

Study: Infant Mortality in African American Infants and Infants in Rural Areas Study

Work Group Meeting, August 27, 2019

Meeting Summary

Purpose of the meeting: Discuss draft report for study of infant mortality in African American Infants and Infants in Rural Communities, including discussion of draft recommendations.

Attendance (In person/phone):

Ben Steffen- *Chair*

Dr. Lee Woods-*Co Chair*

Participants

Senator Shirley Nathan Pulliam

Hosanna Asfaw-Means

Carla Bailey

Matt Celetano

Dr. Cheryl DePinto

Maisha DouyonCover

Robin Elliot

Anne Eder

Lauren Harrington

Marianne L. Hiles

Dr. Lee Hurt

Neil Karkhanis

Pam Kasemeyer

Dr. Arethusa Kirk

Sandy Kick

Dr. David Mann

Dr. Russell Moy

Dr. Lillian Norris-Holmes

Brenda Overton

Dr. Meghana Rao

Kristen Silcox

Dr. Donna Strobino

Shanna Wideman

Ben Wormser

MHCC Staff

LaWanda Edwards

UMD Team

Dr. Sandra Crouse Quinn

Dr. Marian Moser-Jones

Amelia Jamison

Debbie Quint Shelef

Dr. Dushanka Kleinman (phone)

Dr. Marie Thoma (phone)

Agenda Item #1: Welcome & Introductions

Ben Steffen facilitated introductions and reminded the workgroup of the purpose of the meeting.

Senator Shirley Nathan-Pulliam expressed her support for the recommendations, particularly the focus on addressing implicit bias and on addressing the social determinants of health. She describes stories she's heard from constituents where Black mothers and babies were not given equal consideration from providers due to their race.

Agenda Item #2: Discussion of Prioritization of Recommendations

Dr. Sandra Quinn provided a high-level overview of the recommendations related to Care Coordination. Senator Nathan Pulliam asked about the role of transportation in continuity of care. She has had discussions about the critical lack of transportation across the State, especially in the Eastern Shore of Maryland. Perhaps instead of developing a transportation system, integrating ride-share services could be cost-effective.

A workgroup member expressed concern that recommendation #1 (on strengthening existing care coordination measures) was not strong enough. Other workgroup participants agreed.

One of the tensions that the workgroup discussed is between adding specificity without adding more recommendations.

The current recommendation focusing on improving continuity of care could be addressed by linking obstetricians and pediatricians to primary care models. Senator Nathan-Pulliam recalls a successful program that had utilized pregnancy navigators in minority communities incentivizing one-on-one attention to mothers.

Another specific concern was about the recommendation on birth spacing: do resources exist to help providers manage this issue?

Mr. Steffen suggested that the recommendations be reorganized into categories such as insurance, technology, clinical, etc.

Medicaid coverage

The workgroup also discussed the lack of dental coverage postpartum in Medicaid. Extending medical coverage for 1 year post-partum would have to be funded through State funds, which would require a budget initiative and approval of a waiver amendment from CMS. Currently 81% of women eligible for Medicaid during pregnancy remain on Medicaid after that period expires.

Implicit bias training

The workgroup also discussed the recommendation on trainings related to implicit bias. Should these trainings be mandatory or should they simply be framed as “training opportunities” and offered with incentives? If the trainings should be mandatory, how would it go into effect? There was concern that legislators would not want to create a mandate. Existing policy statements from the Academy of Pediatrics on the importance of addressing race in healthcare provides support for the mandatory training. Mr. Steffen suggested that some incentive may need to accompany the mandate, to ensure that it is actually incorporated. Others noted the importance of all professionals understanding the impact of bias. A cultural change is required so

that daily interactions change: a one-time training is not enough. Measuring of patient experiences of bias could evaluate healthcare organizations, incentivize organizational change and could produce system-wide effects. The group discussed how the content of training would be defined.

There was a discussion providing progestin (progesterone). If the one week delay between identifying eligible patients were removed, patients could complete the sign off form with their doctor and have it sent to the insurance company. Another barrier is that it must be administered weekly. Perhaps self-administration could be explored.

Agenda Item #3: Discussion of Centralizing Responsibility / Permanent Council

The workgroup discussed the requirement to make a recommendation related to a permanent council. Any configuration of a council would require a funding source.

Several workgroup members remember a previous commission on infant mortality from the 1990's that was successful. The commission had specific goals based on data, created perinatal standards, and administered grants (for instance for Healthy Start in Baltimore).

The workgroup discussed the council's potential role. It could be a "think tank" and a "do tank". The Maryland Quality and Cost Council is a good example of a "do-tank". A membership of high-profile individuals could marshal resources to make something happen. Perhaps tying the council to the Total-Cost-of-Care model would make sense.

A number of members of the workgroup would like the council to have a focus on both infant and maternal mortality.

The meeting wraps up with discussions of timelines for feedback on the report draft.