A Community-Engaged Approach to Addressing the Social Care Needs of Birthing People in Atlanta

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Introduction

- Rates of maternal mortality and morbidity in Atlanta, Georgia are consistently higher than national rates.
- There are persistent racial, ethnic, and socioeconomic disparities in rates of adverse maternal outcomes.
- Pregnancy is a unique timepoint in a person's life course when social needs may change or become amplified (e.g., childcare, financial strain, food insecurity, etc.)
- Unmet social needs are a key driver of maternal health disparities in Atlanta and nationally.
- Social needs screening is increasingly implemented in obstetric care settings but best practices for social needs screening and referral for pregnant people have not been fully elucidated.

Objective

To characterize the processes by which pregnant and postpartum people find and connect with needed social resources, identify barriers and facilitators to effective referral, and develop a protocol for social needs screening to be implemented during routine obstetric care.

Methods

Eligibility criteria:
- Currently pregnant or given birth within a year
- Live in Atlanta, GA
- Above the age of 18

15 Key informant interviews
- 8 Birthing Individuals
- 7 Social needs organization representatives

Thematic analysis by developing deductive and inductive codes utilizing MAXQDA & Microsoft Excel

"I knew this from even before I started my nonprofit, a lot of times when someone becomes pregnant, yes, they are very open to new education and new experiences, but it needs to come from a trusted source. So, partnering with a provider…is usually the best way for people to follow a certain practice" (Social needs organization leader)

"Maybe like not reaching out to the right people, I would say, or just not really knowing like who or what to ask." (Lived experience participant)

"A lot of people don't know that a lot of resources are available through Medicaid, or insurance, or whatever, but they don't know they could pick up these opportunities, or whatever…then they probably think like they don't have the support or transportation, or food." (Lived experience participant)

"We've gotten referrals from providers, which is mind-boggling, and we saw not a lot as I would like to see, but at least some right from hospitals. And we'll get it through our partnerships as well." (Social needs organization leader)

"Maybe if there were pamphlets, or if there were information given to us at the doctor's office, because we do have to go, I mean…Or even if you know, we could, opt-in at the doctor's office to have our information shared with the resources that might be available to us, and they could reach out, or something. (Lived experience participant)

"I think that if we ever refer people to certain programs. They're almost always full cause there's not enough of those programs…there are a couple of resources, but you know the families have to wait…I just think there's there's a lack of systemic processes and resources for families." (Social needs organization leader)

Identified Barriers

- Lack of overall information
- Complex enrollment processes
- Inadequate insurance coverage
- Individual stigma
- Limited availability of resources for certain needs (e.g., housing, transportation) and capacity constraints within existing programs

Identified Processes

- Word of mouth was the most common way people identified social resources.
- Few people described physicians and hospitals as a referral source.
- Both birthing people and organizations wanted providers to provide information and referrals for social needs.
- Some individuals requested that advertisements be made in community spaces and organizations.

Identified Facilitators

- Trusted information sources (e.g., health care providers)
- Up-to-date sources of contact information and availability
- Active navigation of social resource linkages

Next Steps

- Convene a SDOH working group composed of 10 community members
- Conduct the remaining two working group meetings from Feb '25 – May '25
- Integrate information from the interviews, current literature, and lived experience to develop a social needs screening protocol
- Disseminate the materials and incorporate them into obstetric care clinical settings

References →