Mauricio Leone graduated from the Pontifical Catholic University of Chile in 2005. After moving to the United States and learning English, he earned a Master of Public Administration degree from the University of Texas at San Antonio, where he participated in The University of Texas Archer Center Graduate Program in Public Policy, in Washington, D.C. He has dedicated his career to serving low income populations by securing funding for Federally Qualified Health Clinics in Texas and California. In 2013, he joined The Obria Group, Inc. with a vision to expand the development of a life-affirming medical model. As the Chief Operations Officer, Mauricio secures and manages major federal grant programs including Title X Family Planning, Title V Sexual Risk Avoidance Education, and Teen Pregnancy Prevention. Mauricio has a passion for community initiatives to address health disparities and the social determinants of health.

Mauricio Leone, MPA
Chief Operations Officer
The Obria Group, Inc.

U.S. Commission on Civil Rights

Thank you so much for the invitation to testify and share my experience. My name is Mauricio Leone. I am the Chief Operations Officer for The Obria Group and I am here today to present a "boots-on-the-ground" perspective from the field.

First, to provide some background on where I have gained my perspective, I will start with a brief background on The Obria Group. We are a 501(c)(3) nonprofit organization which oversees a nationwide network of more than 20 community health clinics in several states across the nation including California, Oregon, Washington, Texas, Georgia, and Florida. Obria's target population experiences significant disparities accessing quality health care and health education. We serve low income communities with lower life expectancy, higher infant mortality, and a higher likelihood of chronic and communicable diseases. Obria is committed to improving access to affordable, high-quality health care services, health education and supportive services for medically disenfranchised women, men, and adolescents. We provide quality sexual and life affirming reproductive health care services to anyone in need, regardless of race, ethnicity, age, gender, creed, national origin, or ability to pay. We offer prenatal care, well woman care, STD testing and treatment, family planning services, Sexual Risk Avoidance Education, parenting education, and pregnancy resources (free diapers, formula, and baby clothes) to over 10,000 patients a year. Of those seen, more than 90% are below 200% of the federal poverty line, 78% are female, 41% are between the ages of 15-24, 35% are Hispanic, 26.3% are White, 12% are African American, and 8% are Asian. Obria is a recipient of Title X funds to help women and men achieve or postpone pregnancy, Title V funds to provide Sexual Risk Avoidance Education, and Teen Pregnancy Prevention funds to help prevent teen pregnancies.

Although we live in one of the most developed nations in the planet, there remain significant barriers to life-affirming sexual and reproductive health care services for low income individuals. We at Obria have observed the following:

1) There are still challenges navigating health insurance for pregnant women,[i] which is a significant barrier to access appropriate quality prenatal care.[ii] Although pregnancy Medicaid coverage is widely available in California for pregnant women under 213% of the federal poverty level, it is still extremely difficult for women and health care providers to navigate. For instance, a pregnant woman in Orange County, CA that qualifies for pregnancy Medicaid coverage can be automatically assigned to any of 10-

20 different Medicaid HMOs in the county, which may or may not be accepted by both health care providers and laboratory companies.

2) There is a lack of providers who accept Medicaid for pregnant women,[iii] including federally funded health clinics which are required to serve low income population regardless of insurance coverage. Health care providers do not necessarily have a contract with every single Medicaid HMO out there and/or do not want to serve Medicaid patients due to the low payments. Others accept Medicaid HMOs but provide substandard health care. A few months ago, University of California representatives approached us seeking a partnership with Obria for the provision of obstetric care and family planning services to formerly incarcerated women. They informed us that nobody else in the community wanted to partner with them because of health insurance issues. We were the first organization that did not require their patients to have any specific health insurance program.

3) There is ineffective sex education for teenagers based on state sanctioned Sexual Risk Reduction strategies. There is lack of access to evidence-based primary prevention strategies such as sexual risk avoidance education,[iv] especially for the adolescent population in public schools, which results in a disproportionate rate of teen pregnancy and STDs. This is very important because teen pregnancy is linked to low birth weight and infant mortality.[v] In spite of the documented benefits of sexual risk avoidance strategies in decreasing teen pregnancies and STD infections,[vi] in 2016 the State of California enacted and implemented the Healthy Youth Act Comprehensive Sex Education Program which intended to prevent pregnancies and STDs in young people.[vii] However, cases of STDs have just reached a 30-year high in California, and, some STDs have reached 400% increases in the last five years in some counties.[viii] Sadly, women are more impacted with STDs than men. Unintended teen pregnancies are also very prevalent in some communities such as Santa Ana, CA in which there are 27.5 teen births per 1,000, which is significantly higher than the national average of 20.3 per each 1,000 teens.[ix]

4) Although there is a positive downward trend in late or no prenatal care,[x] we see a significant proportion of expectant mothers of all races who still come in late to our clinics for prenatal care services due to lack of education about their health care options in the community. Our medical providers have reported that, in most cases, there is very little information available for pregnant women about their health care options in the community, including information about health insurance coverage options, for bringing pregnancies to term.

5) There is a prevalence of substance abuse among pregnant women coming to our clinics, independent of racial background. This can produce preterm births and have a negative impact in women and babies who are at risk for developmental, physical, behavioral, and social disabilities.[xi] We

see the need for risk avoidance primary prevention strategies because they can lead to health outcomes that are improved when risky behaviors are avoided.[xii]

6) There is no consistency or follow through with preventive screening and treatment, which leads to disparities in pregnancy care. We see a trend in our patient population that, due to low educational attainment and health literacy,[xiii] patients do not follow preventive health screening recommendations. They usually come to our clinics when they are overweight, already infected with an STD, or are late in their pregnancy. This generally occurs independently of racial background.

7) Lastly, we observe in our clinics a lack of medical compliance by pregnant women. Medical noncompliance has been deemed the most ignored national epidemic in the nation,[xiv] and one of the most challenging scenarios in obstetric care.[xv] There is a small but consistent percentage of patients that do not fully comply with their care recommendations. This includes complying with follow-up appointments and routine lab tests such as urinalysis, blood count, blood type, and glucose tolerance tests, among others. Lack of medical compliance is frequently due to obstacles caused by lack of education or poverty, such as transportation issues, lack of childcare, health insurance problems, communication issues, and/or other psychosocial factors.

In sum, my observations are the product of a "boots-on-the-ground" perspective from the field. There are significant disparities still affecting low income pregnant women in this country. These disparities have a negative impact on accessing quality life affirming health care services early in pregnancy, which may partially explain the differences in pregnancy outcomes among different populations. We also think that it is critical to address another social determinant of health that is equally important to positive outcomes for mother and child: evidence-based risk avoidance education because it has an emphasis on personal responsibility, healthy relationships, and self-regulation skills. As public health representatives, we advocate for strategies that help low income individuals develop the skills necessary to make healthy choices and avoid risky behaviors. Our goal for every patient is optimal health outcomes. When we have the active involvement of the patient in avoiding risky behaviors and planning, monitoring, and evaluating his or her care, we are more likely to achieve this goal.

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