

DRAFT Recommendations and Discussion Questions

Introduction

In 2018, Senate Bill 266 directed the Maryland Health Care Commission (MHCC) to conduct a study on Mortality Rates of African American Infants and Infants in Rural Areas and make recommendations on the following topics:

- methods to reduce the mortality rate of African American infants and infants in rural areas;
- ways to use pregnancy navigators or community health workers to assist pregnant women in reducing the infant mortality rate;
- the establishment of a permanent council for lowering rates of disparity in infant mortality; and
- methods to reduce the costs associated with low birth weight infants and with infant mortality.

These recommendations will be included in a report that also includes an overview of State data on infant mortality, results of national literature reviews, a summary of the program inventory, and other relevant information covered by the study. A draft of the report will be presented to the work group in August for initial review.

The task of the work group is to advise the MHCC on recommendations that MHCC should make to the legislature. The MHCC is made up of 15 Commissioners, appointed by the Governor.

This document is a set of draft recommendations designed to promote discussion in the work group. These draft recommendations were developed based on the results of the literature reviews, program inventory, work group meeting notes, and other resources, which will be described further in the draft report. The questions for today are—

1. Are these recommendations that the work group supports?
2. If not, how should this document change?
3. What is missing from this set of recommendations that should be included?
4. Focus and priority setting is important. Which recommendations are highest priority?

After the discussion in this meeting, staff will revise the recommendations. The work group will have another chance to discuss and further refine the recommendations in August.

This document is organized by theme and includes (1) brief statements on the background/conclusions that led to identification of the theme and (2) the recommendations and sub-recommendations that are related to the theme.

Theme: Expanding and Enhancing Access and Utilization of Services

Enhanced Prenatal Care Models: Home Visiting and Group Prenatal Care Models

The Study's literature reviews, program inventory, and interviews with experts provided strong evidence for the feasibility and efficacy of perinatal home visiting programs in reducing infant

mortality, increasing breastfeeding support, and optimizing health outcomes among both African American and rural infants and mothers. These programs use trained, culturally competent staff including perinatal community health workers (CHWs) (including Doulas and/or “resource parents” from the community); nurses; or a combination of both types of staff. Program staff visit the client’s home regularly during pregnancy and postpartum. Five evidence-based home visiting programs are in use in Maryland: four of these programs begin during pregnancy and continue postnatally, during the child’s infancy.¹ Interviews with home visiting program leaders indicated that many existing programs lack reliable funding sources. Funding for home visiting programs in Maryland currently comes from a variety of Federal, State, and Local sources.

1) Recommendation: Expand perinatal home visiting programs throughout the State as a cornerstone in the effort to reduce infant mortality and disparities and improve maternal and infant health.

- a) Develop approaches for improving access to funding for evidence-based home visiting programs.²
- b) Improve screening of women for high risk pregnancies and/or needs for supports with social determinants of health and improve referrals to appropriate services and programs to support identified needs.
- c) Home visiting programs in Maryland should begin in early pregnancy and continue at least through the infant’s first birthday.
- d) Maryland should consider the design of effective programs from other states, including best practices related to recruiting and training the workforce, as described in the summary of the literature review.
- e) Payers, providers, and home visiting programs should seek to better coordinate care to improve outcomes for the families that they serve.
- f) The State should develop a specialty for perinatal CHWs in the CHW certification program slated to go into effect in January 2020. The State should identify training programs that support the competencies for that specialty area. This could include trainings for existing evidence-based home visitor programs.

Discussion Questions for Recommendation #1

1. What is the current gap in access to home visiting programs?
 - a. Is there a lack of slots in existing programs or is there excess capacity?
 - b. Are certain geographical areas or populations not served by existing programs?
2. What type of support do local programs and counties need for these programs? Is it workforce, funding, other types of support?

¹ https://phpa.health.maryland.gov/mch/Pages/home_visiting.aspx

² Maryland plans to begin certifying Community Health Workers in January 2020. <https://health.maryland.gov/mhhd/Pages/Community-Health-Worker.aspx>

3. For recommendation 1(b), several tools exist to support this work, including PRAs for women in Medicaid, tools that are built into EMRs, and other assessments. What is the barrier now to identifying patients and making appropriate connections?
4. Is recommendation 1(c) too prescriptive? What impact would it have on existing home visiting programs?
5. How should recommendation 1(f) relate to doulas?

2) Recommendation: Increase adoption of group prenatal care programs to enhance prenatal care.

Group prenatal care (including a specific model called “Centering Pregnancy”) is effective in improving birth outcomes among African American and rural women. This program works best for women who have high needs related to social determinates but who have pregnancies with low medical risk. This program model is already in use in Maryland. In group prenatal care, women with pregnancies of the same gestational age meet regularly for visits with a clinician. The group participates in self-assessment, support, and prenatal education. Group prenatal care has a high initial startup cost but saves money in the long term. To increase adoption of group prenatal care programs we recommend the following:

- a) Expand existing group prenatal care programs throughout the State.
 - i) Focus the program expansion on populations for which the program has demonstrated success.
 - ii) Provide start-up funds and other incentives to clinicians for training in “Centering Pregnancy” and other group prenatal care models, to encourage providers to adopt this model.
 - iii) New group prenatal programs should implement quality control measures to ensure that they maintain fidelity to the models previously shown to be effective.

Discussion Questions for Recommendation #2

1. What barriers do health care providers face in adopting these models?
2. What else can the State do to support these programs (e.g. training, other technical assistance)?
3. The State budget is limited. How important is funding to expansion of these programs? Where should that funding come from?

3) Recommendation: Improve continuity of care.

Preconception, prenatal, and post/inter- conception care are important to infant and maternal health. Women and infants benefit from the mother’s life-long access to culturally-sensitive primary care, management of chronic conditions, family planning services, and health education. Continuity of care is most concerning for women who are uninsured before, during, and/or after pregnancy or who change insurance providers during this time period. Disruptions in care resulting from transitions in insurance coverage and related provider networks can interfere with health outcomes. One of the most common transitions of coverage for women who receive Medicaid coverage during pregnancy occurs 60 days after childbirth, when

eligibility for Medicaid through the pregnant woman eligibility category ends. Women who have incomes under 138% of the Federal poverty level may qualify for continued Medicaid coverage under the adult Medicaid expansion eligibility category. Women with higher income levels must inform the Maryland Health Connection of their change in coverage to allow for enrollment in a subsidized Marketplace insurance plan.³ The following recommendations are designed to support continuity of care throughout the life course for the purpose of improving birth outcomes and infant and maternal health.

- a) Provide support for women during the first year post-partum, such as access to care managers, to ensure that they do not have gaps in insurance coverage.
- b) Provide access to navigators at the Maryland Health Connection to enable women with incomes above 138% of FPL to understand their options for subsidized Marketplace coverage

Discussion Questions for Recommendation #3

1. What other barriers to continuity of care exist and what recommendations would address them?
2. Are there any specific recommendations that should be made about continuity of care that includes the preconception period?
3. How can these recommendations be refined and clarified?
4. ACOG recently changed recommendations about post-natal visits. Should this document include recommendations about educating providers about these changes, encouraging co-location of services for parents and infants, or other related issues?

4) Recommendation: Improve clinical adoption of evidence-based use of progestogens to prevent preterm birth.

The administration of progestogens through injections or as vaginal suppositories, when begun by the 16-20th week of pregnancy, significantly reduces rates of repeat pre-term birth in mothers with a previous preterm birth, but the literature suggests adoption of these practice could be improved. The following recommendations are based on these findings:

- a) [INSERT RESPONSIBLE ENTITY] shall plan and hold training sessions throughout the State for clinicians and leaders of organizations involved in perinatal care among high risk populations, on the availability and use of 17p in order to increase the knowledge of existing ACOG guidelines and increase technical capacity of the clinical workforce in providing this treatment. Trainings will be held in different geographic locations to allow attendance by clinicians from across the State.
- b) Perinatal CHWs, nurses, and other home visiting staff should be provided with education about the importance of identifying pregnant women with a prior

³ See reference. <https://www.healthaffairs.org/doi/10.1377/hblog20190501.254675/full/> ; <https://www.kff.org/womens-health-policy/issue-brief/expanding-postpartum-medicaid-coverage/>

preterm birth and encouraging them to discuss that history with their medical provider to help ensure that they receive appropriate care.

Discussion Questions for Recommendation #4

1. These seems to be a topic area where the context is changing quickly (availability of a generic version of 17p, ACOG guidelines, etc.). Is this a continuing problem that needs to be addressed through recommendations in this study?
2. How should the education program in recommendation 3(b) be implemented? Could this be incorporated into existing trainings for home visiting programs?

5) Recommendation: Continue investment in Safe Sleep education and increase investment in resources.

Safe sleep programs have been demonstrated to reduce infant mortality from SIDS and other sleep-related injuries. Sudden unexpected infant death (SUID) is the third leading cause of IM in Maryland. Additionally, sudden infant death syndrome (SIDS) and sleep-related deaths are much higher among black infants than among white infants. Evidence from existing national and local programs suggests that safe sleep education can dramatically reduce the number of unsafe sleep practices. However, our program inventory identified a need for more existing programs to explicitly embrace safe sleep as a programming focus. In particular, there is a need to identify the families with the greatest risk (families with smokers, infants in the NICU, and parents with unstable housing) and specifically target them for interventions. In addition to providing education on safe sleep during the postpartum period, it may be beneficial to provide resources like cribs, pack n' plays, or other safe sleep environments to allow families with limited resources to implement safe sleep practices. The following recommendations are intended to improve Safe Sleep programming throughout the State.

- a) Encourage existing programs serving pregnant women and families to promote best practices for safe sleep and engage in safe sleep education if the program does not already include safe sleep education.
- b) Increase resources and funding for safe sleep education and providing safe sleep materials (e.g. cribs) to at-risk families.
- c) Expand Prenatal Risk Assessment to include assessment of social determinants of health needs, inclusive of a safe sleeping environment

Discussion Questions for Recommendation #5

1. Much work is already being done on safe sleep education, but less work is being done to provide safe sleep settings (ex. cribs). What recommendations are necessary to really make a change in SIDs outcomes in Maryland?

Theme: Care Coordination

A challenge identified through the study was care coordination; i.e. how to ensure that families are identified and connected to services that they need and qualify for, and that care is coordinated through the preconception period, pregnancy, birth, and postnatally. Models to address infant mortality and reduce disparities rely on health care across the life course (i.e. preconception, prenatal, and postpartum care). A number of existing processes and programs exist to support care coordination during pregnancy, including Medicaid's Pregnancy Risk Assessment (PRA) tool. Medicaid regulations mandate that Medicaid Managed Care Organizations provide care coordination for special needs populations, such as pregnant individuals and infants. Yet, work group members have discussed the need for better care coordination.

- 6) **Recommendation: Improve existing care coordination processes and tools.** Rather than creating new processes and tools, existing processes and tools should be enhanced and strengthened. The following recommendations relate to care coordination:
- a) One improvement would be moving paper documents to an electronic format that can allow for more efficient and accurate data sharing across providers, as well as improve availability of data for program evaluation. For example, converting the PRA to an electronic format State-wide to allow for more rapid and accurate referral to appropriate services for women in Medicaid.
 - b) Identify challenges and opportunities to optimize use of Medicaid Administrative Care Coordinator Units for care coordination among Medicaid participants. The primary purpose of the ACC Program is to assist HealthChoice eligible Medicaid and MCHP beneficiaries in accessing and appropriately using their health care benefits.
 - c) Integrating preconception through postpartum care services
 - i) Use of a reproductive life plan could identify women who may want to become pregnant and direct preconception care and education to these women.
 - ii) Enhance electronic communication across care delivery systems for preconception health, pregnancy, and post-natal periods.
 - d) Expand opportunities to collocate postpartum and pediatric care.
 - e) Improve rates of screening for maternal depression and anxiety and the provision of guidance on safe sleep, breastfeeding, and child safety in prenatal care and well-child visits with pediatricians

Discussion Questions for Recommendation #6

1. What is missing from these recommendations with respect to data sharing and/or EMR functionality? What are the specific gaps in data sharing that you hope will be addressed in recommendations?
2. Recommendation 6(a) assumes that a provider or payer has completed a risk assessment, like the Medicaid PRA. However, that step is not always completed. What recommendation should be included to address that issue?
3. For recommendation 6(c), are providers best positioned to make these changes? Is there a role for other entities?

4. For recommendation 6(d), should the focus be on reimbursement, training on best practices, or both?
5. Protecting patient privacy is important. To the extent that this group decides to recommend increased data sharing, how will privacy protections, including appropriate use of Data Use Agreements and consumer options to opt-out, be taking into account?

7) Recommendation: Care coordination should include programs to address social determinants of health.

Many factors affect the health and well-being of our children. A life course approach that addresses the needs of both families and communities is critical. Such an approach must address systemic inequities, bias, and health disparities. Coordinating programs that address social determinants of health and address the root causes of these systemic inequities. These resources include nutrition and food access, housing, transportation, and job training and workforce development programs will have long term impacts on infant mortality and infant well-being.

- a) Programs serving families should use tools and approaches that are appropriate for their community to connect clients with social supports and resources. Many existing tools exist in the community and nationally to provide these connections.

Research has shown that unconscious bias impacts everyone, including patients and health care providers. There is additional research that shows when bias goes unaddressed, it can have a detrimental effect on the patient and provider relationship, and ultimately impact patient care. There is also emerging evidence that physician bias plays a role in the consistent disparities in infant and maternal mortality.

- b. Establish regular implicit or unconscious bias training with physicians, nurses and other health care professionals in collaboration with their professional organizations, as a component of on-going quality improvement efforts.
- c. Create a strategic vision to increase the diversity of the healthcare workforce and students in training through partnerships with academic institutions.

Discussion Questions for Recommendation #7

1. What is missing from these recommendations with respect to social determinates of health, addressing disparities, and connection to community resources?
2. Should a recommendation related to CHWs be included here, given their unique ability to understand community needs and barriers?

Theme: Permanent Council on Disparities in Infant Mortality

As noted in the introduction to this document, MHCC must include a recommendation related to “the establishment of a permanent council for lowering rates of disparity with respect to infant mortality” in the final report to the legislature.

The recommendation related to a permanent council could take a number of forms:

1. A recommendation to establish a new permanent council focused on disparities in infant mortality
2. A recommendation to establish a new permanent council focused on disparities in infant mortality and maternal mortality
3. An additional or expanded set of roles and responsibilities for an existing component within the Maryland Department of Health to increase focus and accountability related to infant mortality.

In January, the work group discussed the idea of the council. Workgroup members felt that it was important to have a centralized entity that could focus public and stakeholder attention on disparities in infant mortality. The workgroup felt that a permanent council, if created, would recommend actions to mobilize and coordinate resources within the State of Maryland to create sustainable reductions in disparities in infant mortality across the State and hold State entities accountable for that change. It was undecided if the Council would be purely advisory in function or would have operational authority and responsibilities.

The workgroup felt that it was important to have a single entity that could center public focus, action, and attention on the issue of disparities in infant mortality, to provide a plan, structure, and accountability for continuing change. However, the Permanent Council should not pull resources from existing infant and maternal mortality work; the Council should coordinate existing resources; fill gaps, and avoid duplicating efforts.

At the end of the meeting in January, a number of outstanding questions remained.

Discussion Questions on Permanent Council

- (1) Disparities also exist in maternal mortality. Would it make sense to combine the focus on infant mortality with a focus on maternal mortality, so that the focus is on the maternal/child dyad?
- (2) Should a new entity be created or could the gaps identified by addressed through an existing entity within the State? Please see the attached document for a description of existing State entities.
- (3) Should the work group be advisory and/or think tank in nature, or should it have a more operational role? What should that role be? Potential duties include:
 1. Monitor State operated and State-funded programs related to infant mortality;
 2. Monitor stratified race and ethnicity data on infant mortality and infant health.
 3. Convene meetings of community members and stakeholders where community groups have an articulated role in developing interventions to address disparities in infant mortality.

4. Create recommendations for interventions to reduce racial, ethnic, geographic, and other disparities in infant mortality in the State of Maryland;
 - a. Consider the role of poverty and historical racism and structural inequities in our society, and the causal relationship to the social determinants of health in creating recommendations.
 - b. Consider opportunities for administrative simplification and streamlining of programs and processes in the State to focus more resources on families and less on administration/program overlap.
5. Monitor the implementation and impact of such recommendations on reducing disparities in infant mortality;
6. Report annually to the Governor and the legislature on recommendations, implementation progress of past recommendations, and the impact of those recommendations.

(4) Should we specify the membership of the council? Membership could include community leaders and organizations; mothers and family members; youth; State Agencies; lactation consultants, home visitors, doulas, and/or community health workers; OBs and nurse midwives; non-profit organizations; faith-based organizations; organizations that may benefit from savings or face increased costs generated by actions of the council (e.g. Managed Care Organizations, insurance companies, hospitals); experts in key social determinates of health (housing, transportation, economic development and workforce, and food access), experts in health data sharing, and faith based organizations.

(5) Would ensuring a minimum percentage of community health workers and community representatives help ensure effective participation?

General Discussion of Draft Recommendations

1. Do the recommendations in this document adequately address the specific needs of African American Infants and Infants in Rural Communities? If not, what is missing?
2. The current draft recommendations do not directly address the statutory requirement to recommend “methods to reduce the costs associated with low birth weight infants and with infant mortality.” Do you think the recommendations above adequately address this topic, if indirectly? Do you have other ideas for addressing this topic?

3. The recommendations currently do not address care for substance use disorder, although this is something that the work group has discussed. What, if anything, should be added on this topic?

DISCUSSION DRAFT