Infant Mortality in African American Infants and Infants in Rural Areas Study
Advisory Work Group

July 19, 2019
3:00-5:00PM

Meeting Summary

Location: Maryland Health Care Commission, Room 100, 4160 Patterson Ave., Baltimore, MD. 2125, Remote Access Available.

Purpose of the meeting: Provide an overview of the Maryland Patient Safety Center's Maternal Health programs; review key findings from the survey of programs impacting infant mortality and interviews focused on the use of Community Health Workers, and a discussion of initial draft recommendations.

Agenda Item # 1: Welcome & Introductions

Attendance (In person/phone):
Chair: Ben Steffen
Vice Chair: Dr. Lee Woods
Vice Chair: Mark Martin as delegate for Noel Brathwaite.

Dr. Carla Bailey (phone)
Samuel Biddle
Matt Celentano
Charlotte Davis (phone)
Rebecca Dineen
Bonnie DiPietro
Maisha Douyon Cover
Anne Eder
LaWanda Edwards
Marianne Hiles
Pam Kasemeyer (phone)
Sandy Kick (phone)
Dr. Arethusa Kirk (phone)
Jane Krieke
Dr. David Mann
Dr. Lillian Norris-Holmes (phone)
Dr. Sheila Owens-Collins
Megan Renfrew
Scott Rhonda
Kristin Silcox (phone)
Dr. Donna Strobino (phone)
Amanda Thomas (phone)
Andrea Williams-Muhammad (phone)

UMD Contractors:
Dr. Sandra Crouse Quinn
Dr. Dushanka Kleinman
Dr. Marian Moser Jones
Dr. Marie Thoma
Amelia Jamison
Deborah Quint Shelef

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Agenda Item 2: Maryland Patient Safety Center: Past Programs & New Initiatives

Ms. DiPeitro presented an overview of the infant and maternal health work being done at the Maryland Patient Safety Center (additional background available at https://mhcc.maryland.gov/mhcc/pages/home/workgroups/documents/african_american_study/PtntSftyCnterHndout07192019WGmeeting.pdf).

The Maryland Patient Safety Center has worked on this topic since 2007 with projects focused on reducing elective c-sections and primary c-sections, implementing best practices for very low birthweight infants, and treating neonatal abstinence syndrome and providing OB care for women with opioid use disorder. The Center is currently engaged in a safe sleep collaborative with birth hospitals.

The Safe Sleep program is focused on hospitals modelling safe sleep practices through nurse modelling. Monthly cribs audits are held in 31 (of 32) birthing hospitals in the state. One new aspect of the project is to have hospitals partner with OB practices and pediatric practices to check to see if these partners are also providing safe sleep education and modelling safe sleep practices outside of the hospital walls. This project is funded through the MD Department of Health.

Dr. Woods voiced her support for the programming at the Safety Center, calling it the "strongest program in the bureau". The Safety Center has tremendous support from hospitals and a very active listserv that has increased communication across the system.

The workgroup discussed the safe sleep program, including partnerships with local OB practices and pediatricians.

The workgroup also discussed the issue of transfers of infants between hospitals, a topic that was addressed in the neonatal abstinence syndrome project. No data on the race of infants transferred was available, but transfers were more common from rural hospitals. Level 1 hospitals were the majority of the transfers. Level 3's and 4's rarely transfer, but would occasionally transfer to longer term care facilities. Now, they'll opt to keep the baby one more day rather than transfer to another hospital. One issue was insurance, but with some data these decisions were sometimes successfully appealed.

Agenda Item #3: Survey and Interviews: Key Findings

Survey Results

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Dr. Marie Thoma from the University of Maryland provided an update on the survey of Maryland programs providing direct services related to reducing infant mortality, a component of the inventory of programs presented in June. Survey response rates were high. All programs were focused on addressing both social and health factors.

Programs report that their clients need services beyond the ones that they provide, including: transportation, childcare, housing, nutritional assistance, translation, mental health and substance abuse. Another need for medical services dental assistance and low-cost medical assistance for individuals not eligible for Medicaid. Workforce development to help with the pipeline of potential program staff was an additional identified need.

Funding and sustainability were common concerns, including competition for grant funding, changing funder priorities, and flat funding despite increasing costs. These issues were for both local health departments and private non-profits. Programs described entering strategic partnerships, sharing resources, staffing modifications, and dependence on volunteers as some of the ways they manage limited budgets.

Common 'best practices'/successful strategies include use of incentives to encourage program participation, community outreach, and partnerships to leverage resources. Programs describe funding as their greatest challenge. Participant recruitment and retention were also challenges for some organizations.

The workgroup discussed the importance of housing, particularly for homeless families. Connection to housing appears to be a gap in current programs in the state. The workgroup also discussed transportation, particularly in Medicaid. Representatives from Maryland Medicaid explained it should be the "method of last resort" to request transport through the local health department and the transportation offered requires advance planning.

Interview Findings

Dr. Marian Moser Jones from the University of Maryland presented major themes from the ten phone interviews conducted with program directors and others familiar with community health worker (CHW) programs related to maternal and infant health in Maryland and in other States. The interview-based research was exploratory, and was not an attempt to create a comprehensive inventory of all CHW programs in the state.

Many successful program models for using CHWs to serve mothers and infants exist across the country. Institutional knowledge on best practices and challenges is no often disseminated outside of the organizations running these programs.

CHWs have been instrumental in helping to improve birth outcomes across the State. Some advantages of these programs:

- Clients need to be listened to, and CHWs can serve as an 'extra set of eyes an ears'
- Mental health concerns - some CHW are trained in Mental Health First Aid and can conduct screenings.
- CHWs can assist with needs assessment and addressing social determinants of health, including housing, transportation, and nutrition, as well as assisting with care coordination.
- Strengths-based approach to encourage positive parenting.

The interviews included programs in local health departments and private organizations. A need for more CHWs in rural communities was identified in the interviews, but recruitment, training, and retention is difficult. There are a variety of CHW models and the interviews provided examples of several models. It is important use CHWs in a way that enhances system capacity and is not duplicative. A workgroup member suggested "mapping out" the various workforces involved in perinatal care across the state, to understand the complementary workforces and perhaps identify the "ideal mix" for a given area.

Agenda Item #4: Discussion of Draft Recommendations

Ms. Renfrew reminded the workgroup of the statutory requirements for recommendations made through this Study.

The workgroup discussed the theme of care coordination and agreed that it should be the first recommendation. Existing programs should be strengthened and improved. Home visiting and community health worker programs would benefit from improved care coordination, including a streamlined process and deduplication of efforts.

The workgroup discussed the definition of 'care coordination' as including everything from the moment a patient is identified through to the delivery of services. Care coordination is something that everyone needs. All patients will be "touched" but the needs of each patient will be different. Coordinating between nurses and CHWs is essential: nursing staff can help train and support to CHWs and CHWS could provide cultural context. CHWs help the patient execute the task that the medical system has assigned to the patient and address barriers that the patient faces to following through, including addressing the social determinants of health.

The workgroup discussed "Centering Pregnancy", a group prenatal care model. Workgroup members felt that while this is a good program, it is expensive, launching the program is difficult, physicians may be hesitant, patients are difficult to recruit, etc. Other group prenatal care models do not have the same evidence base, but the concept of bringing women together

who share a common background is worthwhile and could be a good alternative to home visiting, and some models show success in initiating breastfeeding, in improved birth spacing, etc.. The "Centering" model typically exclude those with high medical risk, and women with some medical risk could benefit from group prenatal care programs. Other peer support groups, Mocha Moms, Mothers with Bumps, etc. are also valuable

The group then discussed Recommendation #3: Medicaid coverage during the postpartum period. This recommendation could be for coverage for 1 year postpartum at for all under the 250% FPL threshold, addressing the current gap that applies to women over 138% but under 250% FPL. Workgroup members noted that expansion of coverage to 1 year post-partum has been a priority for ACOG. Implementing this recommendation has State budget impacts and requires CMS approval. Workgroup members also discussed using insurance navigators to make sure women transfer smoothly from Medicaid to private coverage.

Agenda #5: Next Steps

The work group agree to set up call for discussion of the care coordination recommendations. Written comments on the recommendations were due to Ms. Renfrew by Friday, July 26th.