Key Informant Interview Report

Prepared by the UNC Team

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Powered by the Missouri Foundation for Health

KEY INFORMANT INTERVIEW REPORT

INTRODUCTION

Missouri Foundation for Health (MFH) launched the Improving Maternal Health Outcomes initiative (IMHO) to promote high-quality, equitable maternal care. With this report, our team from the University of North Carolina at Chapel Hill (UNC) and R.A.C.E. for Equity are sharing a summary of interviews conducted with interested parties across the maternal health landscape in Missouri. Members of the North Carolina team are affiliated with the Maternal Health Learning and Innovation Center (MHLIC) the Maternal and Child Health Workforce Development Center at UNC. As part of this work, the UNC team has met with interested parties throughout the state to learn more about current efforts, successes, aspirations, and the resources or strategies that may be of value to building a more effective, inclusive, and connected system for maternal health.

The maternal health landscape in Missouri is rich with individuals, organizations, resources, ideas, and energy for change. While there is much work to be done to realize a collective, shared vision of having Missouri be one of the best places in the country for all birthing people to have a baby, there is also a lot of great work underway. The purpose of our key informant interviews was to connect with the people in Missouri who are working to improve maternal well-being and listen for ways to support an inclusive, connected, and effective system. By meeting with organizations and people throughout Missouri we sought to compile current efforts, successes, aspirations and the resources or strategies that exist now.

The information presented here reflects the rich perspectives and energy and intention of people working across the system; the UNC team has summarized, grouped, and analyzed in order to inform the system, and to guide our own next steps in helping the system learn and transform.

We are grateful to everyone who took time to talk with us and help us connect with others. We hope this report offers an on-ramp for others in the system to validate these findings, add their own perspectives, and join in the hard and refreshing work of transformation.

APPRECIATIVE INQUIRY FRAMEWORK

Appreciative Inquiry (AI) is a process for facilitating positive change in organizations, groups, and communities. Appreciative Inquiry assumes that every human system has something that works right – things that give it life and foster vitality and success. This strengths-based model starts with individuals sharing what is positive and working well (Discover). Next it elicits details about aspirations to articulate shared goals (Dream). These steps provide the framework for the group to identify action areas for change (Design). (https://www.centerforappreciativeinquiry.net)

We designed the key informant discovery phase of this work on this approach for several reasons. First, we wanted to center conversations on assets and strengths. Research that focuses on problems often overlooks resources and people already in place. Second, we wanted people who participated in the interviews to feel uplifted and seen – both for the work they are proud of and the aspirations that drive them. This allowed for these conversations to not “extract data” but rather to generate connectedness

to the larger work at hand. Finally, we wanted to model a liberating structure and a different approach to strategic thinking that could carry the work forward.

Appreciative Inquiry is consistent with the three guiding principles of IMHO. Individual voices are the foundation of the system view that AI creates and of the system goals that AI articulates (Systems Thinking). It is an appropriate and supportive approach for highlighting and valorizing multiple "ways of knowing" (Cultural Rigor). And it explicitly rejects incremental framing (e.g., "reduce maternal mortality") and instead requires that system change dialog drives toward positively framed future states (Reproductive Justice).

Our team interviewed over 50 people in advance of this report. Detailed information about the methods our team applied in the interview process are available in Appendix A.

APPRECIATIVE INQUIRY INTERVIEW SUMMARY

We report here the results of our appreciative inquiry interviews in Missouri. Interviews focused primarily on the first two steps in the process, called "Discover" and "Dream," that elicit information about current state and desired future state. We offer a high-level summary of the Discover and Dream results in the following two sections. The full list of findings for each is available in Appendix B (available upon request).

DISCOVER: BRIGHT SPOTS

The "Discover" section reveals existing capacity. Our interviews asked what respondents are proud of, what they are passionate about, good outcomes they are getting, emerging bright spots in their work, and bright spots they see elsewhere.

> Direction: Among our respondents there is broad agreement about the direction: improving maternal health in Missouri. Capitalizing on this energy in the state is a key opportunity for the IMHO project. Many cite Black maternal health outcomes and health outcomes of people living in certain ZIP Codes as a key interest and motivation for their work. Many also see Black maternal health as a key success measure in the longer term for the state.
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> Community Voice: Some organizations are listening to community voices and integrating what they hear. Many respondents note the excellent models in the state for engaging with community. Generate Health and FLOURISH are examples of community-centered practice. Vision for Children at Risk is a good model of community engagement. The EleVATE Women Collaborative housed at Integrated Health Network brings together radical listening and true partnership in a wonderful way. Uzazi Village, Jamaa Birth Village, the two Rural Maternity and Obstetric Management Strategies (RMOMS) projects, and the Missouri Regional Bootheel Consortium, Inc. (among others) are organizations and projects demonstrating strong community engagement. Managed Care Organizations (MCOs) working with patients and community stakeholders to address non-emergency transportation challenges is another bright

spot. Generally, we hear an interest in learning more about engagement and an appetite to continue to learn how to do this well among organizations.

Community-based Support: Doulas are seen as a powerful new resource for pregnant and postpartum people. There are strong, Black-led organizations in the state. Numerous programs are focused on supporting mental health and those with substance use disorders. There are Community Health Worker, MCH navigator, and mobile unit initiatives happening in the state. Missouri organizations and leaders are serving as national models in some cases.

Innovative Research: Researchers in the state are generating knowledge about how to improve maternal health in Missouri. Examples include the EleVATE study focused on providing services to eliminate disparities at Washington University and a study underway at University Health in Kansas City focusing on pain management during labor and postpartum. Emerging work has the potential to improve cardiovascular health – a leading cause of maternal death.

Robust Data: Organizations are leveraging data as well. The Pregnancy Associated Mortality Review data is being used to guide strategies for change. The MO HealthNet Data dashboard provides information about performance on a variety of indicators by Managed Care Organization and race. Organizations are applying quality improvement data to improve patient experience. Others are using Results-Based Accountability to find shared goals and draw strong links to action steps. This strong footing in leveraging data is a bright spot.

Networking: Connecting structures are bringing groups together on different initiatives. The Maternal Child Learning Action Network (MC LAN) is a coalition that has been going strong for 4 years with many dedicated participants and an eye toward expanding to integrate more community voice. The Pregnancy Associated Mortality Review Committee is a cohesive, diverse, equitable group that focuses not only on individual issues but also on structural issues. Missouri Hospital Association (MHA) and the Missouri Department of Health and Senior Services (MDHSS) are working together. Public health is organized to increase and leverage work across divisions and agencies. The home visiting collaborative was a very successful initiative in their work with many partners to identify a common intake for families. This model shows how this work can happen in Missouri.

Policy Successes: Medicaid expansion getting passed is a big point of pride. There is a "small but mighty" core group fighting daily battles in the policy/advocacy areas. Leaders in the state are being proactive in policy and advocacy and aligning around maternal health and the national movement. There is funding to move forward with a platform addressing social determinants of health. The Uplift Connection can provide foundational communication about maternal health, activities, and resources. The existing networks and the ability to share information is a strong foundation to further build capacity and connections focused on improving maternal health outcomes throughout the state.

New Narratives: People are working to shift the narrative to combat stigma. Mental health is a focus area for de-stigmatizing language, particularly when substance use is involved. There are

training opportunities on racial equity and reproductive justice. In addition to these trainings, EleVATE supports a learning community for people post training to support peer-to-peer learning and help them continue to peel back layers and talk about what is hard.

COVID Growth Opportunities: While the COVID-19 pandemic was a major challenge, some positive things emerged. The MFH-funded COVID response grant program, and the Foundation's willingness to modify the grant making process to be able to meet immediate needs, helped grantees do important work. The Foundation shifted their grant process to be more responsive, nimble, and easier to administer. Preterm birth rates went down during the COVID-19 pandemic: that's unexpected and interesting. The ability to use Zoom and telehealth expanded access to care and connection (e.g., virtual meetings) and improved efficiency.

DREAM: FUTURE STATE

Participants shared their aspirations, hopes, and dreams for the future, without regard for timeframe or feasibility. Some shared things they wished for, in order to reach a specific dream.

We have organized the dreams into hash-tagged thematic groups that can be used for action planning in subsequent phases of the work. For the most part we have kept the original language from participants in describing the characteristics of the theme.

#EQUITY

Equity is a powerful theme for many of the dreams we heard. Specific characteristics include Missouri being the state with the lowest Black maternal mortality rate, eliminating disparities for Black moms, and Missouri being a place where people feel great giving birth no matter their identity.

In this future state, birth outcomes wouldn't be predictable by race. Actions and work in maternal health would integrate racial justice, reproductive health, and healthy environments. Teaching institutions would fully recognize their extraordinary responsibility of not harming people when providing care.

Equity is a cross-cutting vision that is infused in many of the dreams in the following sections.

#ALIGNMENT

Many respondents articulate dreams regarding future alignment resulting in coordinated services, collaborating networks, mutually supportive strategies, and supporting policy.

Participants described a future where there would be seamless transitions of care and open communication across systems about patients, so that no one falls through the cracks. Groups and hospitals would coordinate (and not compete). The care coordination space would be well organized so people can work with one person with whom they identify and trust to coordinate all of their care and needs. Providers, patients, and community members would understand the resources available to them (or their patients) and how to access them. All the dots would be connected.

The vision of alignment includes adding partner organizations to the network. Corporations would be engaged in maternal health efforts, including providing gift cards usable in rural convenience stores that automatically restrict certain items (e.g., tobacco and alcohol) which would make it easier for HRSA-funded projects to provide gift cards for focus groups/people with lived experience.

This vision includes alignment around policies and the work to develop them. There would be good relationships between people doing the work of improving maternal and infant health and policy makers in the state with open communication and working together to solve problems and improve outcomes. There would be more connection with and across statewide groups around policy. This includes a regionalized perinatal network in multiple areas and then those networks have a way to be connected to elevate larger issues and policies at state and even national levels.

There would be a common goal, and all would work together to make it happen. The organizations that individuals work for might put some boundaries and frames on what they can do, but here is where people can bring their unique skills and resources to the table for collective impact and positive outcomes. There would be a collective, layered shared agenda so everyone could keep doing their work but there could be a larger strategy and everyone joining together to push in key areas. Organizations would be accountable to common goals and to each other.

#ENGINEFORCHANGE

This theme focuses on efforts to build sustainable "engines" for capacity growth: workforce development, resource creation, and innovation.

There would be a lot of funding available in the state to support big ideas – there is no shortage of innovation and ideas (e.g., legal help center for women, places for women with substance use disorder to live with supports, cardiovascular care projects – many ideas). MFH would leverage their influence to bring private philanthropies and major corporations and private industry to contribute funds to support these ideas. Missouri would also take advantage of opportunities to bring in funds from national funders/initiatives/grants. Funding would be trust-based and flexible so programs could use it to support clients with exactly what is needed to move them on their journey instead of assuming what is needed.

Pregnant and postpartum people and their babies would have support for good nutrition. There would be more Black lactation consultants and more human milk feeding support. There would be "no wrong door" for pregnant women in receiving needed interventions. They may not trust health care providers and therefore not disclose needs but may trust another person in the system – who should be able to refer and should get paid for screening and referral. One respondent suggested a navigator for all the navigators! The vision includes providing mental health support to health care providers and their teams. Medicaid would pay a fair and livable rate for doula care and services.

#VOICE

The theme of "Voice" is a cross-cutting theme including both individual and community characteristics involving dialogue and decision-making.

Community leaders, organizations and people with lived experience will be fully part of all conversations and in designing the work. Women's voices would be routinely heard across all the work that is being planned and done. Community would be the driving force behind change. People across Missouri would know how to support this engagement. The stories and information that women and communities have already shared about what isn't working would be shared instead of asking people again to talk about where the system is causing them pain. There would be focus on listening to and acting on ideas for change. Hospitals and health departments and others would coordinate who they speak to and the stories they receive and avoid interview fatigue and retraumatizing people. People would watch the many films and books out there (e.g., The Color of Medicine) that clearly describe the problems and focus resources toward change.

Organizations would recognize the good work underway in communities and offer to help broaden or scale, rather than recreating the work. Clinicians would be willing to truly share power in the exam room. Medical culture and practice would shift so clinicians would be more responsive to patient and community perspectives and integrate their needs into their care.

#OUTCOMES (DATA, ACCOUNTABILITY)

This theme encompasses data and accountability dreams.

People and organizations would be committed to collecting and using data to fuel quality improvement, demonstrate outcomes, and tell their story to decision-makers and funders and the larger state community. There would be radical transparency. We would shift Medicaid incentive structures to focus on outcomes for patients. MCOs could be held accountable for equitable outcomes, an outcome measure that would support the expansion of Missouri's growing doula system. Accountable care models would be reimbursed through a value-based payment. Incentives should be tied to outcomes that matter. Measures would center the patient-experience of care, equitable care, quality care and reproductive justice-oriented care. Maternal health outcomes should be prioritized on MCO Quality Dashboards. Providers would know their numbers around procedures such as c-sections and would have conversations about why c-sections happen. Doulas would lead the design of services and how their role is structured; larger organizations would support doulas' efforts to achieve their vision. They would work with Medicaid to demonstrate their return on investment. Participants highlighted a future where there would be time to celebrate successes and talk about the positive results that are being seen in Missouri.

#ACCESS

The Access theme is about a future state of full support for people of child-bearing age, across the lifecourse. It encompasses Medicaid transformation on the payer side, trust and availability on the provider side, and accessibility throughout.

Many respondents dream of the expanded and transformed Medicaid program that is already a focus of the work of many of our respondents. Medicaid expansion and Medicaid extension for one year postpartum would be fully in place, functioning well, and having good outcomes. People would access this resource without shame or stigma and would receive the same or better care than people with private insurance. Everyone in the state would fully understand what is going on with these programs so they can promote enrollment and rollout.

Specific access-related characteristics of the future state include the following:

- A statewide call center to offer centralized intakes for women seeking prenatal care. It would prevent pregnant people from going "cold turkey" off important medications when they find out they are pregnant and make sure everyone is connected to the care they need, creating engaged and responsive care right from the beginning.
- A mobile mom unit that would go around the region bringing providers to women – ideally at places that are having their Women, Infants, and Children program (WIC) day and other places where people are using transportation social capital to get there.
- Pregnant people are no more than 30 minutes away from a maternal fetal medicine specialist. Maternity care is easily accessible to all people regardless of identity.
- Birthing people will understand their risk, and then that they choose risk appropriate care for themselves, and that we have organizations or groups and communities that are available to support what that risk appropriate care is.
- Rural providers are available; rural hospitals are open and thriving.
- Transportation would be flexible and easy so pregnant and postpartum people could easily get to the providers they trust.

Direct care organizations would feel like a second home – truly safe where people can go in trust and confidence without judgement to get what they need. Organizations would be a place where birthing people and families can get their needs met and rest and connect with others - a place for peace of mind. A place to deal with 'at the moment' stressors and receive help in removing them. Funding would allow people to offer holistic care – mind, body and spirit – inside out.

DESIGN: ACTIONS TO GET FROM HERE TO THERE

The DESIGN phase is dependent on group dialogue to do the required brainstorming, strategizing, prioritizing and planning for aligned system change. The summary here offers ideas about how to categorize the design work ahead and provides an initial mapping of some potential opportunities for action.

In our NEXT STEPS section below, we do outline several concrete steps that the UNC team intend to undertake with Missouri groups that will forward the collective work of design.

The basic interview question that frames this summary is this: "How might Missouri move from the current state toward the dreams and vision?" We offer three categories of design ideas here, along with a few examples from the interviews to support each one. This approach is one that others in the state might use when they review the results themselves (full list in Appendix B) and/or build on this work.

STRENGTH-BASED design ideas build on positive energy and outcomes identified in the Discovery phase. Strength-based action ideas might highlight or scale up a "bright spot," adapt a best practice for a new purpose, or explore promising practices.

> In Missouri, there is an opportunity to engage community-based organizations in advancing maternal health, especially in their role to address the nonmedical and social determinants of health (SDOH) issues. This includes working with trusted community organizations to do care coordination work at a rational local level and amplifying the work of Black-led organizations to shift trust balance.
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> Workforce development is a growth area with existing bright spots around developing new skills and creating new roles in the system. Expanding the definition, training, and reimbursement for Community Health Workers (CHW) was one idea. People highlighted the importance of training more of the kind of people needed to do the work of our future-state system. There is a chance to leverage the ability of doulas to see and case-manage all sorts of upstream risks (e.g., nutrition, transportation, physical activity) and create formal mechanisms for doulas to engage with healthcare systems. Learning communities might work well for health departments working on common issues around maternal health. Providers would receive training on empathy and how to bridge science and emotion.
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> Expanding the strong network in Missouri is another opportunity. We might engage people working in areas that may not seem directly connected to maternal mortality but are. For example, public health's Rape Prevention Grant held focus groups on barriers to employment for women and families. The Missouri Coalition Against Domestic Violence is an important group to connect maternal health efforts with the larger intimate partner violence (IPV) prevention and support community.
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> Respondents see the Pregnancy-Associated Mortality Review Board (PAMR) as a bright spot, and worth expanding to look at maternal morbidity.

STRETCH-BASED design ideas "stretch" where a distinct future state pulls us forward (perhaps against a specific current reality). The most salient example in Missouri is pushing Medicaid expansion to completion and securing Medicaid coverage for one year postpartum; both of these "future state" ideas are already being pursued by multiple people that we interviewed.

Addressing access to care is a theme in the dream data that seems reflective of impatience with the current state. Specific design ideas include expanding obstetric care (OB) access in rural counties (54 counties without any OB provider). OB providers need to get patients to a high-risk center and patients need to be able to get there. OB providers need to be prepared for high-risk problems, so they don't get burnt out.

Increased access to data is similarly clear-cut. Examples include stronger data connections for the Pregnancy-Associated Mortality Review Board that would allow them to move more quickly and completely to action based on knowledge of system capacity and outcomes. This increase in part requires financial resources to cover time for people to abstract needed data. Building an integrated data structure is a dream: MHA has clinical data, MPCA has out-patient data. They are missing the community data right now, but all the groups using the Unite Us database (RMOMS in the Bootheel, a group in St. Louis and in Springfield) could have SDOH data. This includes data around resources. Graphing or charting grants in different regions might show who has resources to do what.

ADAPTIVE ACTIONS design ideas reflect the intention to step toward system transformation through system complexity. Example adaptive actions might include learning activities, listening to front-line and lived-experience voices, actions to strengthen relationships, sharing perspectives, and developing innovations (prototyping, piloting).

Building trust and relationships are key components of this design consideration. Create opportunities for relationship building with groups like MO HealthNet and public health – both sectors have experienced a lot of turnover and challenge due to politics and the pandemic. Also create space at the table for the Center for Local Public Health. Universities might need some additional support and time to build genuine relationships with community around research and could be key partners. Consider engaging with community health worker networks. Meetings would focus on action and include the chance for in-person networking and connection. There are a lot of people out there who would like to have more connections and be "in the loop." Economic opportunity for women is a protective factor for many issues and an area to explore. The larger community of maternal health supporters and advocates would learn how to really listen to each other and the people they serve. People could work together to build trust and thereby have a better understanding of the challenges individuals face when working within certain systems (e.g., people who work in the hierarchical state bureaucracy face certain roadblocks). Trust takes time to build – including for people from the community who are working in community.

Tangential to this is the need for strong and open communication networks. Build strong information flow systems from healthcare, providers, patients, and community. Ideally, it would be easier for people to receive needed resources without having to provide extensive information about themselves first. Make sure information alerts are reaching the people who need them. Increase communication flow between people who are on the ground advocate and the people who are making policy decisions and recommendations, including MO Health Net as

a partner and ally. Smooth pathways for chief medical officers to be in dialogue with each other and with the broader system. Build patient/provider feedback loops into Medicaid.

Building shared understanding is a key design consideration. Be clear on terms and definitions and everyone's role in addressing role in addressing disparities and racial inequities. Level set top priorities and have networking groups around those priorities to begin to implement evidence-based strategies. Create common understanding and knowledge across providers by having common readings and learnings (e.g., what a doula does, treatment protocols). In order to achieve the proposed visions for Missouri, participants highlighted the need for some shifts in thinking across a variety of areas as well as time for honest and productive conversations on difficult topics. One area of focus is to shift toward abundance thinking. There has been competition for resources and there are difficult histories between groups that need to be discussed. Building forward means learning from the past and working together to find resources to support all the work that needs to be done.

A specific mindset change example might address how care is provided to pregnant and postpartum people with substance use disorder and/or those who live in poverty. In Missouri (and everywhere) there are unspoken biases around what makes a "good mother." There is a real energy in Missouri to intentionally shift away from judging pregnant and postpartum people and instead enveloping them with support and care – paying attention to the full life course of the family.

Finally, as doulas become more widely recognized for their essential role in providing care to birthing people, there will be tensions with the medical establishment. There will be differences of opinion, and many opportunities for learning. This is powerful and adaptive change work.

NEXT STEPS

UNC Team:

1. **Stand up the Lived Experience Advisory Group** [now]

    - Pilot advising role
    - Hold training sessions to develop new Lived Experience Advisory Groups; highlight and hone the practice of existing groups

A Lived Experience Advisory Group (LEAG) is in the process of being established. The LEAG will bring community voice forward to inform the IMHO work. These conversations will inform training opportunities that will be made available, including one focused on how organizations can best work with community-based organizations and people with lived experience.

2. **Share Interview Report broadly**, starting at Uplift Connection's 2022 Maternal and Infant Health Convening in late September 2022

3. Convene Action Groups to step into Design work [through 2023]

- Build Action Groups to validate recommendations in this report and work on specific action areas
- Provide a Network Mapping pilot
- Use Results-Based Accountability to build commitment for specific system outcomes

The UNC Team will also host a series of trainings and discussions around key action areas in this report, using data and results-based accountability as a frame. Our intention is to build groups that cut across existing networks to do relationship-building and preliminary network mapping.

Appendix A: Key Informant Interview Methods

We utilized key informant interviews with key partners and stakeholders from across Missouri. We co-developed our interview guide with colleagues at MFH over the course of several meetings as an iterative process. We also shared recruitment and thank you emails for review. The UNC team submitted information about the key informant interviews to our Institutional Review Board, which deemed this to be "not research" and exempt.

MFH's work in IMHO centers three values and principles to provide a framework for decision-making, establishing common ground with stakeholders, and evaluation: systems thinking, cultural rigor, and reproductive justice.

We utilized Zoom for our interviews, which we recorded (with stated permission) and uploaded to our password protected UNC Microsoft Teams page. We uploaded our typed notes and transcripts to Teams as well. All data collection and storage procedures followed UNC best practices for data protection. Before we began recording our sessions, we first made sure participants understood what we were going to do with the information they shared, we described how we would protect their identity, and informed them that they would receive a summary report of what we learned. We also took time to answer any questions they had.

Recruitment: We approached recruitment in several ways. First, we worked with MFH to identify a list of key partners and change agents working in maternal health in Missouri. We had an initial list of over 40 individuals/organizations which we then were able to sort by priority and representation (e.g., we only wanted to talk with one person from an organization). MFH organized a series of "meet and greet" zoom sessions to introduce the UNC team to some of these key partners / gatekeepers.

After about a month, using the principles described above, the MFH and UNC teams met and further expanded the list of key informants. The team also asked people at the end of the interviews to share the names of other people we should meet. This expanded our list to over 80 individuals. We extended 56 formal email invitations. We sent two follow-up email reminders to people who did not respond.

Participants: We completed 36 interviews based on email invitations – three of which were group interviews (n=9 total participants in those sessions). We also were able to conduct one impromptu group interview (n=8) and several additional informal interviews (n=4). In total we spoke with 54 people. Of note there were several people that we spoke with twice. We did not collect demographic data about the people we spoke with, however, we sought to talk with people with diverse racial, ethnic, professional, gender, and geographic identities and believe we were successful in doing so. Participants came from a variety of organizations and programs across the state.

Data Collection and Review: Two members of the UNC team conducted the key informant interviews. At the beginning of the project, they listened to recordings of each other's early interviews to make sure they were consistent in how they were following the interview guide. Both interviewers were highly aligned in their approach, tone, and cadence. The team worked together for the group interviews. The two team members took time over the course of the summer to listen to or read each other's interviews

so both gained a full appreciation for the breadth of information shared. A third member of the team listened to and reviewed most of the interviews as well.

For our analysis we first put together a list of general themes and directions that we heard from our initial reviews (See Appendix B – available upon request). This report is a more fine-grained data review. We specifically name organizations or projects listed as "bright spots" here because other stakeholders named them as a "bright spot," not based on our judgement. We did not offer 'tick marks' to note how many times a bright spot or approach was mentioned; instead, we provide this as an unweighted list. Of note, there are some contradictory statements in this list, indicating that there are differing perspectives on the "current state" in Missouri. These are areas to explore further. See Appendix B for a full list of the findings.

The UNC Team held several sessions where we utilized the A3 change model as a conversation guide to discern current conditions (what is happening now), underlying root causes (why things are as they are), measures (what would indicate progress), and an action plan (specific activities to try) based on what we learned through the interviews and our conversations with the MFH team. This report highlights several of the action plan ideas we generated through this process.

Limitations: There are many partners and stakeholders in Missouri, and we clearly were unable to speak with them all for this initial work. We were able to speak with some doulas but there are many other doula perspectives that need to be heard. We did not speak directly with policy makers or members of the business/industry community. We did begin to reach theme saturation by the end of our key informant interviews, which suggests we reached the limits of the data collection we were able to do with our key informant pool and interview guide. We will continue to reach out to diverse groups as we continue to learn and plan in Missouri.