Empowering Local Health Departments: A Guide to Maternal and Child Health Services and Best Practices

Presented by
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Meet your presenters!

Rachel Freedman, MPH:

- Simmons University - B.S in Public Health
- Tufts University School of Medicine, Population Health Promotion - MPH
- Former Full-Time Doula and Nanny
- Program Associate: Office of MaineCare Services - Transforming Maternal Health (TMaH) Model

Deidra (Clermont) Alexander, MPH

- Towson University - B.S in Health Education and Promotion / Community Health
- Boston University School of Public Health - MPH in Epidemiology & Biostatistics / Maternal & Child Health
- Research Assistant: Center for Black Maternal Health and Reproductive Justice at Tufts University School of Medicine
- Former Birth Doula: Accompany Doula Care
- Former Regional Epidemiologist: Metro Public Health Collaborative (MPHC)

QR Code to View Guide

Agenda

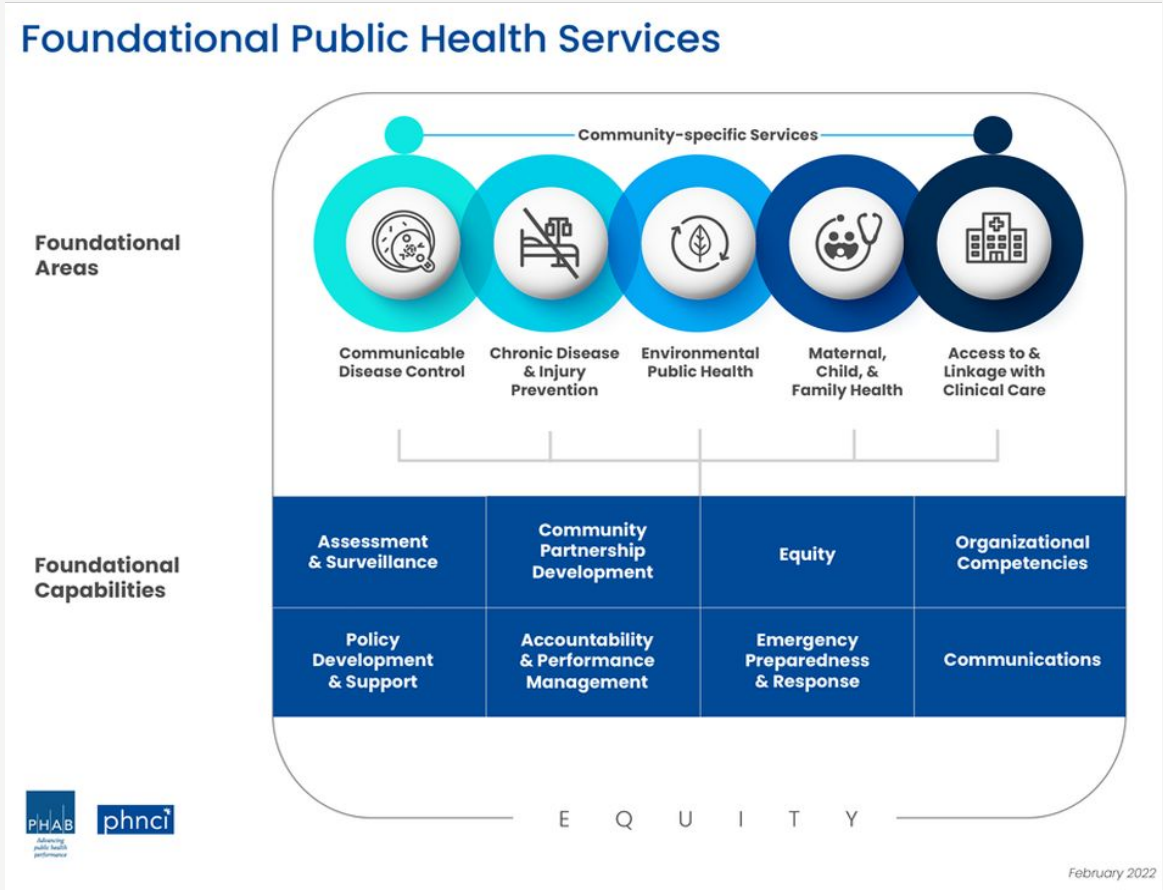
- Welcome
- Health Disparities Analysis + Tools for Assessment
- Collaboration & Advocacy Strategies
- Case Study: North Shore Mothers Visiting Program
- Next Steps & Call to Action
- Q&A + Discussion

Icebreaker

Raise your hand if your department/agency currently has a maternal, child and family health initiative!

Purpose/Impact

Purpose: Empower local health departments to strengthen maternal and child health (MCH) programs through practical tools, data-driven strategies, and evidence-based frameworks for program design and implementation.



Impact:

- Builds local capacity to identify and address MCH disparities.
- Promotes data-informed, equitable decision-making.
- Enhances cross-sector partnerships and sustainability.
- Supports innovation through real-world

Slido Activity

What's a maternal, child or family health issue your community faces the most?

Slido Code:
3249613
(slido.com)

MCH Guide Overview

Health Disparities Analysis

Tools for Assessment

Collaboration Framework

Advocacy and Outreach Strategies

Needs Assessment Checklist

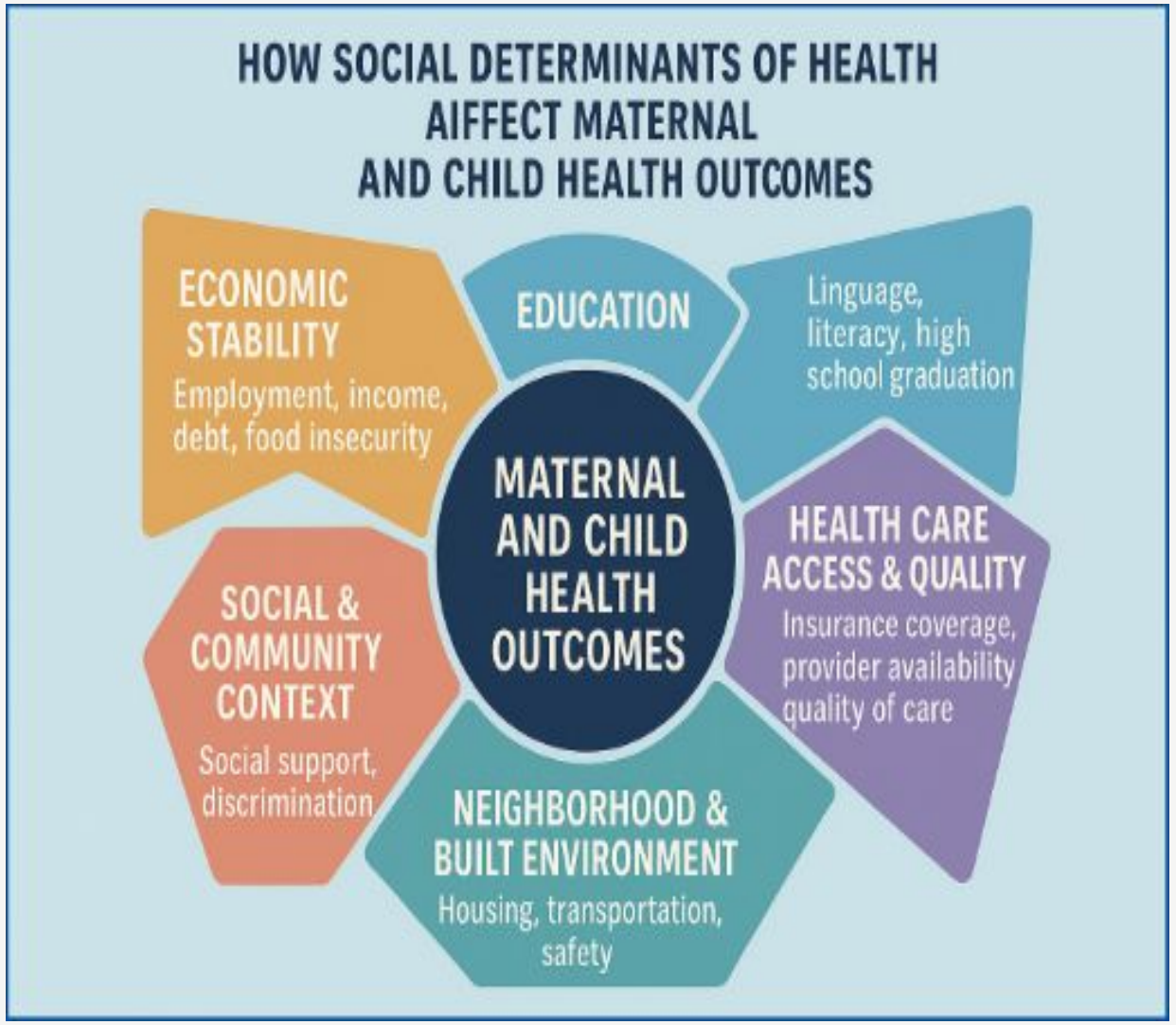
Program Implementation Checklist

Case Study

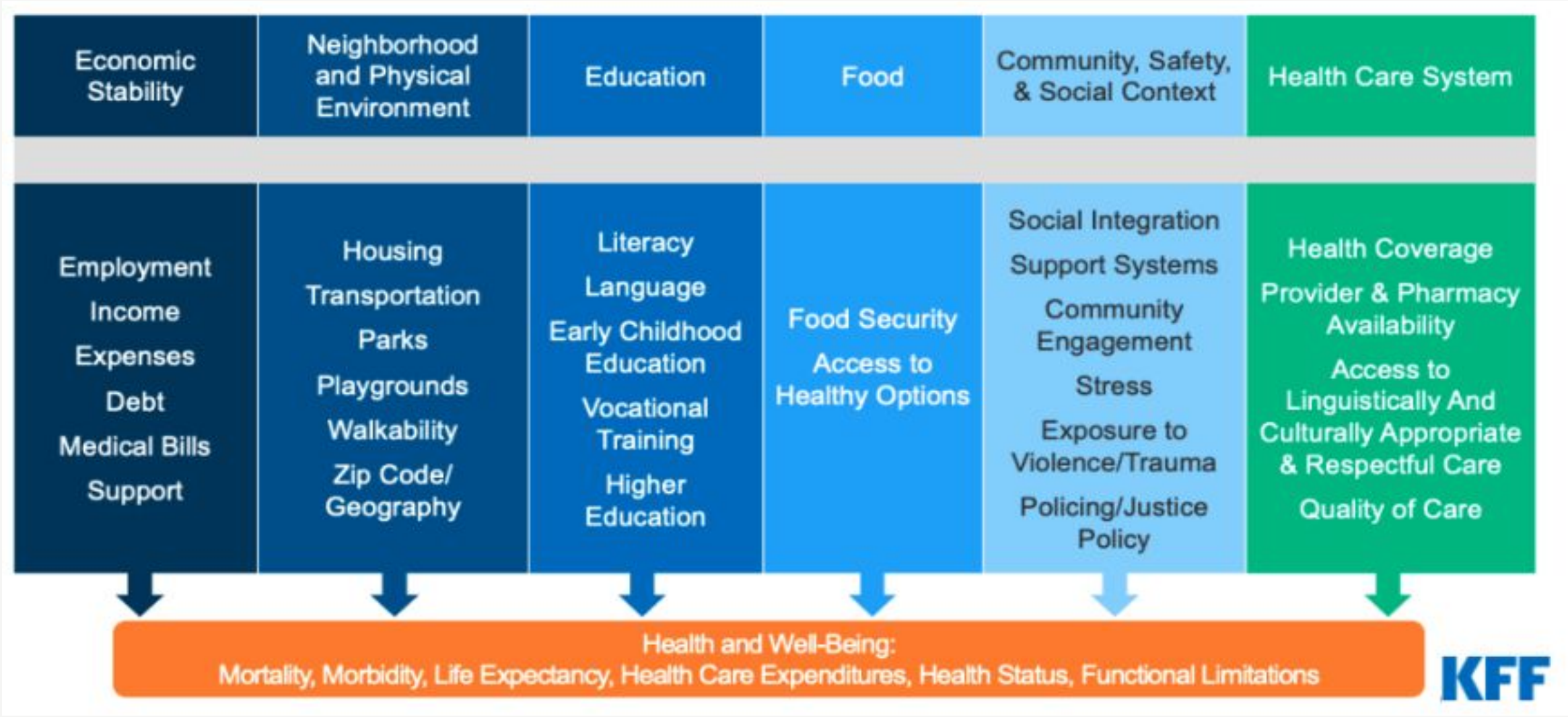
Resources

Health Disparities Analysis

- Health disparities are preventable gaps in health outcomes caused by systemic inequities.
- Most affected: racial/ethnic minorities, low-income, and rural populations.
- MCH disparities include higher maternal and infant mortality and low birth weight.
- Limited prenatal and pediatric care



Social Determinants of Health (SDoH)



Source: KFF's Racial Equity and Health Data Dashboard

Slido Activity

Where do you retrieve data for maternal, child, or family health needs?

Slido Code:

3249613

(slido.com)

Sources of MCH Data

- **Vital Statistics:** Birth & death certificates offer core data on birth weight, gestational age, and maternal mortality.
- **PRAMS (CDC Survey):** Tracks maternal behaviors and experiences before, during, and after pregnancy—ideal for identifying risk factors.
- **Hospital Discharge Data:** Reveals trends in delivery complications, ER visits, and postpartum readmissions.
- **WIC & Medicaid Claims:** Highlights care access, nutrition support, and service use in low-income populations.
- **Community Health Needs Assessments (CHNA):** Combine data and community input to identify service gaps.
- **GIS Mapping Tools:** Visualize disparities geographically—e.g., maternal care or food deserts by ZIP code.
- **Local Surveys/Focus Groups:** Add context and lived experience to quantitative data.

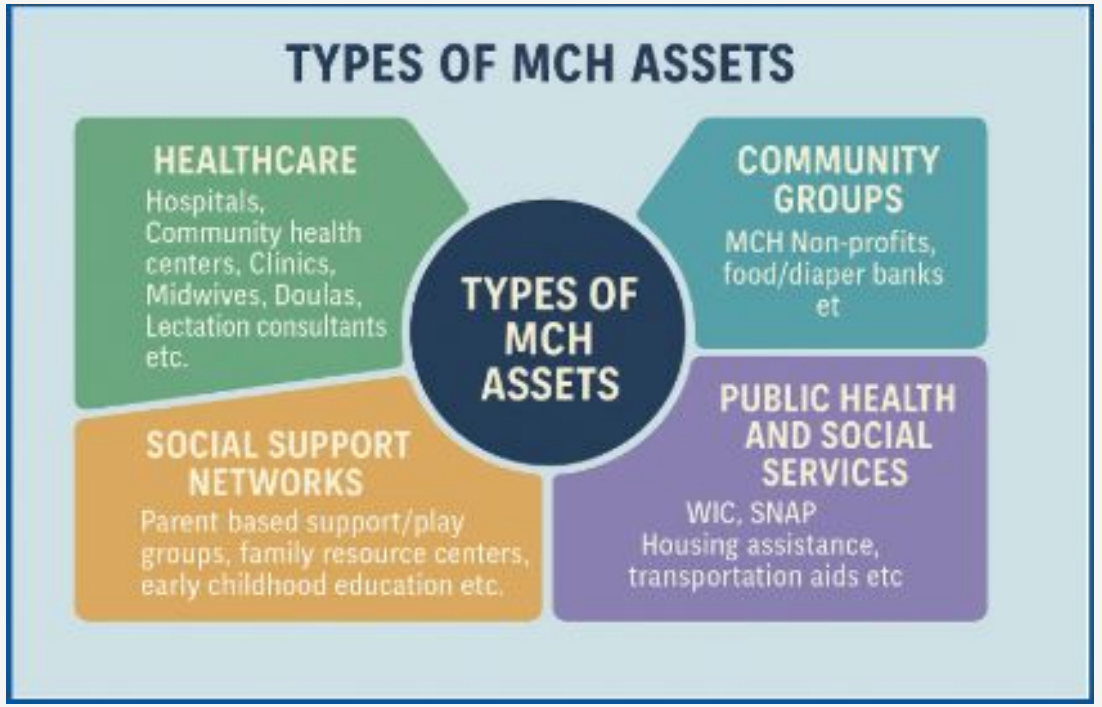
Tools for Assessment

Tools For Assessment

- CHNAs/CHIAs identify local gaps, guide resources, and shape MCH programs.
- Data sources: surveys, vital records, hospital data, Census, Medicaid, WIC, SNAP.
- Maternal focus: prenatal/postpartum care, complications, mental health, mortality.
- Infant/child focus: vaccinations, breastfeeding, care access, mortality.
- Assess SDOH: transportation, housing, food, insurance, cultural competence.
- Use disaggregated data to reveal hidden disparities.
- Asset mapping highlights community strengths for action.

Asset Mapping

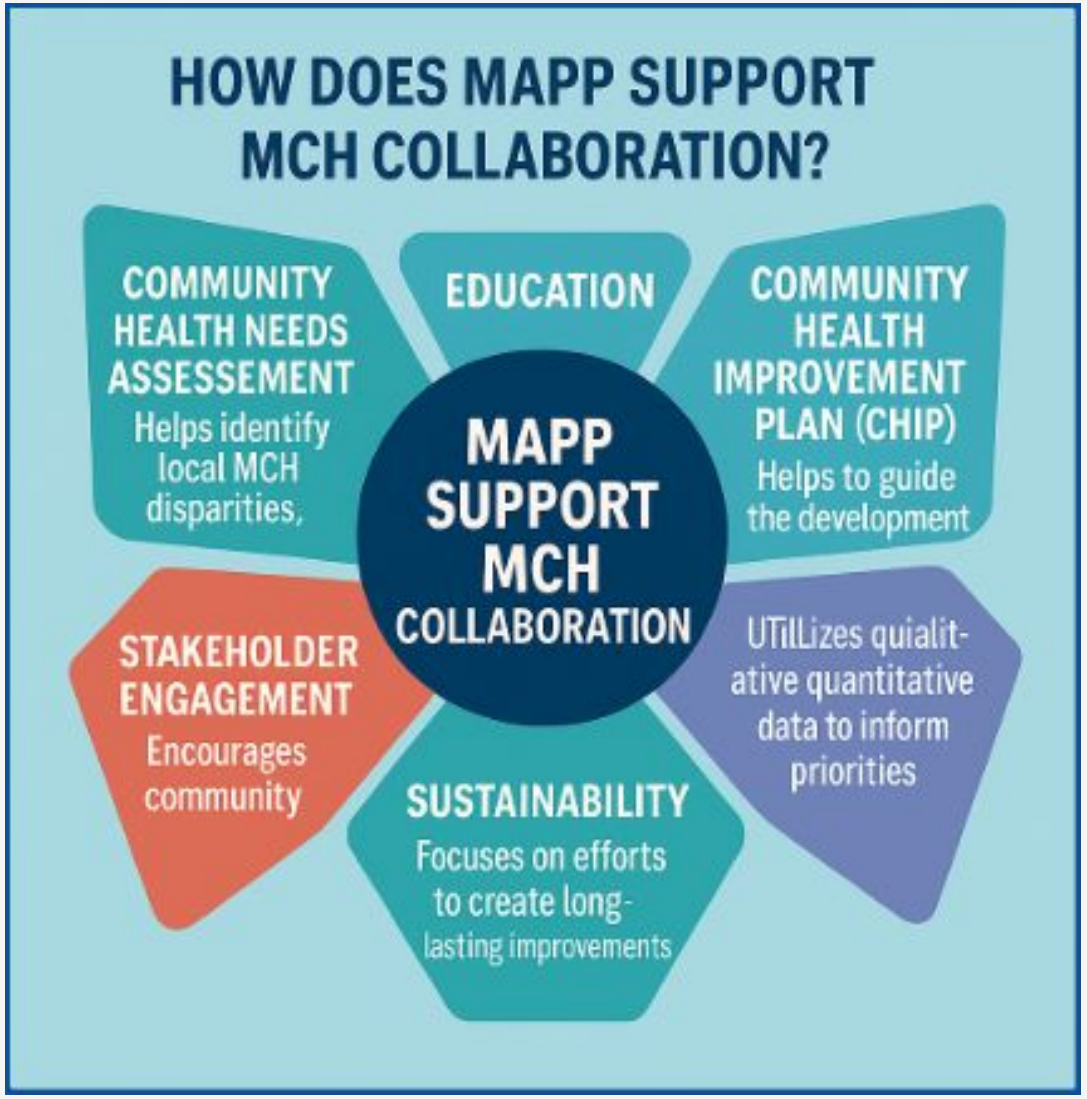
- **Asset Mapping** identifies and visualizes existing resources, services, and strengths in a community.
- **Helps stakeholders:**
  - Understand current resources
  - Find collaboration opportunities
  - Mobilize underused assets
  - Build on strengths—not just deficits
- **Methods**
  - Surveys & community input – Ask residents about trusted resources
  - Stakeholder interviews – Engage providers & MCH leaders
  - GIS mapping – Visually map clinics, support services, and



Collaboration Framework

Collaboration Framework

- **MAPP =** Mobilizing for Action Through Planning and Partnerships (NACCHO)
- A **community-driven strategic planning process** designed to advance health equity
- **Emphasizes:**
  - Inclusive stakeholder engagement
  - Policy, systems, and environmental change
  - Alignment of local resources
- **Why Use MAPP?**
  - Guides development of community health needs assessments (CHNA) & improvement plans



Advocacy and Outreach Strategies

Advocacy and Outreach Strategies

- **Community Forums & Listening Sessions** – Elevate community voices and build trust.
- **Partner with Trusted Leaders** – Doulas, CHWs, faith leaders, and parent advocates.
- **Accessible Outreach Materials** – Multilingual, culturally tailored, clear design.
- **Use Digital Platforms** – Social media campaigns, text alerts, and email newsletters.
- **Promote Civic Engagement** – Town halls,

Case Study

Case Study: North Shore Mother Visiting Program (NSMVP)

Key Components:

- 90-minute visit by a nurse
- Maternal & infant health assessments
- Mental health screening (EPDS, anxiety tools)
- Breastfeeding & nutrition support
- Infant CPR & immunizations (Tdap, flu)
- Referrals to WIC, housing, EI, and more
- Follow-up call 2–3 weeks post-visit

Successes:

- Universal access = reduced stigma
- Strong community trust & high engagement
- Robust referral network
- Positive family feedback

Challenges:

- Limited to one visit

Next Steps & Call to Action

- **Strengthen Partnerships** – Start small with cross-sector collaboration.
- **Disseminate** and **Use the Toolkit** – Customize the checklists and templates for your LHD.
- **Elevate Equity** – Embed culturally competent practices at every stage.
- **Leverage Existing Programs** – Integrate MCH into health fairs, clinics, and screenings.
    - Utilize free evidence-based educational materials

Thank You So Much!

Any Questions?

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