platform (New Jersey Electronic Birth Certificate Database).

Maternity Care in New Jersey

Infant Characteristics

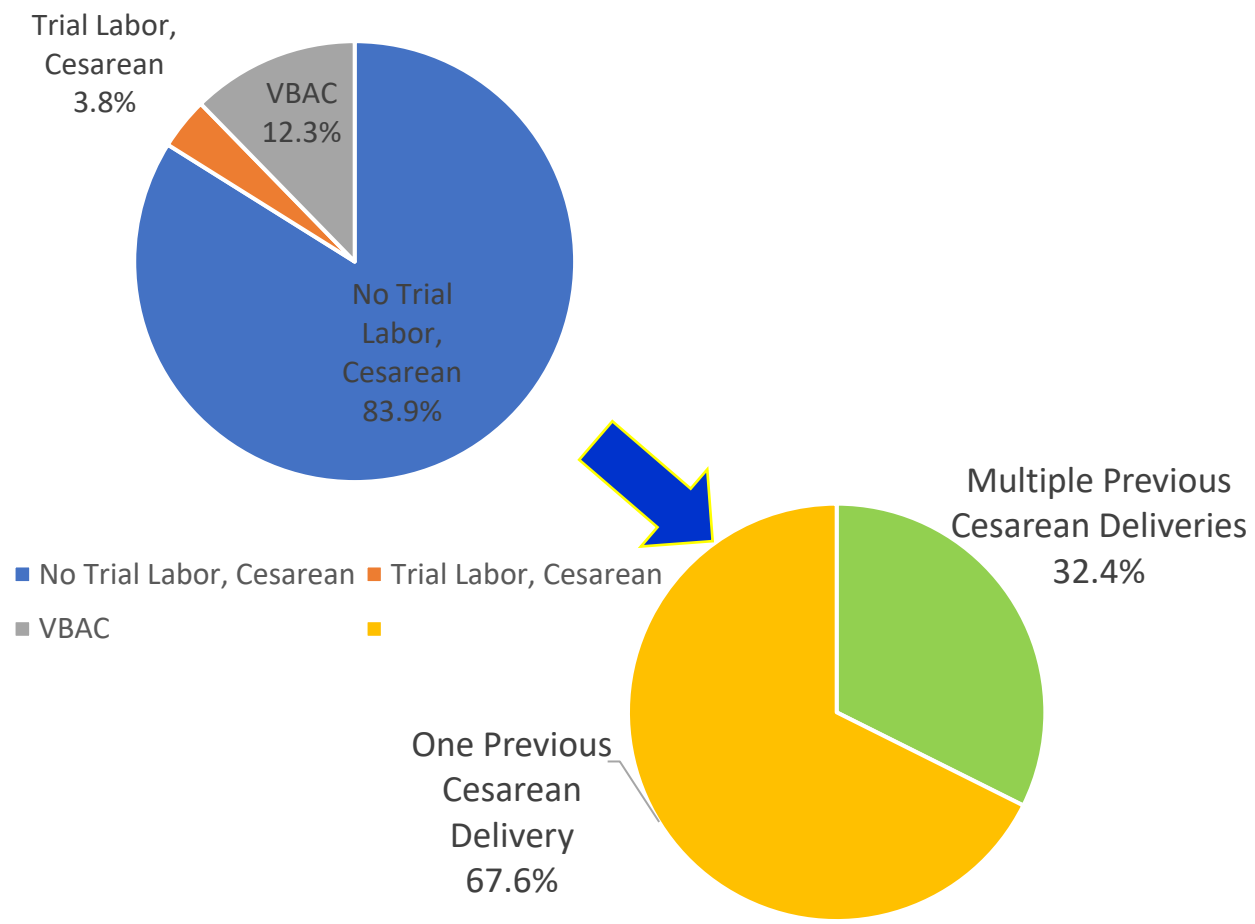
In 2019, 6.9% of mothers delivered low birthweight babies (birth weight less than 2,500 grams), which does not differ from 2018 (not shown). However, there were large disparities by race/ethnicity, with the greatest rate of low-birth-weight babies for Non-Hispanic Black mothers.

In 2019, 8.7% of mothers delivered their babies prematurely (infants less than 37 weeks of gestation), which was a 2% increase from the 2018 rate of 8.5 % (not shown). Disparities in rates of preterm births were also seen, with the greatest rates of preterm babies born to Non-Hispanic Black mothers.

NJ Health NJMDC New Jersey Maternal Data Center

Method of Delivery for Mothers with Previous Cesarean Birth

New Jersey, 2019



In 2019, of mothers that previously experienced a cesarean delivery, 83.9% of them had a repeat cesarean delivery with no trial of labor. Only 12.3% experienced a VBAC and another 3.8% had a trial of labor before ultimately delivering via cesarean.

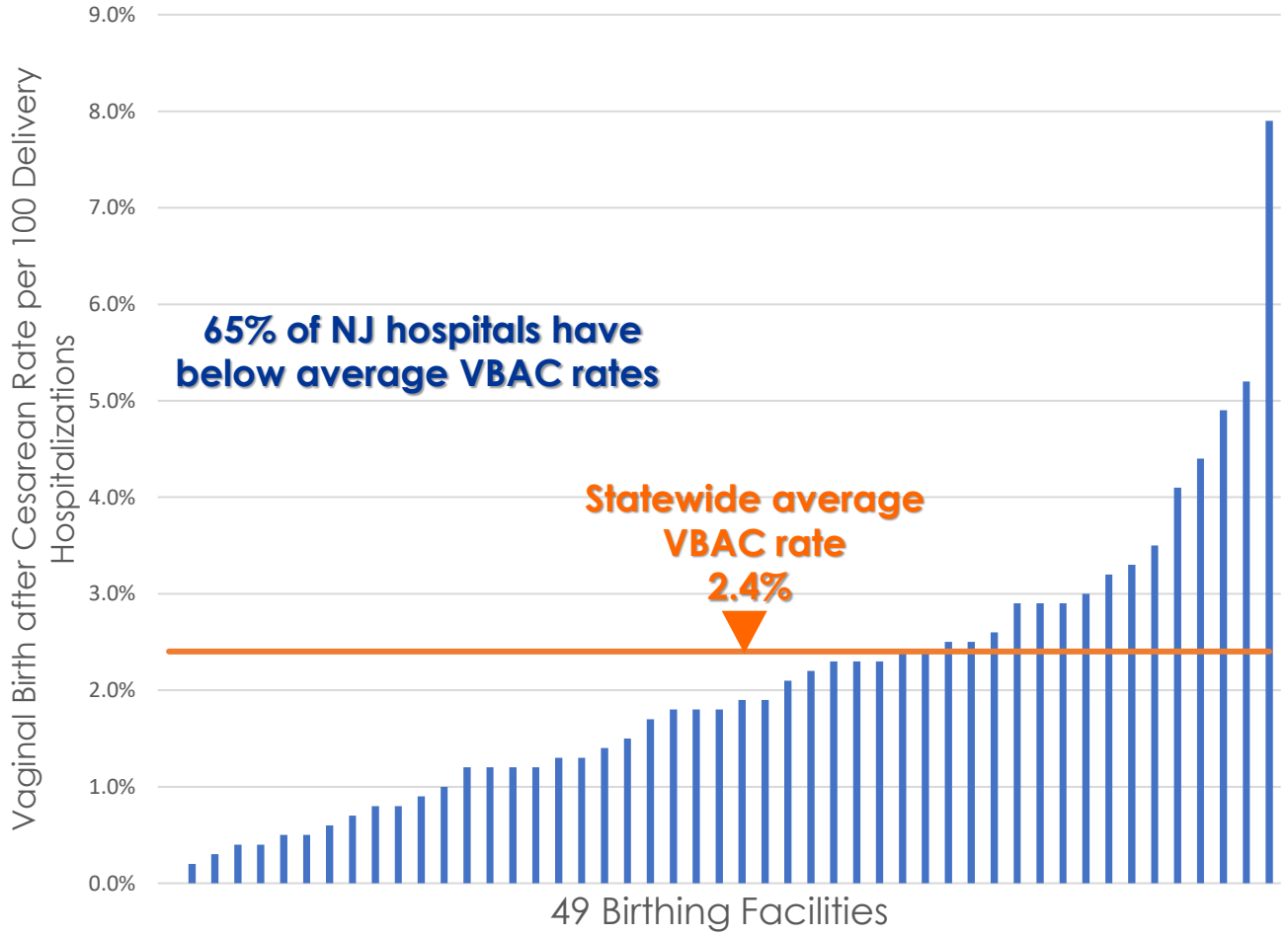
Of the cesarean deliveries for which there was no trial of labor, 67.6% were women who had previously experienced only one cesarean delivery.

Data Source: 1. New Jersey Hospital Discharge Data Collection System, Health Care Quality Assessment, Healthcare Quality and Informatics, NJ Department of Health
2. Vital Information Platform (New Jersey Electronic Birth Certificate Database).

NJ Health NJMDC New Jersey Maternal Data Center

Vaginal Birth After Cesarean (VBAC) Delivery Rate, by Hospital

New Jersey, 2019



Among all delivery hospitalizations, the average vaginal birth after cesarean (VBAC) rate for all 49 birthing hospitals in NJ was 2.4% in 2019, compared to 2.2% in 2018 (not shown), representing a 9% increase.

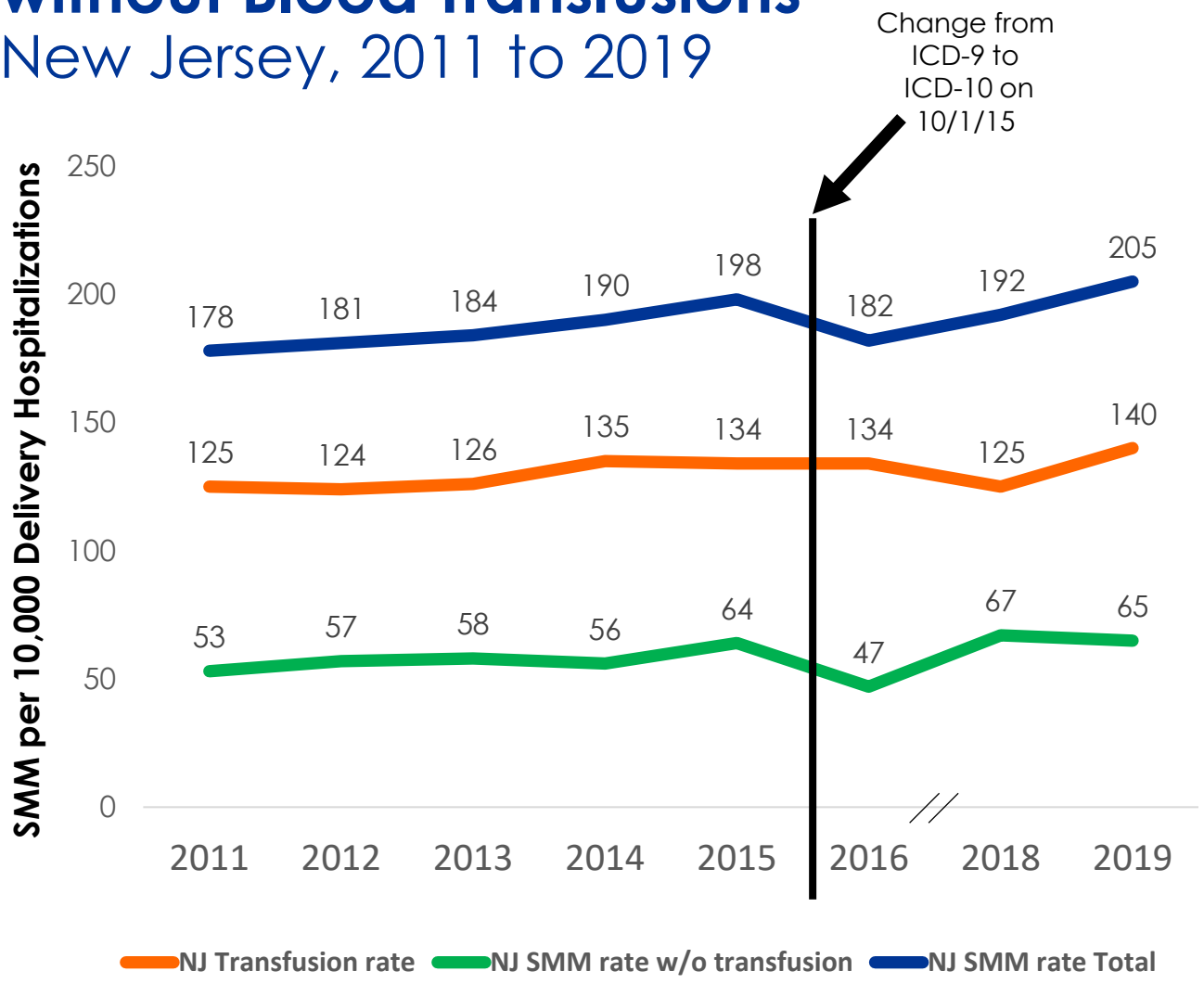
Wide variation in rates across hospitals is evident. Of the 49 birthing hospitals in NJ, 15 hospitals had a VBAC rate greater than the average, and rates varied from 0.0% to 7.9%.

Data Source: 1. New Jersey Hospital Discharge Data Collection System, Health Care Quality Assessment, Healthcare Quality and Informatics, NJ Department of Health
2. Vital Information Platform (New Jersey Electronic Birth Certificate Database).

NJ Health NJMDC New Jersey Maternal Data Center

Severe Maternal Morbidity with and without Blood Transfusions

New Jersey, 2011 to 2019



Maternity Care in New Jersey

Complications

In 2019, New Jersey's total Severe maternal morbidities* (SMM) rate was 205 per 10,000 delivery hospitalizations (including those with blood transfusions), a 15% increase from 2011.

Excluding blood transfusions, the 2019 NJ SMM rate was 65 per 10,000 delivery hospitalizations, a 22% increase from 2011.

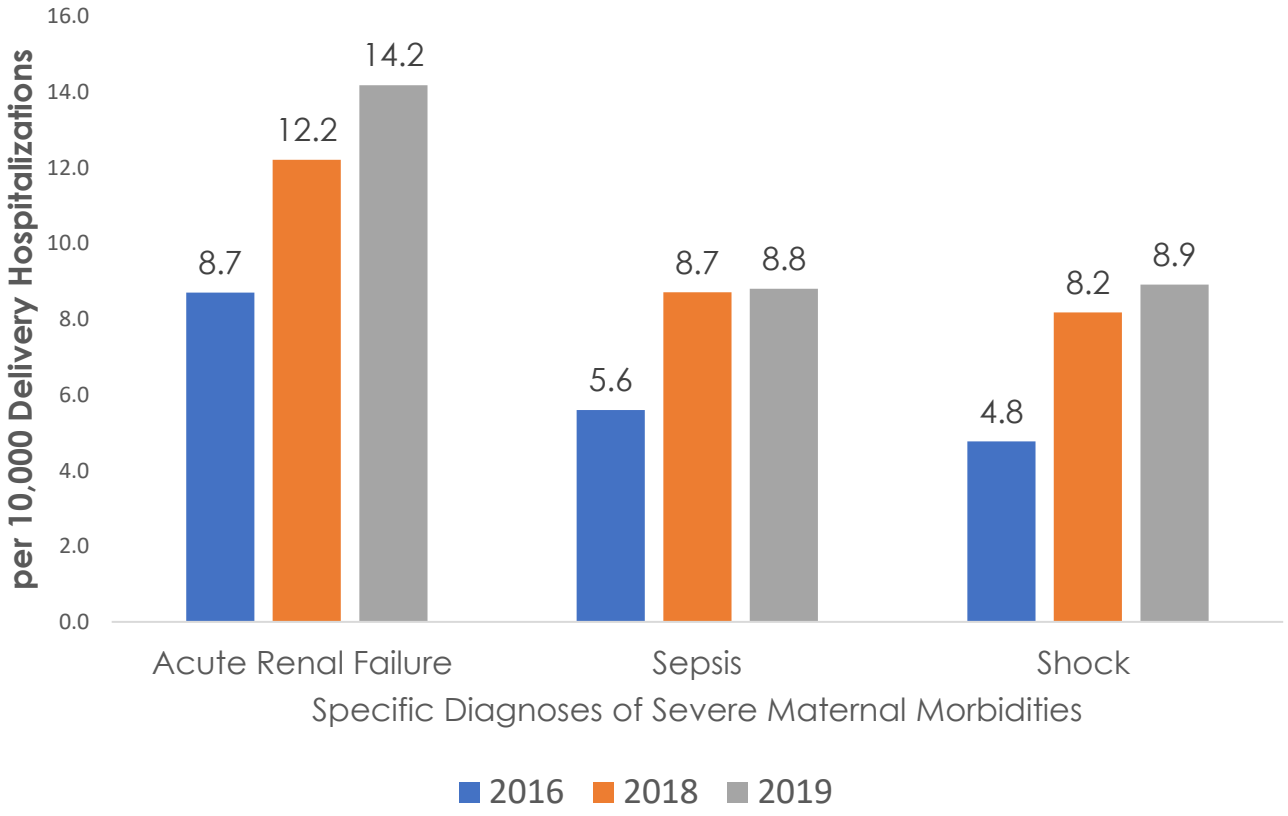
*Severe maternal morbidities (SMM) are defined as unexpected outcomes of labor and delivery that result in significant short- or long-term consequences to a woman's health (CDC).

Data Sources: 1. Healthcare Cost and Utilization Project (HCUP), AHRQ and NJ Hospital Discharge Data Collection System, Health Care Quality Assessment, Healthcare Quality and Informatics, NJ DOH
2. New Jersey Hospital Discharge Data Collection System, Health Care Quality Assessment, Healthcare Quality and Informatics, NJ Department of Health
3. Vital Information Platform (New Jersey Electronic Birth Certificate Database).

NJ Health NJMDC New Jersey Maternal Data Center

Severe Maternal Morbidity, Trends in Top Diagnoses

New Jersey, 2016 to 2019



From 2016 to 2019, acute renal failure, sepsis and rates of shock have been rising.

In 2019, among all delivery hospitalizations, the acute renal failure rate was 14.2 per 10,000 delivery hospitalizations compared to 8.7 in 2016, representing a 63 % increase.

Similarly, the rate of sepsis was 8.8 per 10,000 delivery hospitalizations compared to 5.6 representing 57% increase.

Lastly, the rate of shock was 8.9 per 10,000 delivery hospitalizations compared to 4.8 in 2016 representing an 87% increase.

Data Source: 1. New Jersey Hospital Discharge Data Collection System, Health Care Quality Assessment, Healthcare Quality and Informatics, NJ Department of Health
2. Vital Information Platform (New Jersey Electronic Birth Certificate Database).

NJ Health NJMDC New Jersey Maternal Data Center

NJ Maternal Health Hospital Report Card

Average Age of Mother (yrs), 2019

28.4

Nulliparous, 2019
(First-time mothers)

30.3%

Diabetes Mellitus, 2019

6.8%

Hypertension, 2019

21.4%

Pre-eclampsia, 2019

37.0%

Preexisting Anemia, 2019

31.9%

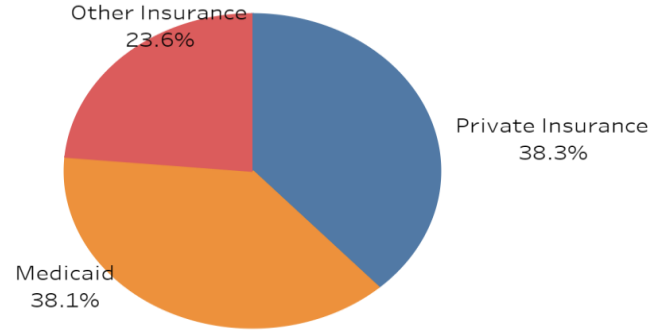
2.5% Non-Hispanic White

47.1% Non-Hispanic Black

47.1% Hispanic

1.4% Asian

Health Insurance Coverage, 2019



NJMDC
New Jersey Maternal Data Center

Maternal Mortality Review Committee Data Compared to Other Maternal Mortality Data Sources

	CDC – National Center for Health Statistics (NCHS)	CDC – Pregnancy Mortality Surveillance System (PMSS)	Maternal Mortality Review Committees
Data Source	Death certificates	Death certificates linked to fetal death and birth certificates	Death certificates linked to fetal death and birth certificates, **medical records, social service records, autopsy, informant interviews…**
Time Frame	During pregnancy – 42 days	During pregnancy – 365 days	During pregnancy – 365 days
Source of Classification	ICD-10 codes	Medical epidemiologists (PMSS-MM)	**Multidisciplinary committees**
Terms	Maternal death	Pregnancy associated, (Associated and) Pregnancy related, (Associated but) Not pregnancy related	Pregnancy associated, (Associated and) Pregnancy related, (Associated but) Not pregnancy related
Measure	Maternal Mortality Rate - # of Maternal Deaths per 100,000 live births	Pregnancy Related Mortality Ratio - # of Pregnancy Related Deaths per 100,000 live births	Pregnancy Related Mortality Ratio - # of Pregnancy Related Deaths per 100,000 live births
Purpose	Show national trends and provide a basis for international comparison	Analyze clinical factors associated with deaths, publish information that may lead to prevention strategies	**Understand medical and non-medical contributors to deaths, prioritize interventions that effectively reduce maternal deaths**

NJ Health New Jersey Department of Health

NJ Health NJMMRC New Jersey Maternal Mortality Review Committee

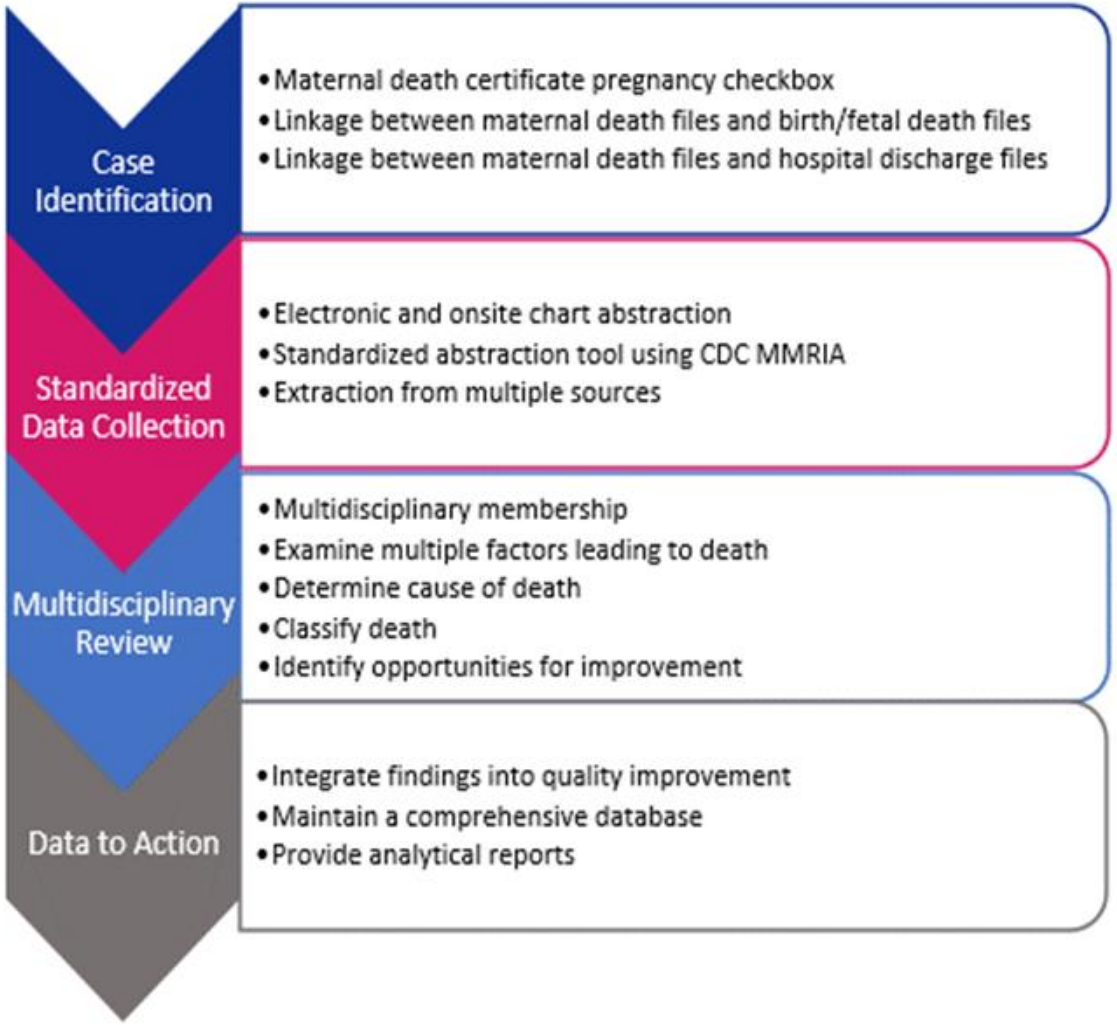
MMRIA Maternal Mortality Review Information App

ERASE MM

REVIEW to ACTION

St. Pierre, A., Zaharatos, J., Goodman, D., Callaghan, W.M. (2018). Challenges and opportunities in identifying, reviewing, and preventing maternal deaths. Obstetrics & Gynecology, 131(1): p. 138-142

NJ Maternal Mortality Review Committee Process



Quantitative data doesn't tell the whole story. Patients want to be seen and feel heard.

Source: Black Birthing Bill of Rights – The NAABB

Community Led Patient Experience

NAACP Maternal Experience Survey

Helen Hannigan, MGA

Maternity Action Plan Work Session:
Collecting and Using Data to Improve Equity and Quality

1/27/2023

Total Responses

216

Most Recent Survey End Date:
1/4/2023

Prematurity Prevention Initiative

- Clinical Expertise
- Clinical Intervention
- Assessment
- Community Engagement
- Community Voice

A Partnership from the Start

- **NJ Department of Health**
  - **Melita Jordan**
  - **Nashon Hornsby, Esq.**
- **Clinical Leadership**
  - **Dr. Ron Librizzi, DO**
  - **Dr. Wendy Warren, MD**
  - **Dr. Judy Ruffin, MD**
  - **Dr. Dianne Timms, MD**
  - **Dr. Lisa Gittens-Williams**
- **Community Partners**
  - **Partnership for Maternal and Child Health of Northern NJ**
  - **Southern NJ Perinatal Cooperative**
  - **Acenda**
  - **Advocates for Children of New Jersey**
  - **Central NJ Family Health Consortia**

NAACP-AC Black Infant and Maternal Mortality Task Force

- Committed to mitigating disparities that impact black birthing people and their families.
- Legislators, health professionals, educators, faith-based leaders, community members and many others who seek change in their communities and the state at large.
- Committed to building a community-level action response to the social and birthing injustice in New Jersey.

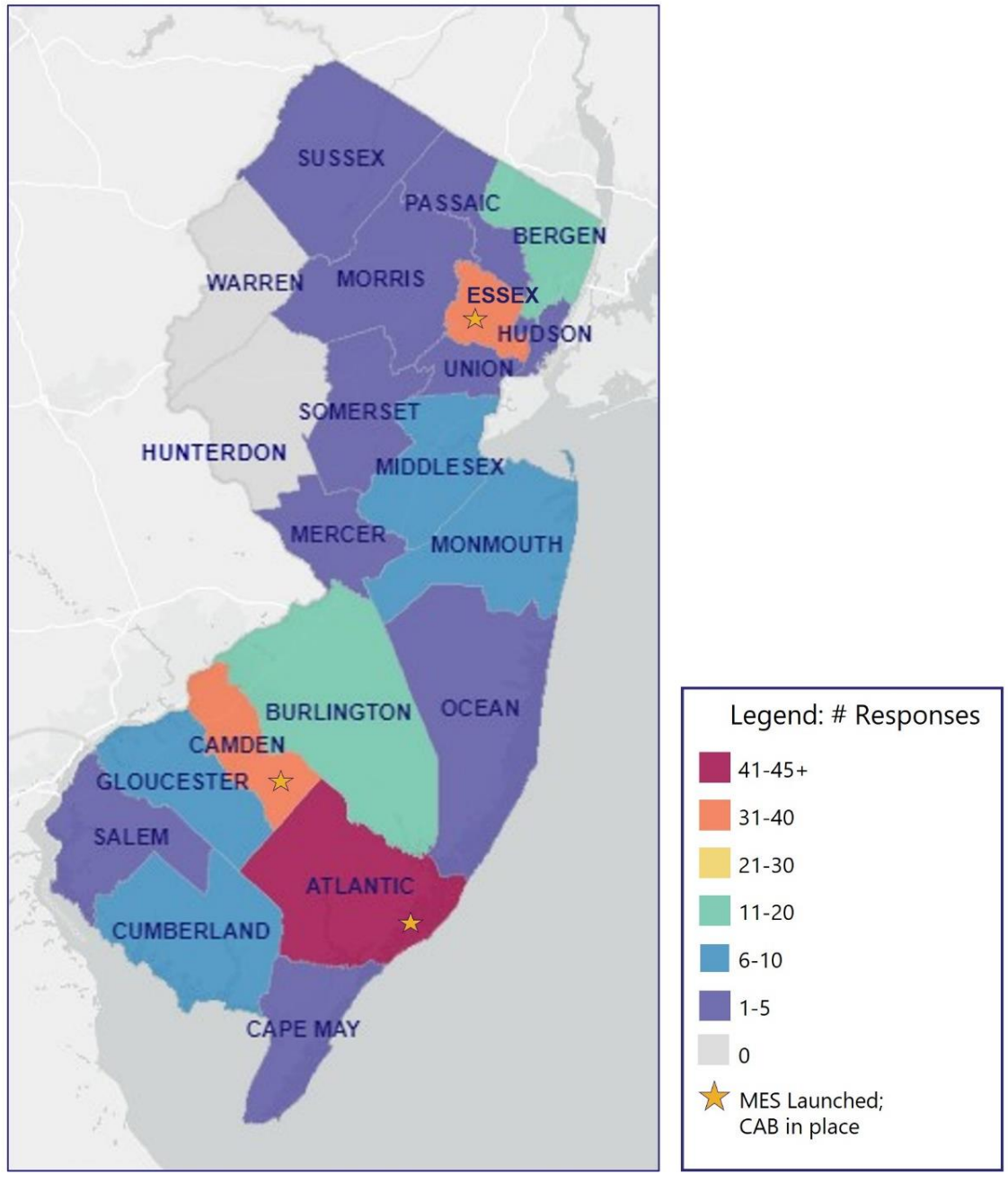
MES Responses through 1/20/2023

Total Responses

216

Most Recent Survey End Date: 1/4/2023

MES Data: # Responses by County



County	Total Complete
Atlantic	20%
Bergen	5%
Burlington	6%
Camden	18%
Cape May	3%
Cumberland	4%
Essex	17%
Gloucester	3%
Hudson	2%
Mercer	2%
Middlesex	5%
Monmouth	3%
Morris	2%
Ocean	1%
Passaic	2%
Salem	2%
Somerset	1%
Sussex	1%
Union	1%
Total	**100%**

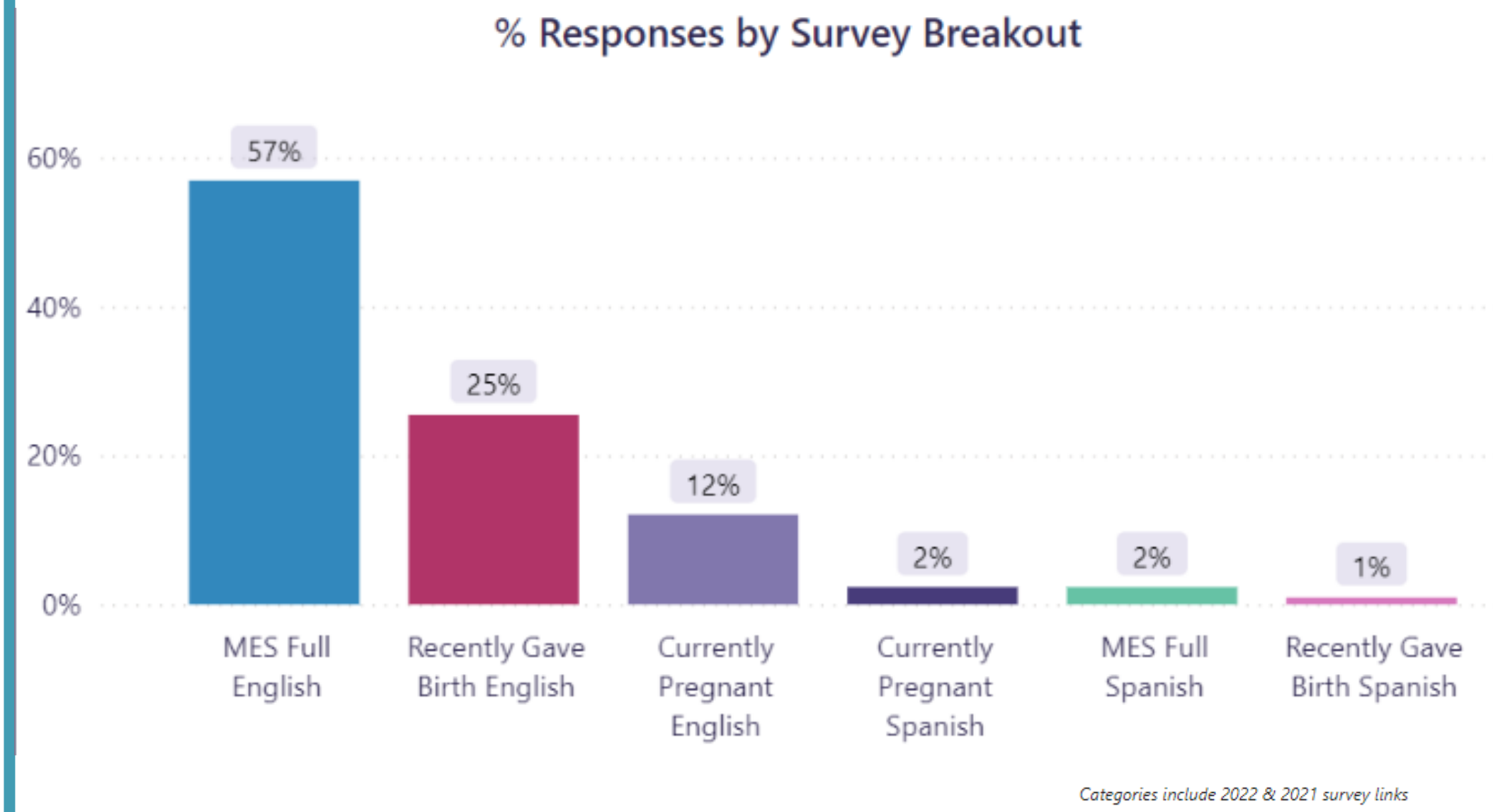
As of **January 20, 2023,**
55% of responses (*n=119)* came from **counties with a Community Advisory Board (CAB) in place: Atlantic, Camden, and Essex counties,** with a total of **216 responses** across NJ.

MES Responses through 1/20/2023

Total Responses

216

Most Recent Survey End Date: 1/4/2023



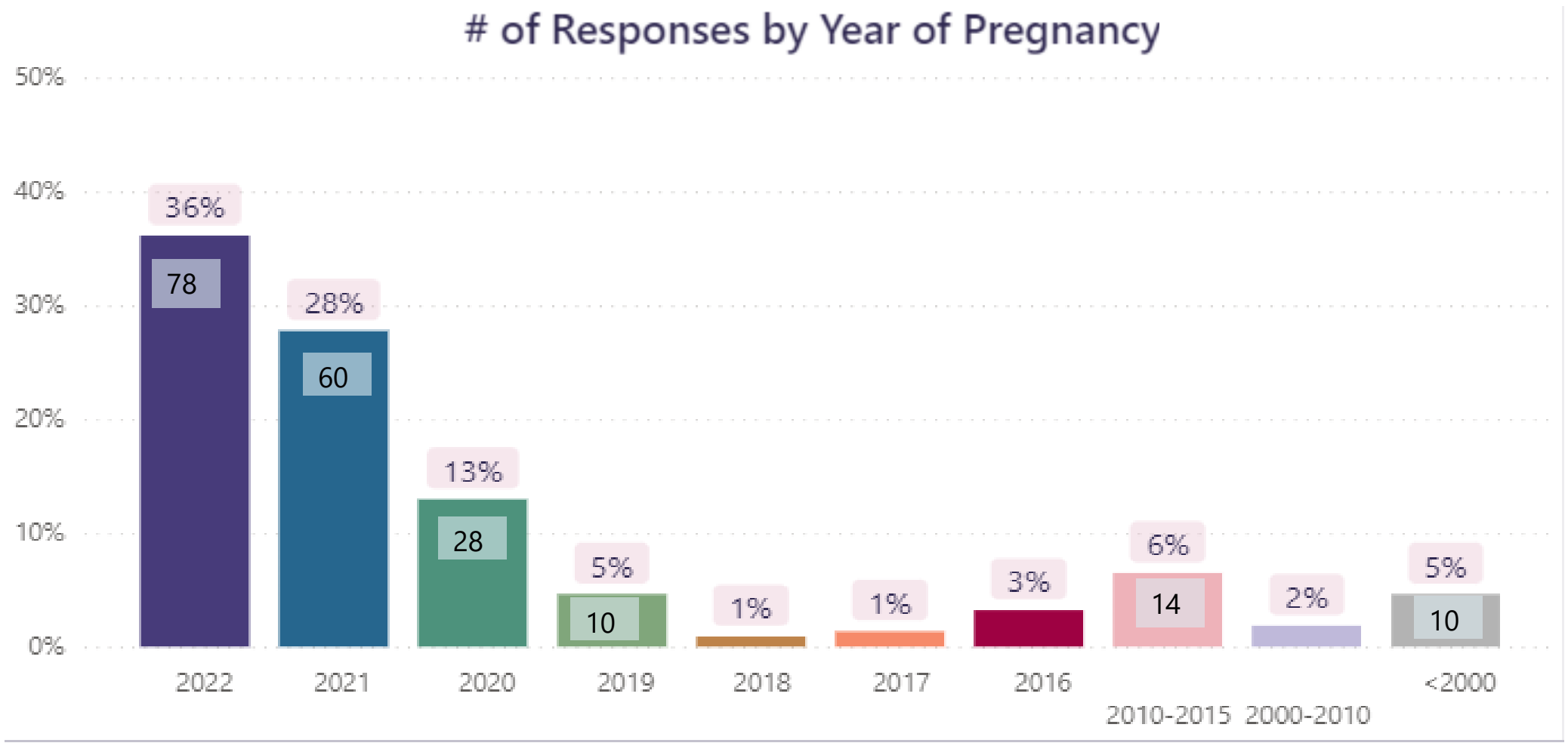
Categories include 2022 & 2021 survey links

As of **January 20, 2023** there were **216 responses** across all MES Breakouts.

59% (*n=128)* of responses came through the MES Full Survey- English or Spanish.

41% (*n=88)* of responses came through one of the MES Breakouts, English or Spanish.

MES Responses through 1/20/2023 by Year of Pregnancy



Total Responses

216

Most Recent Survey End Date: 1/4/2023

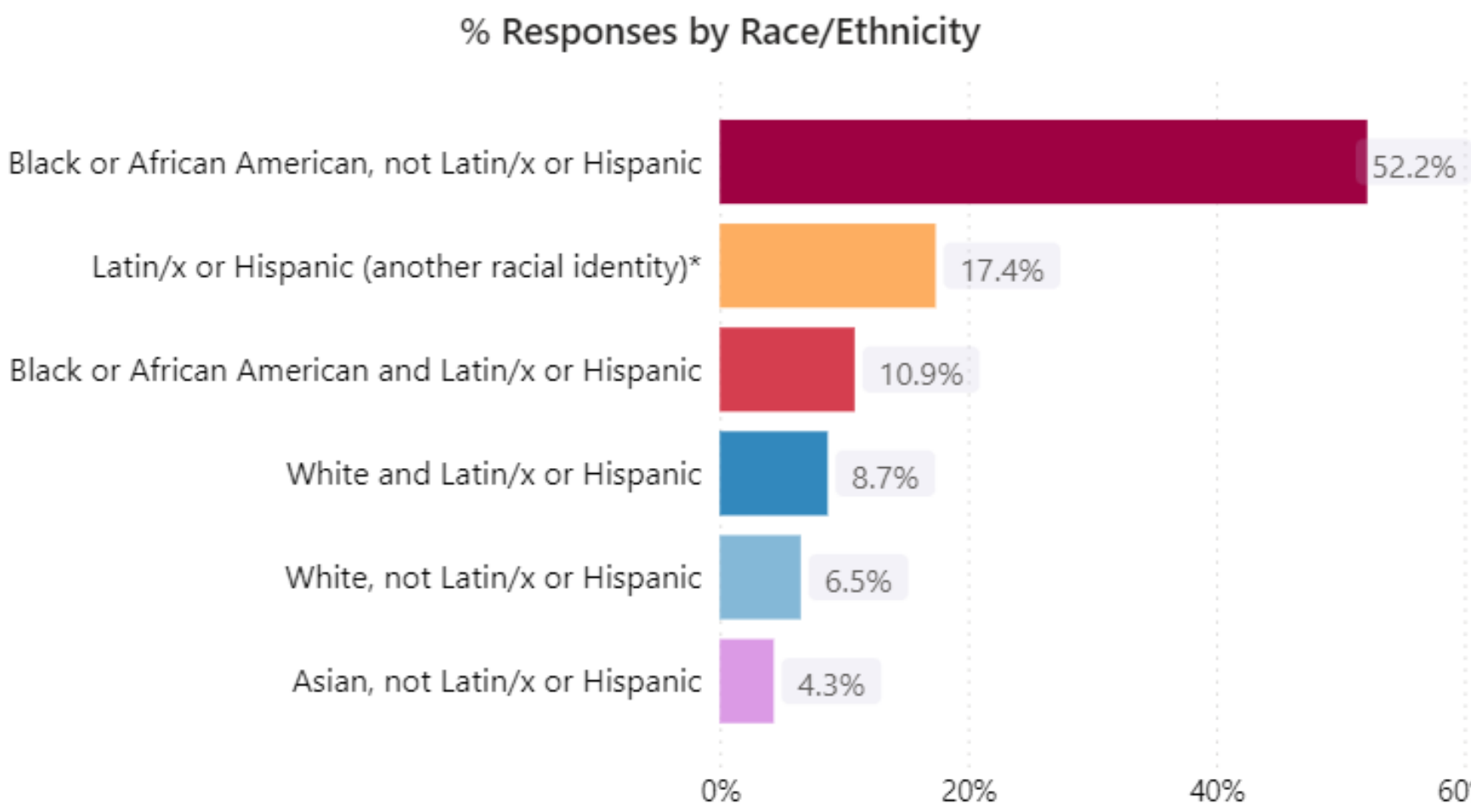
As of **January 20, 2023, out of 216 responses,**

36% (*n=78)* of respondents were pregnant in **2022.**
28% (*n=60)* were pregnant in **2021.**
13% *(n=28)* were pregnant in **2020.**
5% *(n=10)* were pregnant in **2019.**

Of the 216 respondents, 14% (n=31) were pregnant at the time of response and may deliver and/or have delivered in 2023.
86% *(n=185)* of respondents **discussed a pregnancy outcome** including live birth, termination, or stillbirth after 21 weeks.

MES Responses by Race/Ethnicity, 1/1/2021-12/31/2021

Total Responses
46

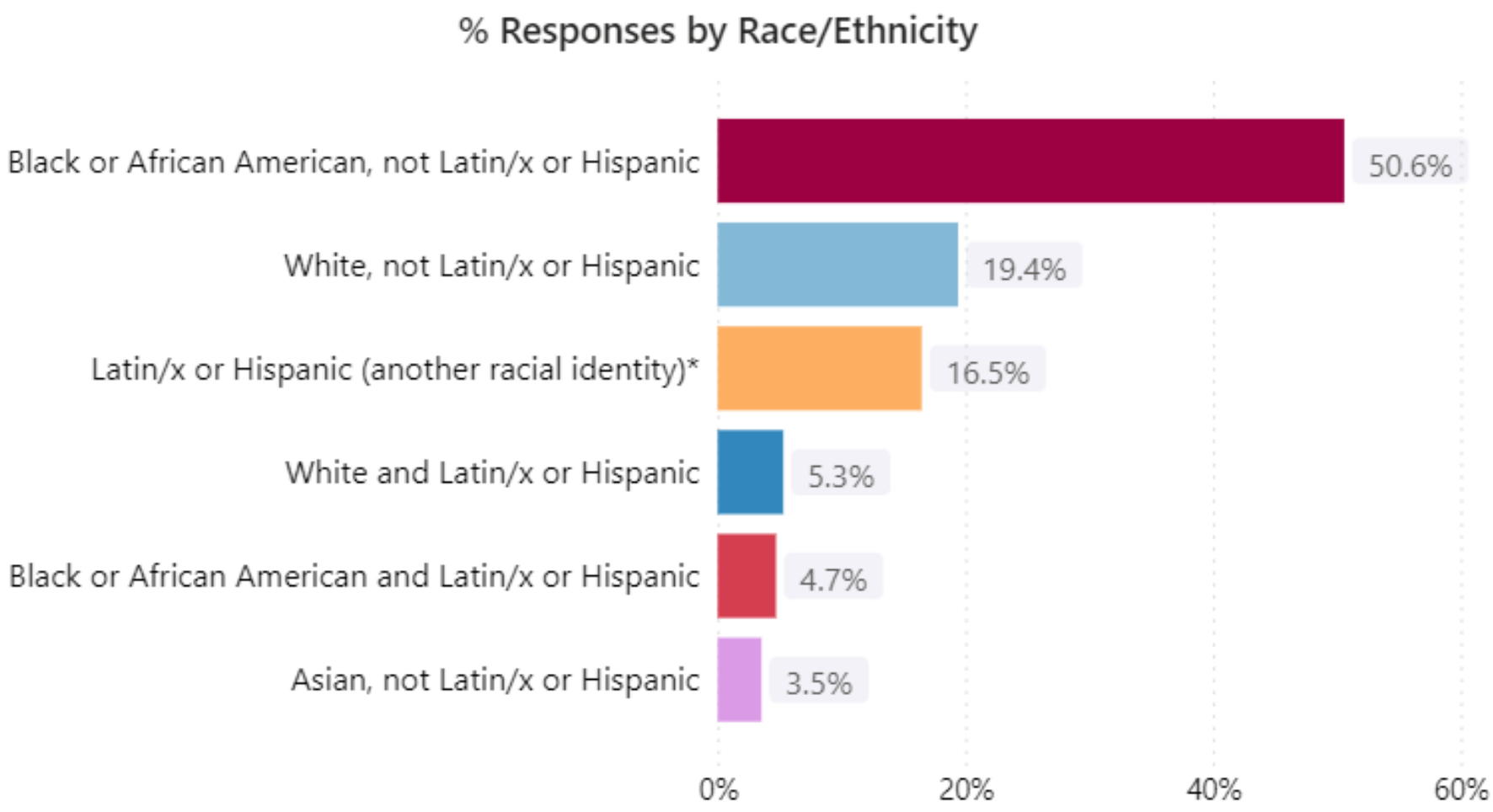


Of the 46 responses collected in 2021,

63% of respondents (*n=29)* identified as **Black or African American,**
36% of respondents (*n=17)* identified as Latina, Latin/x, or Hispanic (of any race)

MES Responses by Race/Ethnicity, 1/1/2022-1/4/2023

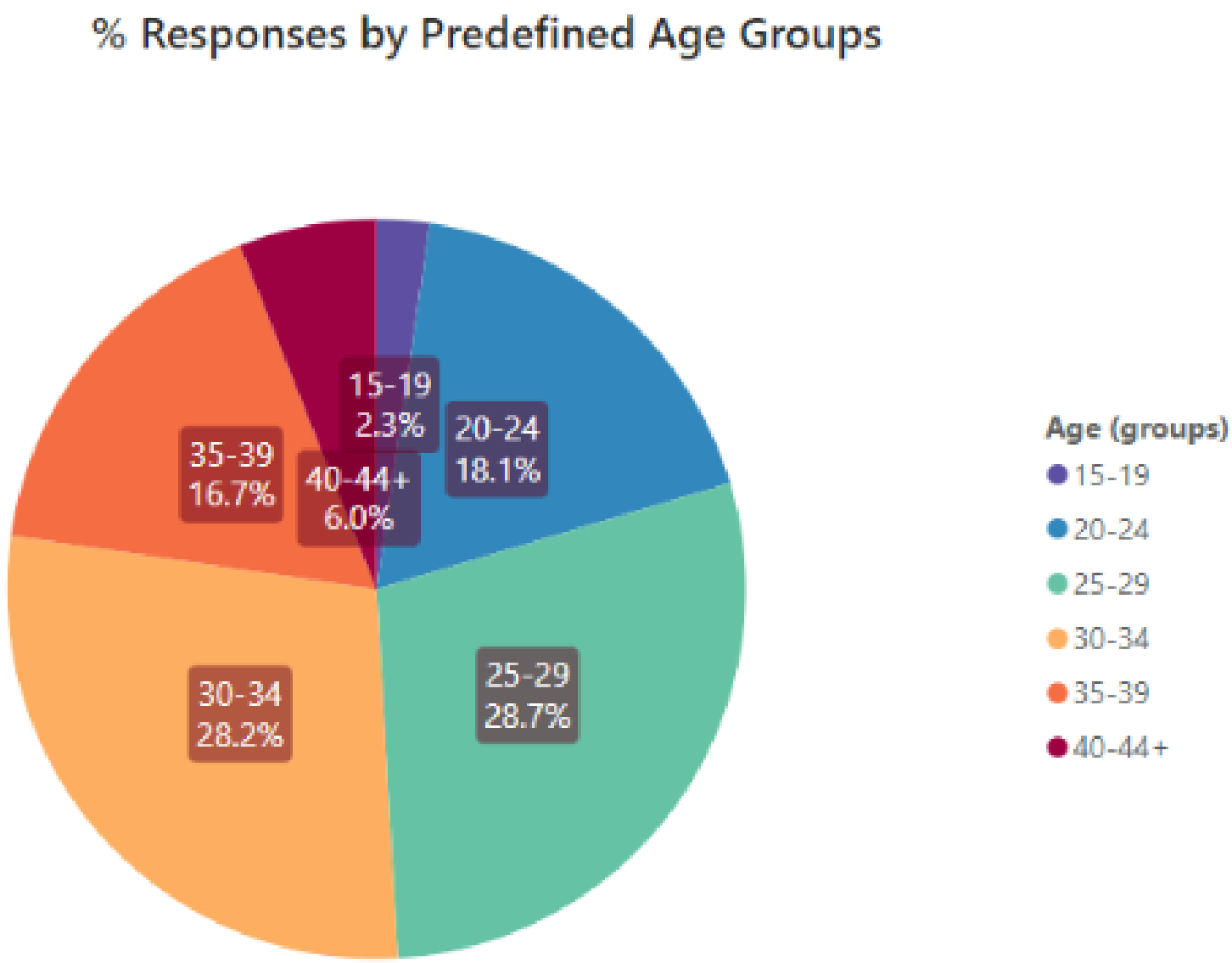
Total Responses
170



Of the 170 responses collected in 2022-2023,

55% of respondents (*n=94)* identified as **Black or African American,**
26% of respondents (*n=45)* identified as Latina, Latin/x, or Hispanic (of any race).

MES Responses by Predefined Age Groups, through 1/20/2023



Total Responses

216

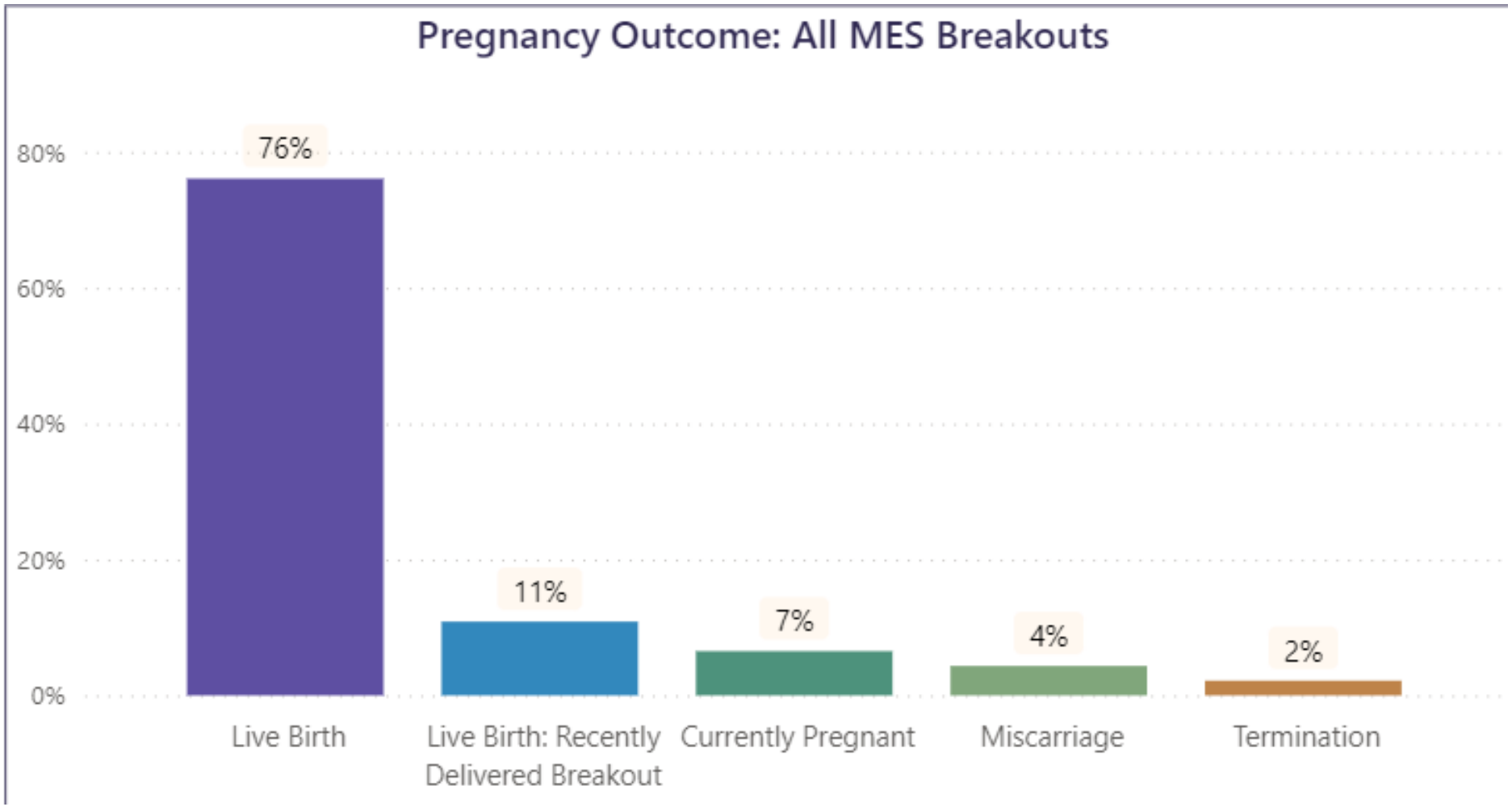
Most Recent Survey End Date: 1/4/2023

As of **January 20, 2023,** out of **216 total responses** across all age groups,
20% of respondents *(n=44)* were **ages 15-24**.
57% of respondents (*n=123)* were **ages 25-34.**
23% of respondents (*n=49)* were **ages 35-44+**

MES Responses by Pregnancy Outcome, 1/1/2021-12/31/2021

Total Responses

46



Of the 46 responses collected in 2021,

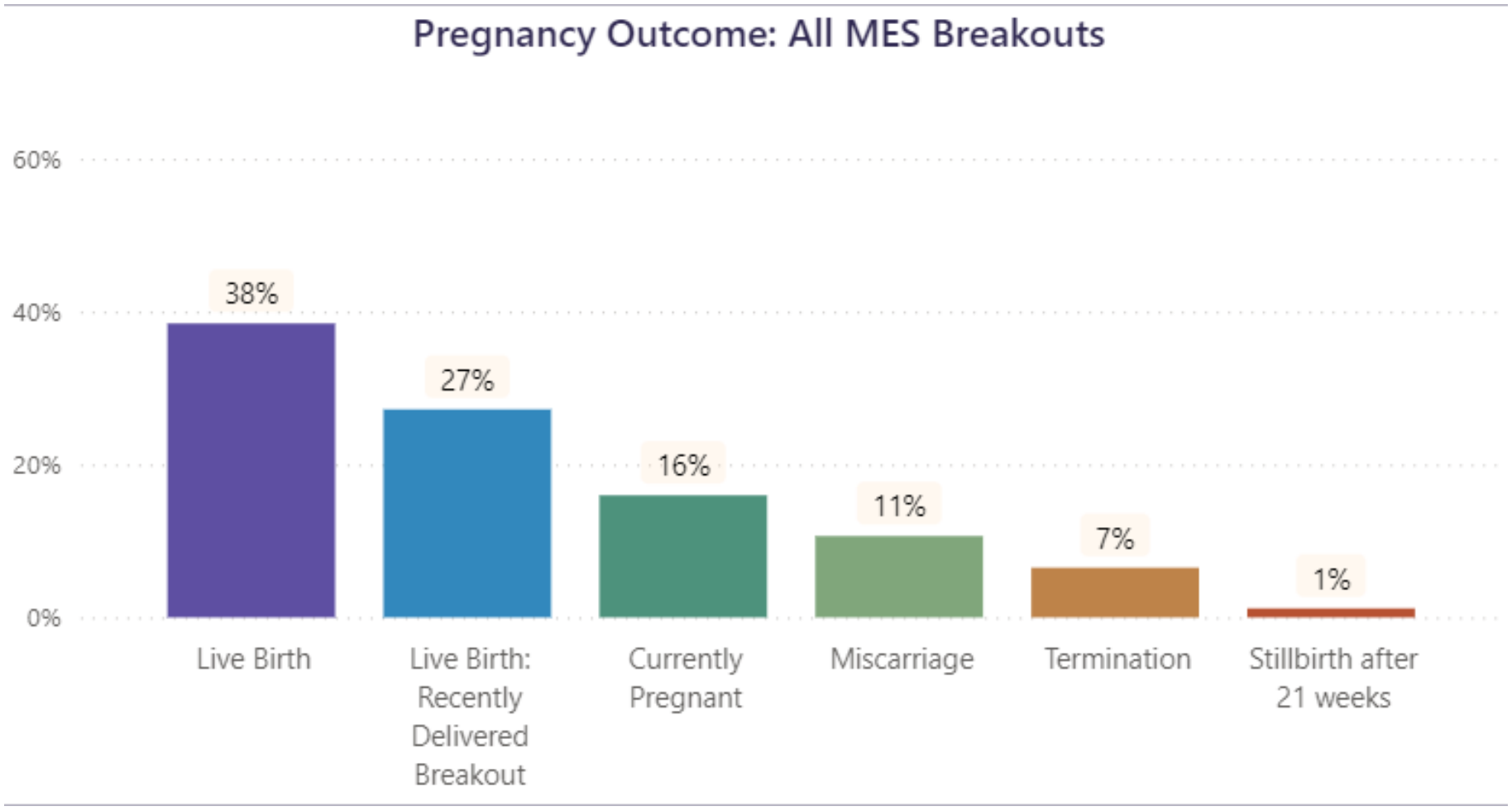
76% of respondents *(n=35)* experienced a live birth and responded to the Full MES,
11% of respondents (*n=5)* experienced a live birth and responded to the Recently Delivered Breakout,
7% of respondents (*n=3*) were currently pregnant and responded to the Currently Pregnant Breakout or Full MES,
6% of respondents (*n=3)* experienced a miscarriage, termination, or stillbirth after 21 weeks*

*Due to small numbers of respondents, this category is currently combined for narrative purposes and will be further broken out when more responses are received

MES Responses by Pregnancy Outcome, 1/1/2022-1/4/2023

Total Responses

170



Of the 170 responses collected in 2022-2023,

38% of respondents *(n=65)* experienced a live birth and responded to the Full MES,
27% of respondents (*n=46)* experienced a live birth and responded to the Recently Delivered Breakout,
16% of respondents (*n=27*) were currently pregnant and responded to the Currently Pregnant Breakout or Full MES,
18% of respondents (*n=31)* experienced a miscarriage, termination, or stillbirth after 21 weeks*

*Due to small numbers of respondents, this category is currently combined for narrative purposes and will be further broken out when more responses are received

NAACP Maternal Experiences Survey

* Thank you for completing this survey and sharing your story.

Your personal story is important to us, and we want you to control how it is shared. We want you to be confident that any responses you share will remain confidential and will not be associated with your personal information.

- [ ] Please check this box to indicate that you have read the paragraph above and agree to share your story.

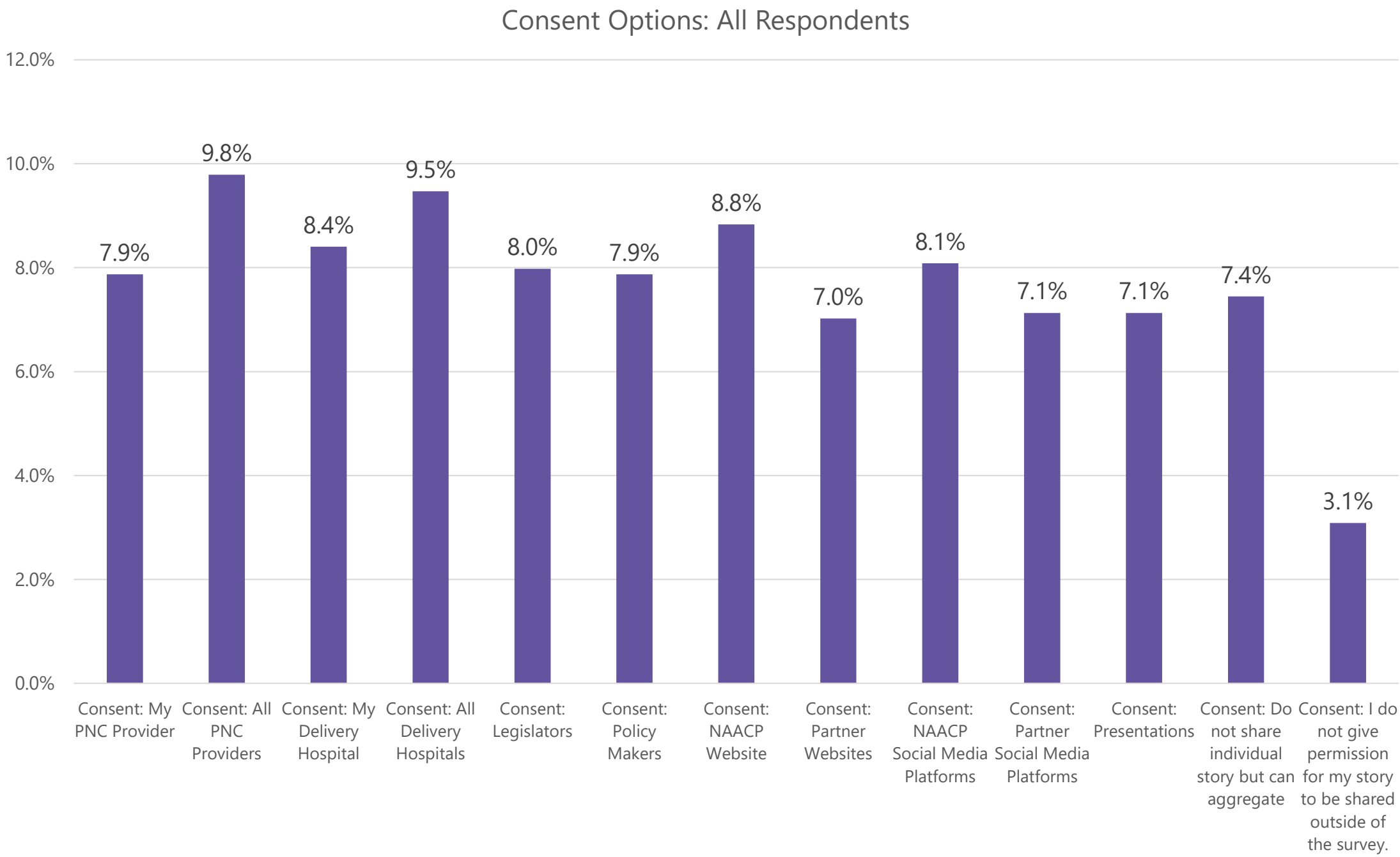
Consent Information

Please check as many boxes below that indicate with whom we may share your story.

- [ ] My Prenatal Provider
- [ ] All Prenatal Providers
- [ ] My Delivery Hospital
- [ ] All Delivery Hospitals
- [ ] Legislators
- [ ] Policy Makers
- [ ] NAACP Website
- [ ] Partner Websites
- [ ] NAACP Social Media Platforms
- [ ] Partner Social Media Platforms
- [ ] Presentations
- [ ] I do not want my individual story shared, but it is okay to combine it with others' stories when analyzing and reporting about the survey.
- [ ] I do not give permission for my story to be shared outside of the survey.

Comments:

MES Responses: Consent Responses through 1/20/2023



MES Responses: Prenatal Care Negative Treatment through 1/20/2023

Data is Statewide; Stories from Respondents who Consented to Share their Story

Total Responses

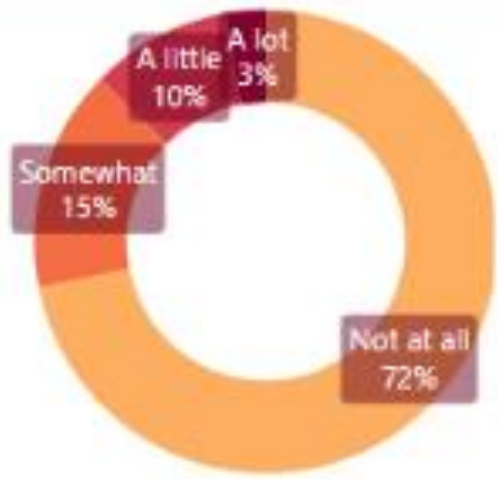
135

Most Recent Survey End Date:

1/4/2023

Race or Ethnic Background Caused Negative Treatment by Prenatal Care Provider

Black or African American, of any Ethnicity



Total Responses, Black or African American

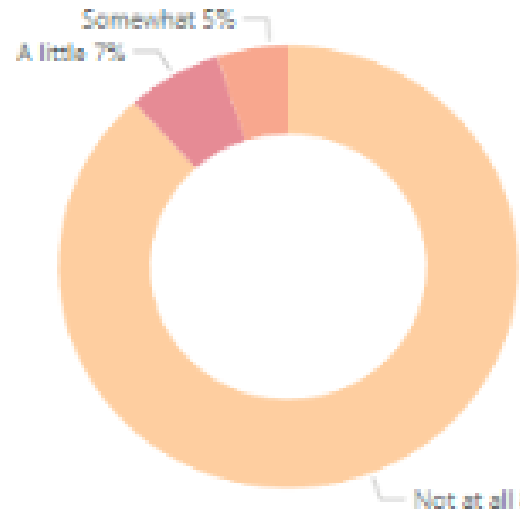
73

Question Text:

"Do you think **your race and/or ethnic background** caused negative treatment by your doctor, nurse, and/or midwife?"

"¿Considera que **su raza y/u origen étnico** afectó negativamente en el modo en que la trató su equipo de atención en el parto?"

Race or Ethnic Background Caused Negative Treatment by Prenatal Care Provider



Total Responses, Racial ID other than Black

62

Hispanic or Latina, white, Asian, Another or Multiple Racial Identities or Ethnicities

My 1st pregnancy, I had **pre eclampsia**. My OB **didn't thoroughly explain all the risks** with it. I learned quickly once at the hospital. **My education should have started during my prenatal visits**, explaining what can happen to me and the baby.

I had to have a **C section** and **my pain afterwards was not address well. I believe maybe no one believe my pain level**.

I had **private insurance**, **my own OBGYN**, but **after attending nursing school**, I know why my concerns were ignored, **Implicit Bias**."

From one respondent's Prenatal Care: Story for which they gave consent to share

"*Provider X* has a very **diverse staff** for prenatal and OB care. There are **black and Latina doctors** so it was much more **competent culturally and I felt supported**. My Dr **advocated for me and insisted I be treated respectfully**.

My Dr was also able to **explain risks to me** and **provide statistics** on **how these things impact me** based on my race and ethnicity. "

From one respondent's Prenatal Care: Story for which they gave consent to share

MES Responses: Prenatal Care Negative Treatment through 1/20/2023

Data is Statewide; Stories are from Respondents who Consented to Share their Story

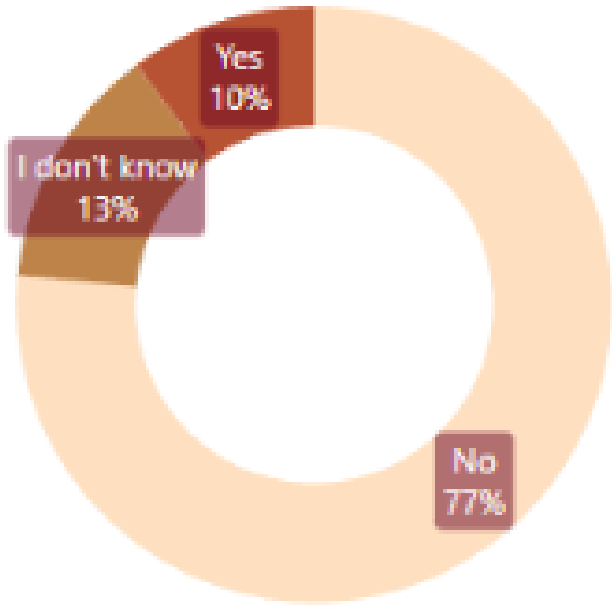
Stories from Prenatal Care Negative Treatment Comments

Total Responses

135

Most Recent Survey End Date: 1/4/2023

How Paid for Care Caused Negative Treatment by Prenatal Care Provider



Question Text:

"Do you think **something from the list below** caused negative treatment by your doctor, nurse, and/or midwife?
Medicaid status or how I paid for my care"

"¿Cree que **algo de la lista a continuación** provocó un tratamiento negativo por parte de su médico, enfermera y / o partera?"
Estado de Medicaid o cómo pagué mi atención"

Did how you paid for your care negatively influence how you were treated?

"My office is for **Medicaid or out of pocket copay based off income**. Its a **longer wait time** and **limited services but it has everything I require**. "

Excerpt from one respondent's Prenatal Care Comments for which they gave consent to share;

When I was on Medicaid going for prenatal care in the hospital clinic. I felt that the nps and obgyn were **rushing in and out of there after doing the pelvic exams and sonograms and concerns and I had about swelling in my legs and feet were brushed off. I was told to put my feet up no connection was ever made about pre-eclampsia** and my key tones kept coming back hi but there was no directions what to do about that except they were asking me if I was eating enough and I was eating enough. **No aftercare was set up** except for the postpartum exam during which **they asked me if while they were down there if I wanted my tubes tied! Seriously?**

Excerpt from one respondent's Labor & Delivery Story for which they gave consent to share;

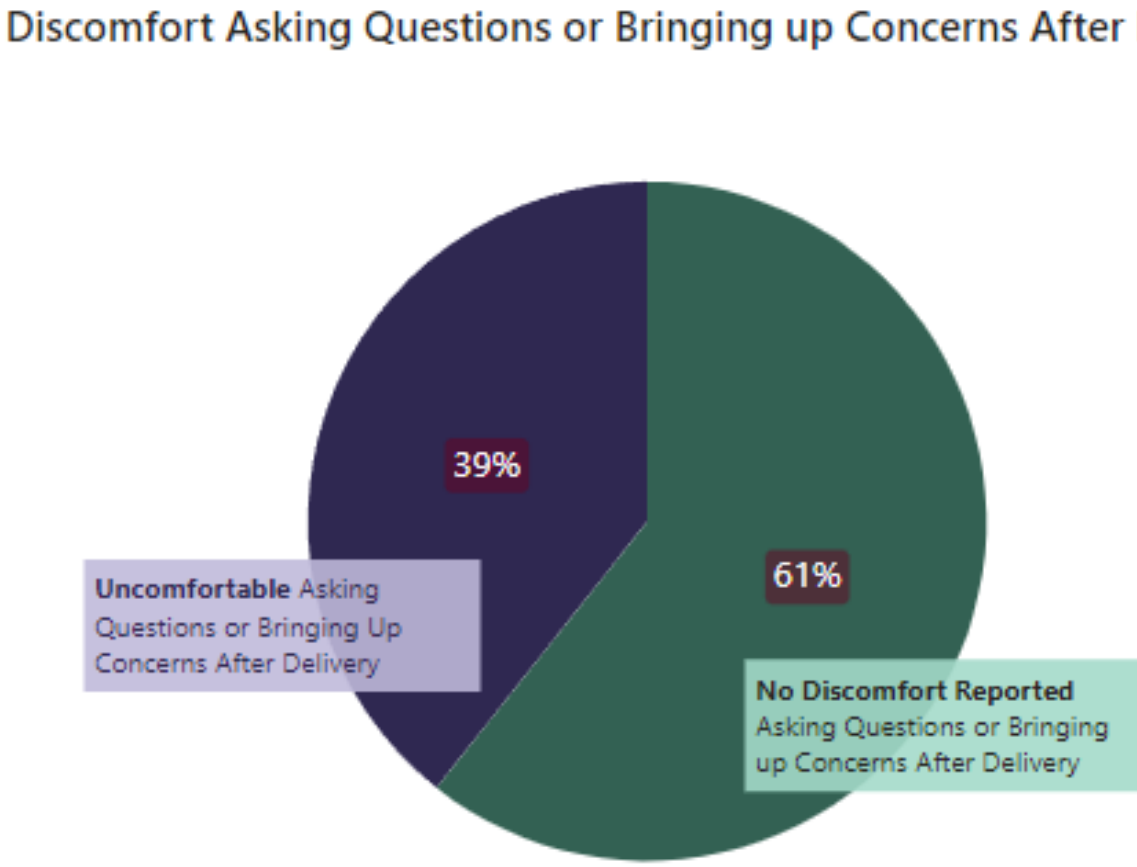
"I **could only get certain care** or **treatments** because of the **state insurance until there was a problem**."

Excerpt from one respondent's Prenatal Care Comments for which they gave consent to share;

This question will be further broken out by racial identity and ethnic group when more responses have been collected in future reports and presentations.

MES Responses: Discomfort Asking Questions or Bringing up Concerns After Delivery through 1/20/2023

Data is Statewide; Stories are from Respondents who Consented to Share their Story



Total Responses
151

Most Recent Survey End Date:
1/4/2023

1. As of **November 18, 2022,** out of **150 total responses** who received questions regarding after their delivery, before being discharged from a hospital,
2. **39%** of respondents *(n=59)* **reported discomfort asking questions or bringing up concerns** after delivery before being discharged from a hospital.
3. **61%** of respondents (*n=91)* **did not report discomfort asking questions or bringing up concerns** after delivery before being discharged from a hospital

One of the ladies had pulled my baby off my nipple very hard while my baby was feeding. **She said that it was more important to get done what she had to do first, as far as giving my baby shots and footprints**. I was just bonding my baby after a few minutes into birthing her and the lady showed no care in me breastfeeding my child. **She didn't look like she wanted to be there** or didn't look like she liked or loved her job.

Excerpt from one Atlantic County respondent's Labor and Delivery Story for which they gave consent to share

"I **delivered during a pandemic**…I felt like they just wanted me in and out. **I felt like a number not a patient."**

Excerpt from one Atlantic County respondent's Post-Delivery Story for which they gave consent to share

I **received quality care** from the health practitioners and I was able to **recuperate** fully. They **helped me cope with depression**.

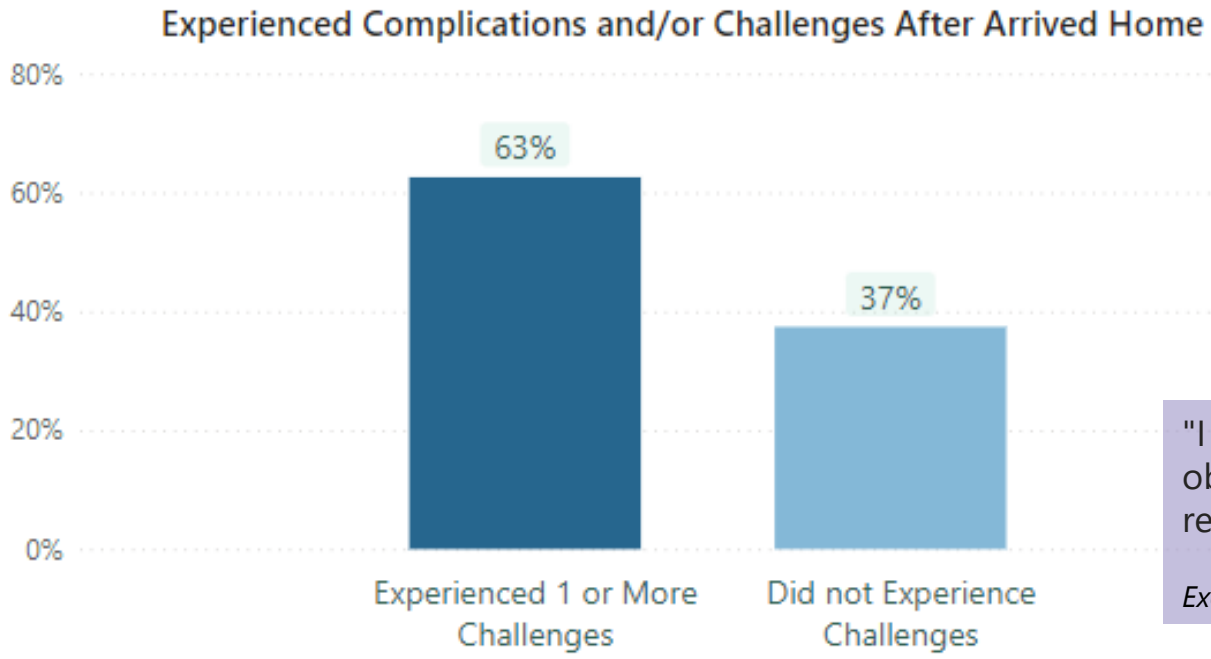
Excerpt from one Atlantic County respondent's Post-Delivery Story for which they gave consent to share

MES Responses: Post-Discharge Challenges or Complications through 1/20/2023

Data is Statewide; Stories are from Respondents who Consented to Share their Story

Total Responses

150

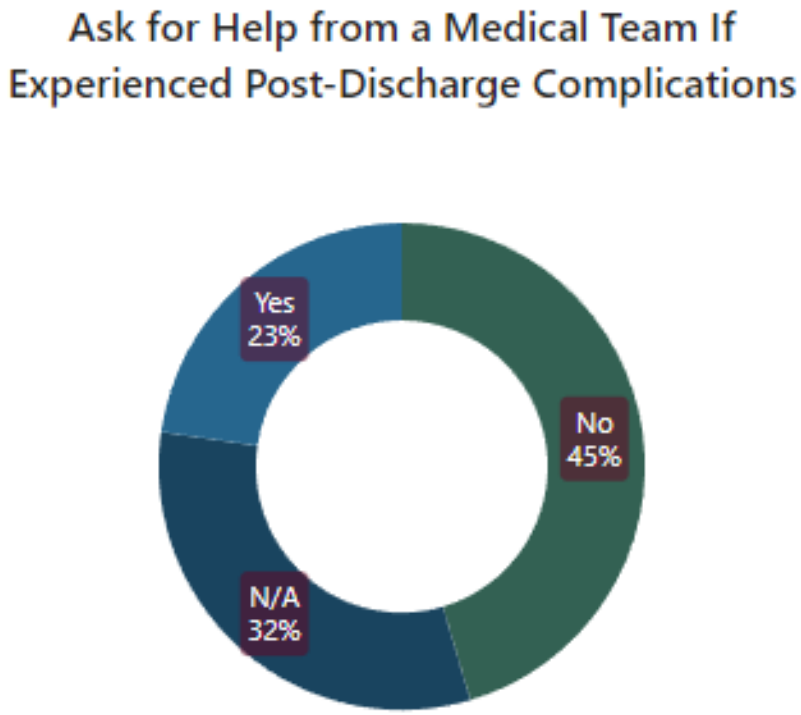


"I did experience pain and headache. I contacted the hospital and they **responded quickly** with the help I needed. Everything was sorted and I had an easy time with the child."

Excerpt from one respondent's Post-Discharge Story for which they gave consent to share

"I tried to get [the] name of [the] np who did my prenatal care and [the] obgyn who also did my prenatal care **and I could not get appointments** the reasons were **not taking patients or moved out of area**."

Excerpt from one respondent's Post-Discharge Story for which they gave consent to share



During my postpartum appointment I was asked by the medical assistant, "Are you breast feeding?" I also had appointments because my breast were so sore from milk production. Also, **almost 2 years later** I still have **pelvic pain that no doctor seems to care about**. Also, **I did not qualify for maternity leave because my babies died.** That is an insult**. Miscarriages should be covered under maternity and not disability.** I had to return to work within a certain timeframe or I would be terminated.

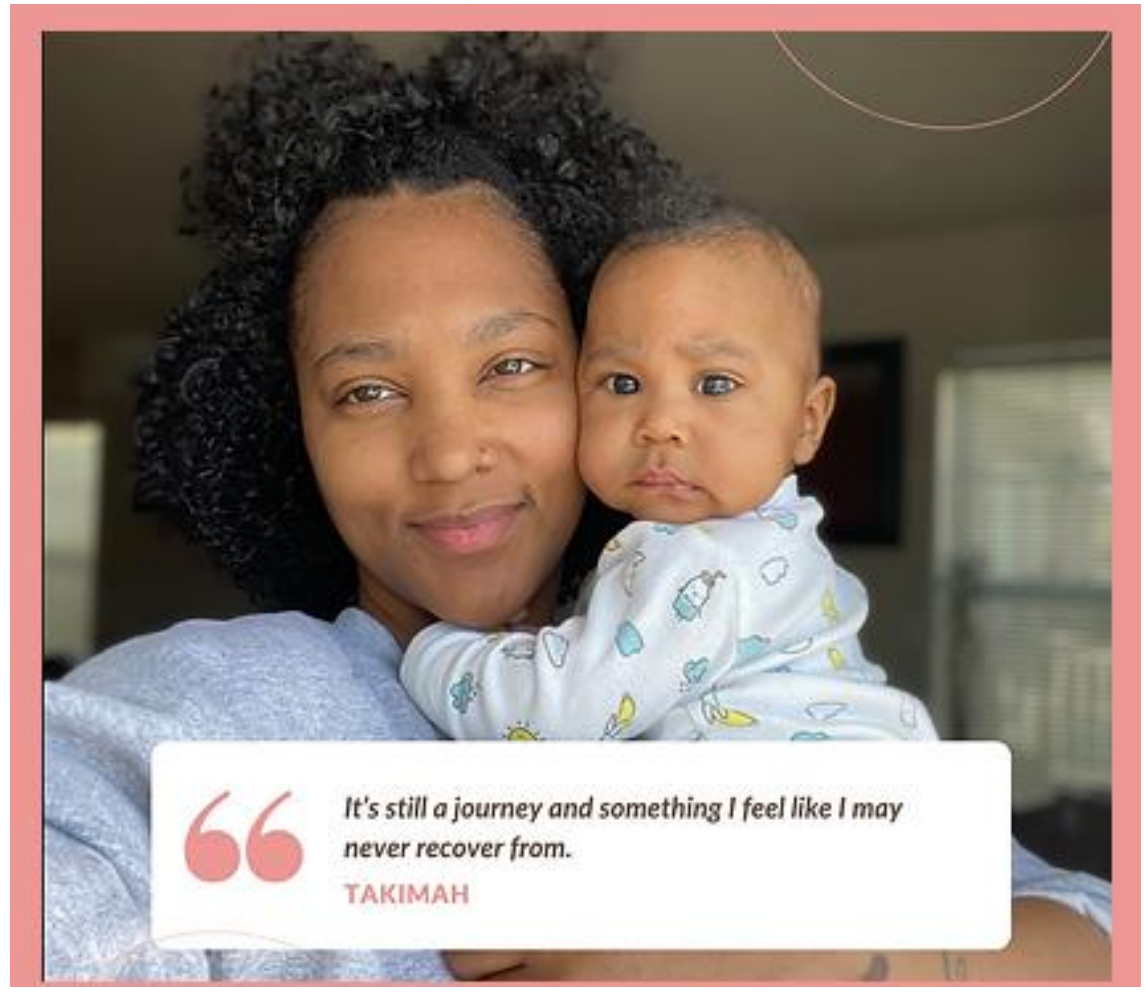
Excerpt from one respondent's Post-Discharge Story after experiencing a miscarriage for which they gave consent to share

During the **newborn assessment** when the **newborn provider** asked about the postpartum anxiety and depression screening **I expressed heightened anxiety** which **wasn't met with much receptivity . I then searched resources outside of my child's pediatrician.**

Excerpt from one respondent's Post-Discharge Story after experiencing a miscarriage for which they gave consent to share

In Mothers' Words

To read Danica's full story visit
https://www.njpreterm.org/mes



To read Takimah's full story, visit
https://www.njpreterm.org/mes

TOMAR LA ENCUESTA EXPERIENCIA MATERNAL

COMPARTIR.

SER ESCUCHADO.

ESPERAR CAMBIO.

Presentado por: NJ NAACP Black Infant and Maternal Mortality Taskforce

Complete la Encuesta de Experiencia Materna para ayudar a mejorar la atención y reducir las injusticias para las personas Negras que dan a luz. Tu experiencia ayudará a producir cambios y mejores resultados en Nueva Jersey.

SI HA TENIDO UNO DE LOS SIGUIENTES:

- Nacimiento Vivo
- Nacimiento Muerto
- Aborto Espontáneo
- Aborto

Escanee el código QR para participar o visite: njpreterm.org/mes

Comparte tu experiencia y recibe un regalo especial.

Si tiene preguntas sobre la encuesta, comuníquese con Christine Ivery al civery@fhiworks.org o al 609-206-8206.

La Iniciativa de Prevención de la Prematuridad es un programa de Iniciativas de Salud Familiar (FHI) respaldado por fondos del Departamento de Salud de Nueva Jersey. FHI es una agencia subsidiaria de Southern NJ Perinatal Cooperative. 2021.

TAKE THE MATERNAL EXPERIENCE SURVEY

SHARE.

BE HEARD.

EXPECT CHANGE.

Presented by: NJ NAACP Black Infant and Maternal Mortality Taskforce

Complete the Maternal Experiences Survey to help improve care and reduce injustices for Black birthing people. Your experience will help to produce change and better outcomes in New Jersey.

IF YOU'VE HAD ONE OF THE FOLLOWING:

- Live birth
- Still birth
- Miscarriage
- Abortion

Scan the QR code to participate or visit: njpreterm.org/mes

Share your experience and receive a special gift.

If you have questions about the survey, contact Christine Ivery at civery@fhiworks.org or 609-206-8206.

The Prematurity Prevention Initiative is a program of Family Health Initiatives (FHI) supported by funding from the NJ Department of Health. FHI is a subsidiary agency of the Southern NJ Perinatal Cooperative. 2021.

How to Access the MES Implementation Report

Updated December 2022

1. Visit https://www.njpreterm.org/mesreport
2. Complete a short registration
3. Download the Report and MES Flyer

MES Implementation Report

Please complete this short form to access the report results.

(we promise we won't sell it or spam your email)

First Name *

Last Name

Email *

Data Notes

1. Introduction (Pg. 3)
In the most recent report from the New Jersey Maternal Mortality Review Committee (NJMMRC), Nantwi et al. (2022) reported in New Jersey from 2016-2018, the Pregnancy Related Mortality Ratio (PRMR) for Black, non-Hispanic women (39.2 deaths per 100,000 live births) was 6.6 times higher than the PRMR for white, non-Hispanic women (5.9 deaths per 100,000 live births). The PRMR for Hispanic and/or Latino women (20.6; n=37) was 3.5 times higher than the PRMR for white, non-Hispanic women. The PRMR is defined in the same report (2022) as the number of pregnancy-related deaths per 100,000 live births (p. 6). Though 13.4% of all live births (n=40,822) were to non-Hispanic Black women from 2016-2018, 36.4% (n=16) of all pregnancy-related deaths in NJ were also to non-Hispanic Black women in the same time frames (Nantwi et al., 2022).

2. Introduction (Pg. 3)
According to 2019 data from the NJ Birth and Death Certificate Database from NJ DOH, the Infant Mortality Rate (IMR) per 1,000 Live Births for infants who were Black, non-Hispanic was 8.5. The IMR for infants who were white, non-Hispanic was 2.9.

3. Maternal Mortality & Morbidity Trends (Pg. 5)
Pregnancy-related deaths are defined by the CDC (2019) as deaths that occur during pregnancy or within 1 year of the end of pregnancy that are related to the pregnancy. The NJ MMRC (2022) defines pregnancy-related death as "a death during or within one year of pregnancy, from a pregnancy complication, a chain of events initiated by pregnancy, or the aggravation of an unrelated condition by the physiologic effects of pregnancy" (p. 16).

4. Statewide Data: Preterm Births (Pg. 6)
According to finalized 2020 birth data from the NJ Birth Certificate Database from NJ DOH, the statewide percentage of all births that were preterm (less than 37 weeks gestational age) was 9.3%. When data were queried on July 5, 2022, there were 9,018 preterm births out of 97,146 live births in New Jersey in 2020.

5. Infant Mortality (Pg. 7)
This chart groups statewide data in 3-year timeframes by race and ethnicity to illustrate the IMR from 2010-2019 (most recent available data year.) The IMR is the number of infant deaths before their 1st birthday per 1,000 Live Births in the same year or group of years.

The MES highlights experiences of Black birthing people in a safe manner embedded with identity acceptance and respect.

The NAACP MES is open to respondents of all races and ethnicities.

Respondents may be of any age.

Respondents will not be turned away from any county in NJ.

All responses are deidentified, reviewed for validity, and processed for reporting.

References

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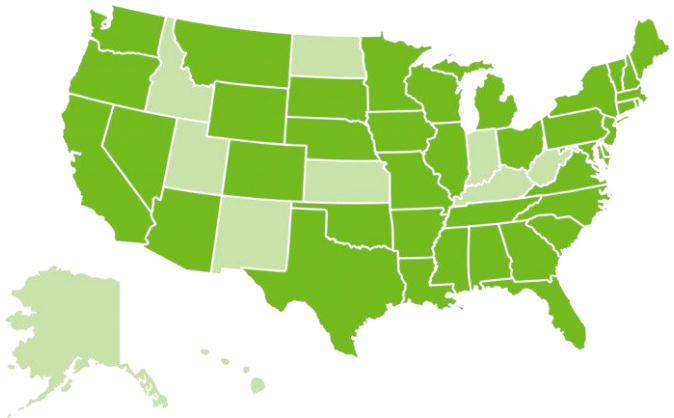
Disclosures

- The Quality Institute serves as the Regional Leader for The Leapfrog Group for New Jersey and New York. We do not receive any funding from The Leapfrog Group for our work.
- Linda Schwimmer is Vice-Chair for The Leapfrog Group Board of Directors, a volunteer position.
- Linda Schwimmer chairs The Leapfrog Group's Ambulatory Surgery Center (ASC) Committee, a volunteer position.

Leapfrog Hospital Survey Data

- Leapfrog is a national nonprofit founded by large, self-insured purchasers in 2000 in response to 1999 IOM Report *To Err is Human.*
- Mission: Trigger giant leaps forward in the safety, quality, and affordability of U.S. health care by using transparency to support informed decision-making and value-based purchasing.
- Leapfrog's data is publicly reported; used by consumers, purchasers and employers, health plans, providers, researchers, and others.
- The Leapfrog Group has regional partners, called Regional Leaders, in over 38 states and communities across the country.

THELEAPFROGGROUP



Leapfrog's Ratings Programs

Leapfrog Hospital Survey

- For over 20 years, Leapfrog has asked hospitals to voluntarily report on the safety, quality, and efficiency of inpatient care they provide.
- In New Jersey, 100% of hospitals participate in the Hospital Survey.

Leapfrog ASC Survey

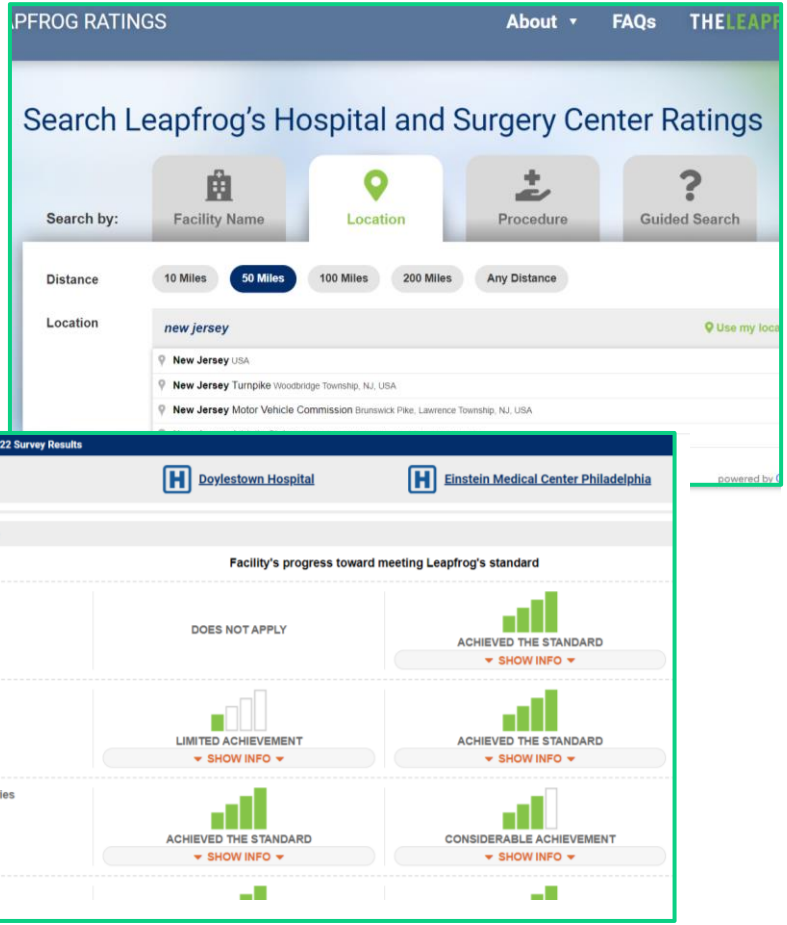
- In 2019, Leapfrog launched their Ambulatory Surgery Center (ASC) survey to assess ASC performance on national measures of safety, quality, and efficiency of patient care.
- Only 4% of ASCs in New Jersey participate.

Leapfrog Safety Grade

- Since 2012, Leapfrog has been assigning A, -B, C, D, or F grades to general acute care hospitals across the U.S., regardless of whether or not they submit a Hospital Survey.
- Hospitals are scored on how safe they keep their patients from *preventable* errors, injuries, accidents, and infections.

How Can Consumers Access Leapfrog Survey Data?

- Leapfrog Survey Results are publicly reported to educate consumers about the safety and quality of hospitals in their community so that **they can choose the best place for their care**.
- View Survey results at www.leapfroggroup.org.
- Leapfrog publishes findings from the Leapfrog Hospital Survey starting in July each year, and monthly through February. (Hospitals have multiple opportunities to submit their annual Survey, with opportunities to update their data monthly.)



Leapfrog Hospital Survey Data

- The Survey includes a variety of nationally standardized and endorsed measures pertaining to the safety and quality of inpatient care, including maternity care, high-risk surgical procedures, Computerized Physician Order Entry (CPOE) system implementation, ICU physician staffing, and more.
- Included measures are predicated on the latest science and selected with guidance from scientific advisors at the Armstrong Institute for Patient Safety at Johns Hopkins Medicine as well as Leapfrog's volunteer Expert Panels.
    - The Maternity Expert Panel includes representation from: the Institute for Perinatal Quality Improvement, the California Maternal Quality Care Collaborative, MetroHealth Medical Center, Massachusetts General Hospital, Cedars-Sinai Medical Center, and Yale University School of Nursing.
- Measures are reviewed and updated annually to reflect the current evidence.
- Hospitals provide all data for the Leapfrog Hospital Survey directly.
- The definitions and instructions for completing the Survey are publicly available on Leapfrog's website.

Survey Section 4: Maternity Care

- The maternity care section currently includes 6 measures:

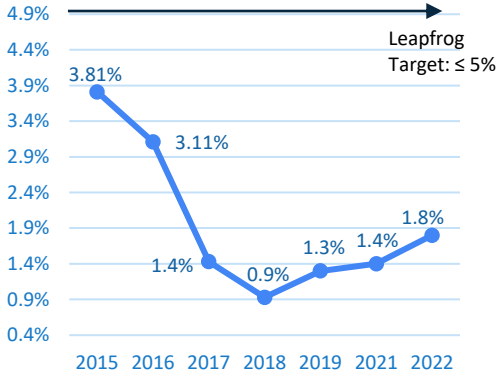
Maternity Care Volume	Elective Deliveries	Cesarean Birth
Episiotomy	Process Measures of Quality: focuses on screening newborns for jaundice prior to discharge and the prevention of blood clots in women undergoing a cesarean section	High Risk Deliveries

- Additional questions proposed for the 2023 Survey, which will not be scored but will be required and publicly reported, focus on the availability of:

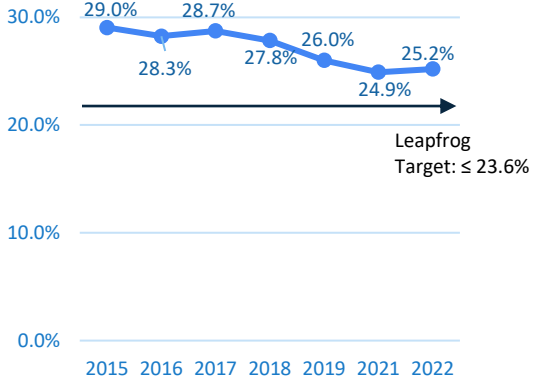
Midwives and doulas	Breastfeeding support	Vaginal delivery after cesarean section	Postpartum tubal ligation

How is New Jersey Doing?

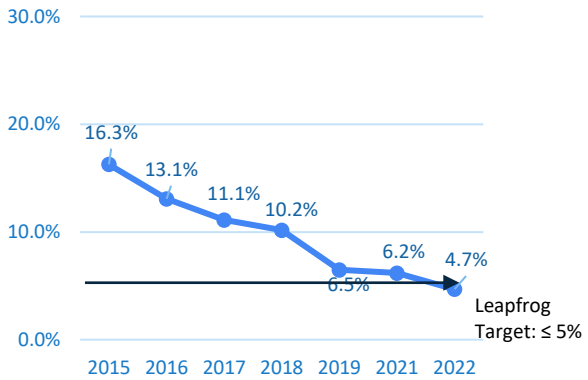
- Leapfrog chose to focus on the following 3 maternity measures because they are medical interventions. Their overuse poses unnecessary increased risks to the mother and baby.
    - **Early Elective Deliveries**: scheduled C-sections or medical inductions performed prior to 39 completed weeks gestation without a medical reason
    - **Episiotomies**: an incision made in the perineum to make the vaginal opening larger during childbirth
    - **Nulliparous, Term, Singleton, Vertex (NTSV) Cesarean Birth rate**: C-sections for mothers with first-time pregnancies (nulliparous) that have reached at least 37 weeks of gestation (term) and have a single baby (singleton) in the head-down position (vertex)



NJ Average - EED



NJ Average - NTSV



NJ Average - Episiotomy

MAP to Action: Data Session
Breakout Room Summary
January 27, 2023

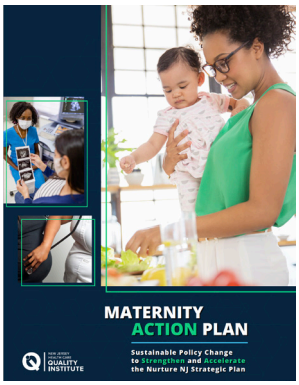
Theme 1: Collecting and accessing timelier, more aligned data across the perinatal period	**Theme 2: Collecting and using patient reported data for meaningful improvement**
What messages/ideas/information from the presentations resonated with you?	
• The timeliness of data is important. Although we may be looking at older numbers, sometimes it is outside of our control. But, once the data is collected, we need a faster process to get it released. If the data cannot be released quickly enough, we should at least publish the recommendations. • Find ways to publicly share that are more accessible to non-experts. • Request for more information on how the MMRC is collecting/reviewing data re substance misuse, SDOH. • Raised the need to implement the "Utah Criteria" to understand conditions that are exacerbated by pregnancy (some of the cases we see as pregnancy-associated are really pregnancy-related). • Raised need for updated support/definitions for suicide/homicide to be seen as pregnancy-related conditions.	• Irth connects to the work being done by UniteUs related to connection to SDOH. Health equity is important to us. • Responses (in the Irth App) show that there is a lot of stereotyping – like asking a Black person if they are on WIC. This is a frequent piece of feedback given. • Importance of saying something happened and then following it up with how many times it happened (with data). • When stories are shared, there needs to be next steps with data, for leadership to be called on to respond. Accountability is needed. • Need for tools to help us tell stories. Broad and easily accessible for community members. They need to be able to say how they want their stories told. Some tell their stories over and over again with no action taken.
Theme 1: Collecting and accessing timelier, more aligned data across the perinatal period	**Theme 2: Collecting and using patient reported data for meaningful improvement**
How does data support your work? Are you engaged in a project that relates to this work?	
• Would like advice/ideas on how to "how can we use the data to change policy?" • Even data may be similar year over year, it needs to be presented in consumer friendly easier to understand. • Examples shared: "Count the Kicks" is a campaign encourages women to the count the kicks from their baby. An App you can download. Another example was how obesity is a risk in pregnancy. How do we get providers/others to relay the information and educate in accessible way? • Data needs to be made accessible to people who don't like data or who don't use it. This is the true essence of the grassroots effort: making information accessible. Doing so affects policy, because we can get a wider range of people familiar with the issue.	• Irth is not currently being used within in NJ but there is the need is great. • Learned from Irth that each state is unique. The tool is very community-oriented, and the aggregate knowledge isn't transferable because it is linked to community. It looks at what are the specific behaviors. Are hospitals following baby-friendly protocols? With data we can see what protocols are not being followed. • There is a framework in which work is done for the Black community (https://blackmamasmatter.org/our-work/toolkits/). The absence of Black-led models in the care we are delivering is troubling. We should be utilizing the Black Mamas Matter framework to collect and extract data. We are not using Black led organizations to lead and do this work. (Additional background- https://blackmamasmatter.org/literature/)

Theme 1: Collecting and accessing timelier, more aligned data across the perinatal period	Theme 2: Collecting and using patient reported data for meaningful improvement
Thinking forward – how would you measure success in data collection, use, and reporting?	
(Not discussed- lack of time)	• Better understanding about what happens before and after the hospital for birthing people. • How can we change lags in data? • What can we do to aggregate data? • How is data from FQHCs included? • Pregnant people are not always interested in providing responses to surveys. • Breastfeeding is often overlooked. We would love to see more data about what's happening in communities even before pregnant people get to the hospital. NJ breastfeeding strategic plan is being updated with good data from around the state. • UniteUs is working on the Healthy Women Healthy Families initiative and working with social care providers, trying to determine reasons for missed care: are women not getting to the doctor because of public transportation for example? They are trying to reduce the trauma of telling your story repeatedly by using data.
In thinking about this topic, what has held you back from this work or a specific project (resources, finances, connection and support from other partners, uncertainty about where to start, etc.)?	
(Not discussed- lack of time)	• Much of the work being elevated in New Jersey is from white-led organizations and white leaders, with its intended purpose to change birth outcomes for Black and brown people. This is a state where there are Black clinicians, advocates, and organizations doing this work and living this experience who should be given the opportunity and the resources to lead. Instead of consistently offering the opportunities to white-led established organizations, there is a place for those organizations to be engaged but the need is great to have this work led by black-led CBOs and those who have a deep understanding of the needs to have a greater impact in New Jersey. • NJ is focused on doing things our own way and recreating the wheel. There has been excellent work done in other states like CA that have worked for the Black and brown community like implementing standard protocols for care. Our state is not strong in that space- we still have hospitals that don't have any protocols in place. • Irth focuses on transparency of our reviews, not just giving them privately to a hospital. Honesty must be at the root of what we're doing. We can't let a lack of

	transparency be an obstacle to those who can get the work done. • We need to get comfortable having uncomfortable conversations. Every statistic is a life, a family, a community impacted. We need to stop looking at individuals as diagnoses or illnesses and see them as human.

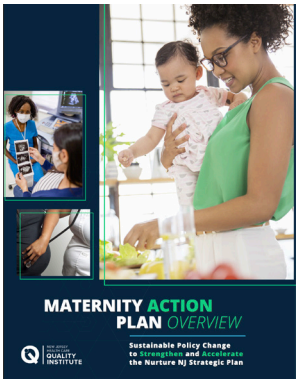
MAP to Action

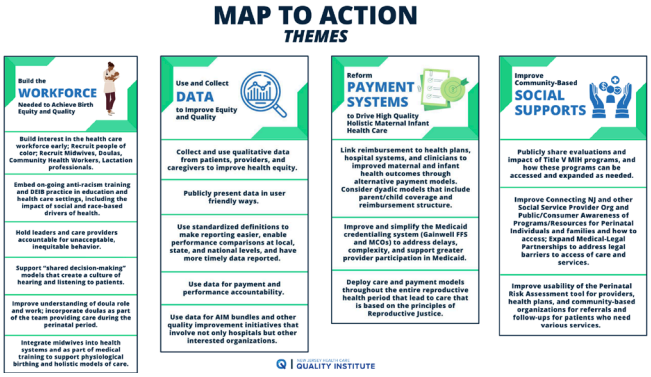
Additional Resources: Data



Maternity Action Plan: https://njhcqi.info/MAP4NJ

MAP Executive Summaries: https://www.njhcqi.org/wp-content/uploads/2023/02/MAP_Summaries_ALL_2023_v2.pdf





Key Themes - ***These are the main concepts that rose to the top throughout the MAP to Action Series*:** https://www.njhcqi.org/wp-content/uploads/2023/06/MAP-to-Action-Themes-State-suggestions.pdf

Connection Guide - ***Use this tool to guide continued collaboration—to share ideas, nurture relationships, and build a coalition*:** https://www.njhcqi.org/wp-content/uploads/2023/04/Connection-Guide.pdf