Welcome.
The webinar will begin shortly.

Health Equity in Birth Outcomes Forum

September 15, 2021

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Welcome

Health Equity in Birth Outcomes Forum

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Bill Jensen

- Master of Ceremonies
- *i*Care VP

Housekeeping

- Today's Zoom Format
  - Q & A
  - Panel discussion
  - Chat is off
  - Attendee microphones are muted
  - Attendee cameras are off
  - Polling basics
  - Technical support
  - Intermission at 10:00

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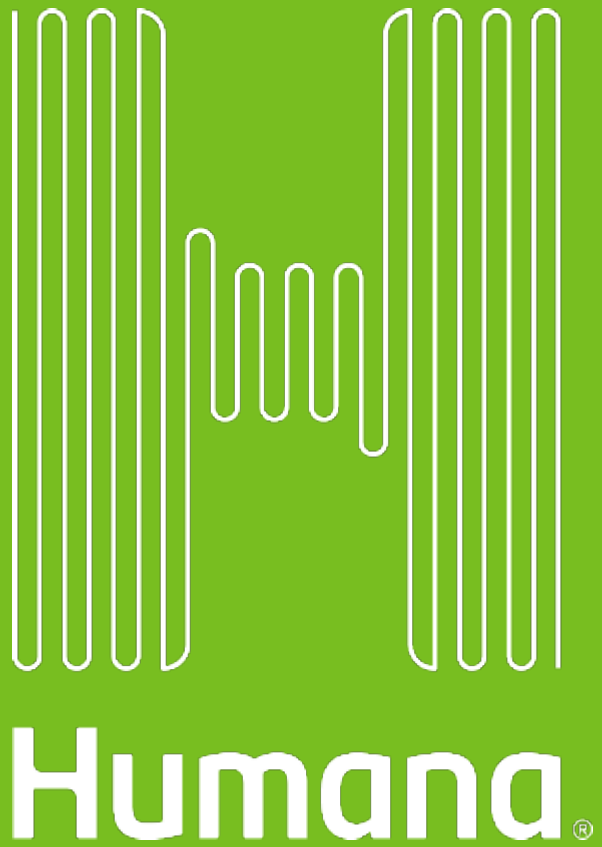

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The Forum is brought to you in partnership with:

Milwaukee
Urban League

Greater Milwaukee
& Waukesha County

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Tony Mollica

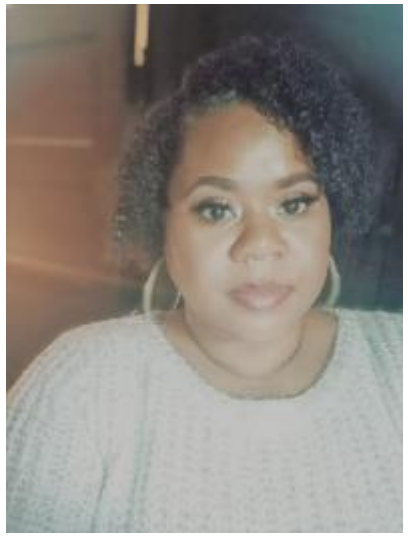
CEO/President

Forum Objective:

Bring together experts from across the country to share insights from evidence-based programs that are working

…and why.

Latrice
Care Coordinator



Kathleen
Care Coordinator

Sharonda
Care Coordinator

Courtney
RN Supervisor

Dorchristalon “Chrissy”
Care Coordinator

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Jim Jones

State Medicaid Director

Wisconsin Department of Health Services

Health Equity in Birth Outcomes and Wisconsin Medicaid

James Jones, Medicaid Director

September 15, 2021

Wisconsin Department of Health Services
Division of Medicaid Services

Wisconsin and Birth Outcomes

Wisconsin 'Highlights' from a Journal of Perinatology article, which is Wisconsin specific (note Dr. Zapata from DPH is an author):

- Black babies are almost three times more likely to die than white babies
- Black babies have higher risk of dying across all of the measured causes of death.
- 77% of black mothers used Medicaid to pay for the birth; compared to 27% of white mothers.

A U.S. DHHS Region V infant mortality disparity report showed:

- Region V is worst in the nation and within Region V WI has the highest black infant mortality rate and biggest gap between black and white babies.
- Milwaukee County is in the top 10 counties nationally for black infant mortality and for the gap between black and white infant mortality rates.
- In Wisconsin, about 1/3 of the excess deaths among black babies are preterm-related; 1/3 are related to SIDS, and 1/3 are other causes.

Medicaid Policies Promoting Healthy Birth Outcomes

Fee-For-Service Medicaid

- Prenatal Care Coordination Services
- Coverage of non-invasive fetal testing protocols

Managed Care Medicaid

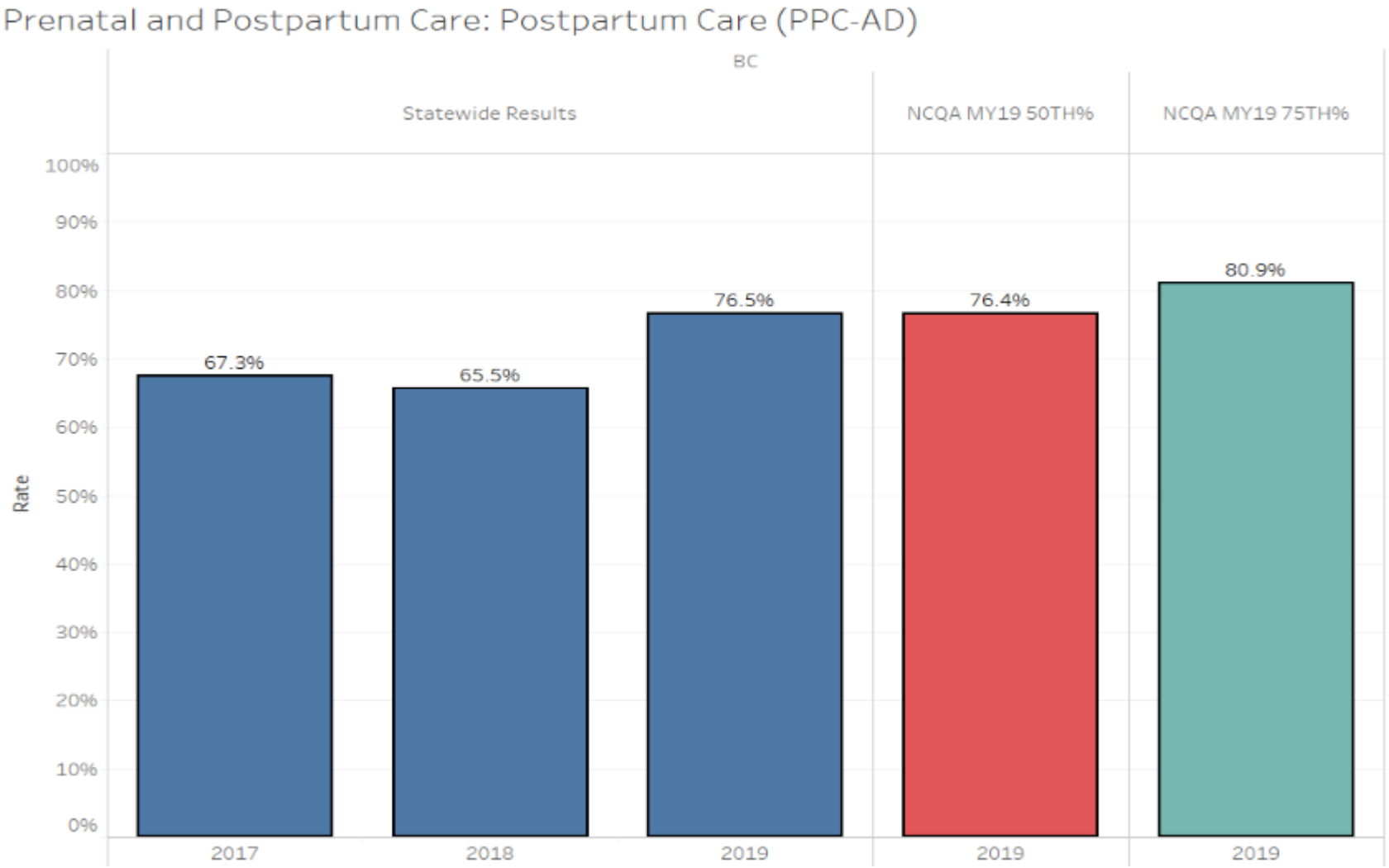
- Global Pregnancy and Delivery Payments in Managed Care
- Managed Care 'Kick' Payments for Labor and Delivery
- Implementing equity requirements for MCP – first assessment of plans and clinics
  - BadgerCare Plus Quality Measurement
  - Obstetrics Medical Home
  - Performance Improvement Projects

BadgerCare Plus HMO Quality Measurement

- BadgerCare Plus HMOs have financial incentives to enhance performance in improving birth outcomes.
- DHS includes NCQA HEDIS quality measures on Prenatal Care and Postpartum Care in our HMO Pay for Performance (P4P) program.
- HMOs must achieve specific targets in order to earn back money DHS has withheld from monthly capitation payments.
- The next two slides show Wisconsin's Postpartum and Prenatal performance for 2019, which improved over 2018's performance, but our state's average is still just over the 50th percentile of national Medicaid HMO performance nationally

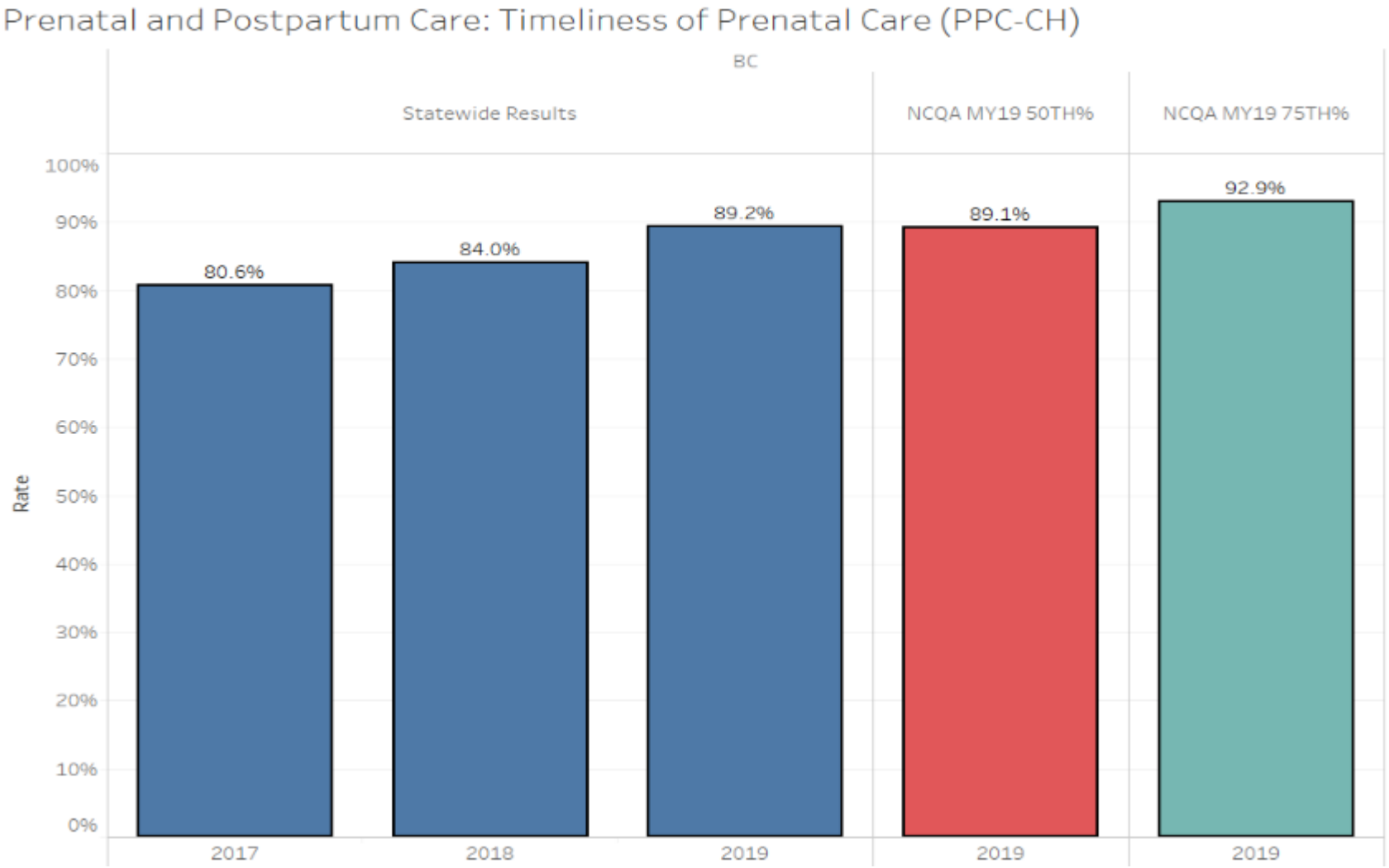
State-wide Results

MY2019 HMO P4P



State-wide Results

MY2019 HMO P4P



BadgerCare Plus HMO Quality Measurement: Report Card

- DHS includes each HMO's performance in our annual HMO Report Card.
- BadgerCare Plus HMOs are ranked on Pregnancy & Birth outcomes, including a combining of the scores of the two HEDIS measures and compares the HMO to national performance.
- Our BadgerCare Plus HMO Report Card ranks plans on a one to five star basis, with our statewide average as three stars.
- The 2019 HMO Report card will be released soon, but the 2018 Report Card is available on our web site.
- This HMO Report Card is shared with members as they select a HMO, so they have information that allows them to choose of a high-performing plan that meets their needs.

HMO Obstetric Medical Home Overview

- The Obstetric Medical Home (OBMH) was initiated in January 2011 and is part of DHS' long-standing efforts to improve birth outcomes and reduce birth disparities in Wisconsin.
- The initiative was first implemented in Southeast Wisconsin, and expanded to Dane County and Rock County in 2014.
- The program is unique to members enrolled in (HMOs), which partner with clinics to serve high-risk pregnant members.
- iCare is one of 12 HMOs participating in the OBMH.

HMO Obstetric Medical Home Overview

- The OBMH provides comprehensive, coordinated prenatal and postpartum care to BadgerCare Plus and Medicaid SSI HMO members who have been identified as high-risk for a poor birth outcome.
- Care coordination is a key component, as is addressing psychosocial issues, (for example, domestic violence, unstable living conditions, inadequate support system) and member engagement in their own care.

HMO Obstetric Medical Home Overview

- The program is designed around early identification of those at high risk for a poor birth outcome, early engagement in care, ongoing care management through the postpartum period, and enhanced payments via an incentive to clinics.
- Data is tracked in the OBMH registry, and DHS collects information via chart reviews performed by our External Quality Review Organization, MetaStar.
- This data is used for evaluating the program as well as performance of HMOs and clinics, and for payment of the appropriate incentives.

HMO Performance Improvement Projects

- Starting in 2020 and continuing through this year, DHS required BadgerCare Plus HMOs to improve postpartum care outcomes through a Performance Improvement Project (PIP).
- HMOs are required to complete specific activities as part of this project, in order to earn back 1.5% of their payment withhold.
- These projects have been impacted by COVID response, but are underway with final reports from each HMO due next summer.

Elements of the Performance Improvement Projects include:

- Partnering with a provider clinic for the two year project
- The HMO and clinic completing self-assessments of cultural competency and staff training
- Developing health disparity reduction plans, with a goal to reduce disparities that the HMO has identified within their membership's postpartum outcomes.
- Evaluating how members are currently screened for social determinants of health, and creating an improvement plan
- Piloting non-traditional provider types, such as doulas, peer specialists, community health workers, or traditional healers.

Future Medicaid Policy and Process Changes

- Justice, Equity, Diversity and Inclusion (JEDI) Focus on Quality – #1 -Healthy Birth Outcomes
- NCQA Accreditation Requirement and NCQA Multicultural Health Care Distinction/Health Equity Accreditation Requirement for Medicaid/BadgerCare HMOS for Certification
- Community Health Workers Coverage (in development)
- Doulas Pilot & PNCC Design

Doula Pilot Project

- Integrates existing Prenatal Care Coordination (PNCC) Medicaid benefit with doula services
- Focuses understanding and support of doulas as trained professionals who provide continuous physical, emotional, and informational support to a birthing person before, during, and after childbirth
- 2 sites identified (Milwaukee/Madison). Collaboration with local health departments and community-based doula organizations to provide culturally competent services to Medicaid-enrolled birthing people to address racial and ethnic health disparities in Wisconsin
- Information collected from doula pilot sites will be used to inform policy surrounding future Medicaid coverage of doula services and PNCC redesign efforts

Future PNCC redesign efforts

- Goal: provide high quality culturally competent prenatal care services to WI Medicaid members
- Review policies surrounding the PNCC program
- Utilize doula pilot project data/understanding to integrate doula services into the benefit
- Evaluate reimbursement rates of PNCC services
- Work with external stakeholders to assess member and provider needs
- Develop educational materials for PNCC providers regarding best practices as well as benefit guidelines
- Develop materials aimed at informing members about the benefit

Questions?

Wisconsin Infant Mortality - 2019

Principal Source of Payment	Race/Ethnicity	Number of Infant Deaths (less than 365 days)	Total Number of Live Births	Infant Mortality Rate per 1,000 Live Births
Medicaid/BadgerCare	Non-Hispanic Black	77	5,472	14.07
	Non-Hispanic White	65	10,016	6.49
	Hispanic	21	4,267	4.92
	Other	20	2,474	8.08
	Total	183	22,229	8.23
Non-Medicaid (Private, Self-pay, Other)	Non-Hispanic Black	8	1,310	6.11
	Non-Hispanic White	142	33,890	4.19
	Hispanic	11	2,121	5.19
	Other	17	2,673	6.36
	Total	178	39,994	4.45

Wisconsin Low Birthweight - 2019

Principal Source of Payment	Race/Ethnicity	Number of Low Birthweight Births	Total Number of Live Births	Percent Low Birthweight
Medicaid/BadgerCare	Non-Hispanic Black	887	5,472	16.21
	Non-Hispanic White	863	10,016	8.62
	Hispanic	310	4,267	7.27
	Other	200	2,474	8.08
	Total	2,260	22,229	10.17
Non-Medicaid (Private, Self-pay, Other)	Non-Hispanic Black	169	1,310	12.90
	Non-Hispanic White	1,968	33,890	5.81
	Hispanic	144	2,121	6.79
	Other	213	2,673	7.97
	Total	2,494	39,994	6.24

Nwando Olayiwola

MD, MPH, FAAFP

Chief Health Equity Officer

Humana

MAKING AN IMPACT FOR HEALTH EQUITY

Humana's Commitment to Health Equity

J. NWANDO OLAYIWOLA, MD, MPH, FAAFP
Chief Health Equity Officer
Senior Vice President
Humana

ICARE HEALTH EQUITY IN BIRTH OUTCOMES FORUM
SEPTEMBER 15, 2021

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Disclosures

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My Story

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Poll #1

Which of the following racial/ethnic groups experiences the highest infant mortality in the first year of life?

Black | Hispanic | Asian | White

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The State of Maternal-Child Health Among Underserved Populations in America

Blacks have 2.3 times the infant mortality rate as non-Hispanic Whites

Black infants are four times as likely to die from complications related to low birthweight compared to White infants

Pregnancy-related **deaths among American Indian / Alaska Native women are nearly four times as high** as the rate for White women

Native Hawaiians are five times more likely than White women to start prenatal care in the third trimester or to receive no prenatal care at all

Even with a college degree, **Black women are 5 times as likely to die from complications during birth** than similarly educated White women

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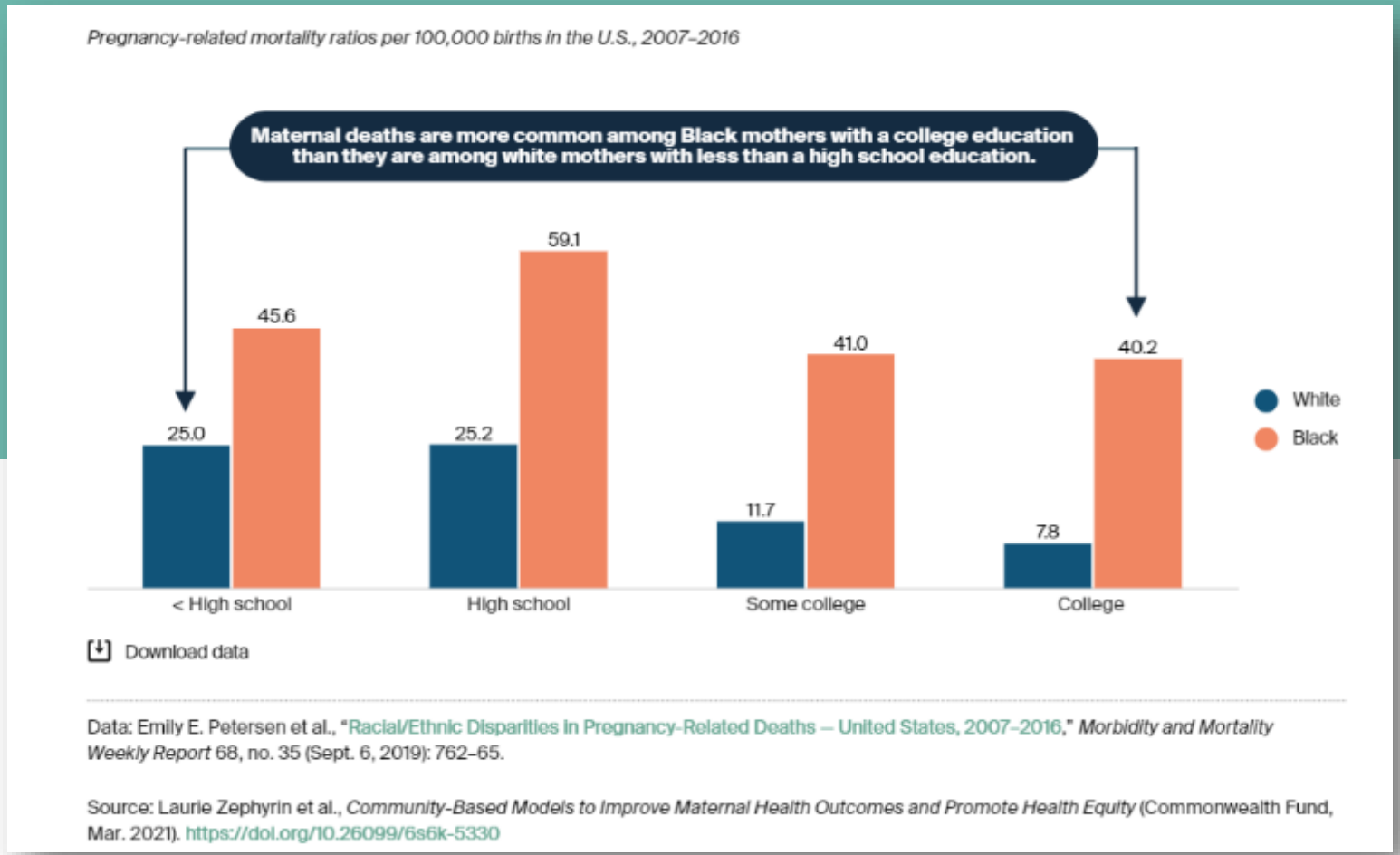
Disparity Persists Despite Education and Income



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Infant Mortality in the U.S.

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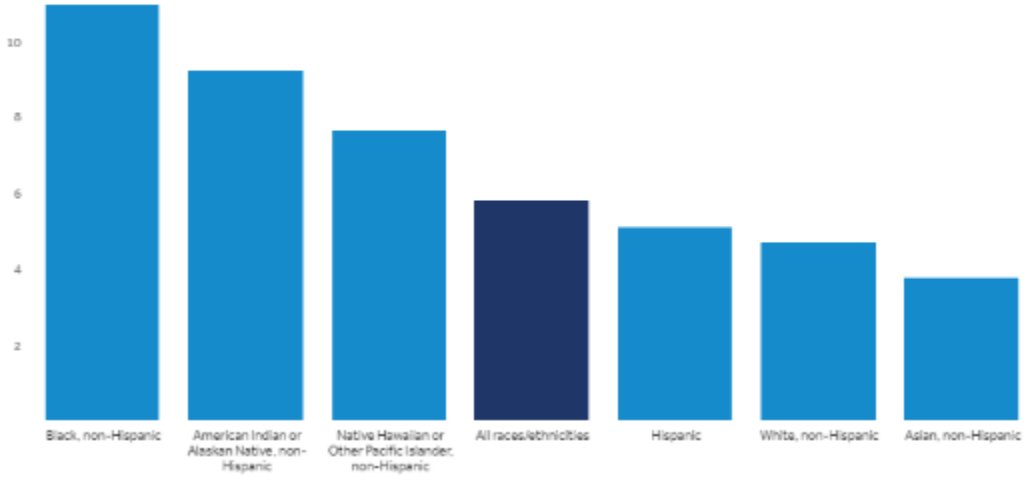
Mortality rates are higher than average among infants born to mothers who are Black, American Indian and Alaska Natives, and Pacific Islanders

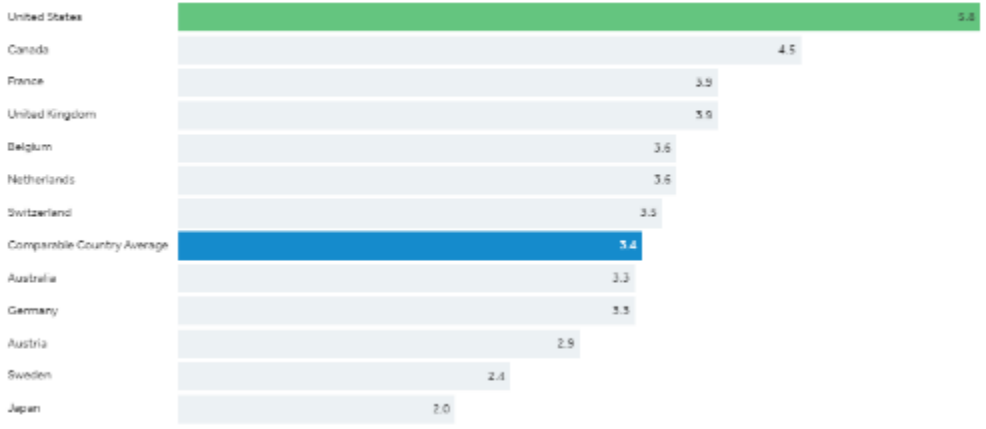
Infant mortality per 1,000 live births, by maternal race/ethnicity, 2017



Peterson-KFF
Health System Tracker

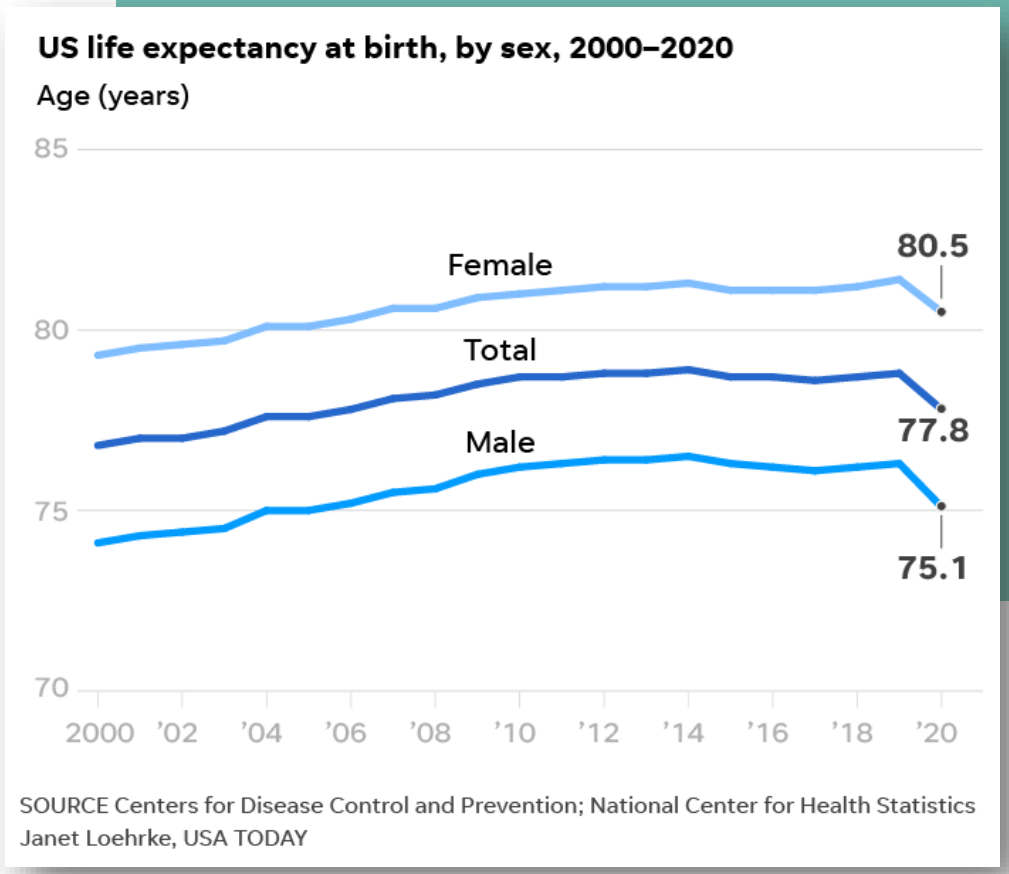
Infant mortality is higher in the U.S. than in comparable countries

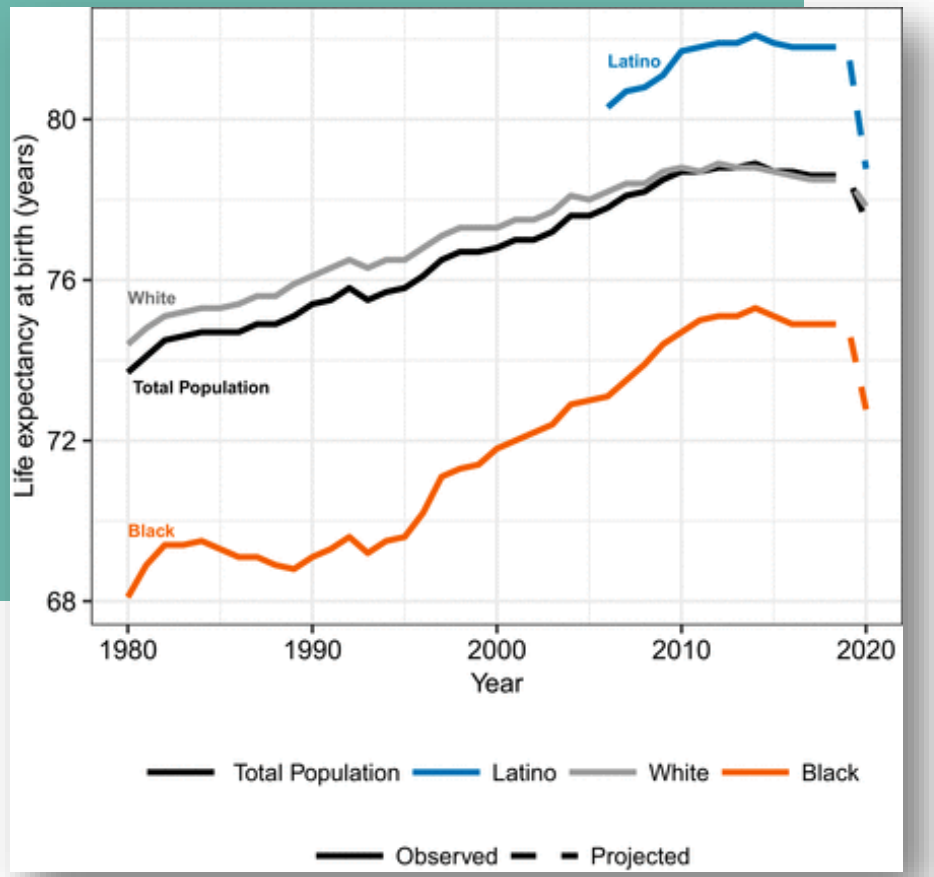
Infant mortality per 1,000 live births, 2017



Note: 2016 data shown for Japan

U.S. Life Expectancy





https://www.usatoday.com/story/news/health/2021/02/18/covid-us-life-expectancy-record-low-blacks-latinos-most-affected/6778474002/
https://www.cdc.gov/nchs/data/databriefs/db218.pdf

U.S. Life Expectancy

U.S. Life Expectancy Plunged in 2020, Especially for Black and Hispanic Americans

The 18-month drop, the steepest decline since World War II, was fueled by the coronavirus pandemic.

2019-2020, life expectancy dropped to rates not seen since WWII:

Hispanic People	Black People	White People
↓ 3 YRS	↓ 2.9 YRS	↓ 1.2 YRS

https://www.nytimes.com/2021/07/21/us/american-life-expectancy-report.html

MAKING AN IMPACT FOR HEALTH EQUITY

The State of Maternal-Child Health Among Underserved Populations in **Wisconsin**

1 out of every 100 delivery hospitalizations results in at least one severe maternal morbidity (SMM); SMM rates are highest for women under 20 years of age, women 35 and older, and Black women

Black women are 3 times as likely to die from a pregnancy-related cause than White women; heart disease and stroke account for more than 1 in 3 of those deaths, with other causes including infections and severe bleeding

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Poll #2

Which of the following is considered an evidence-based solution to addressing maternal-child health inequities?

- **Expanded range of birth options (doulas, midwives, etc.)**
- **Group prenatal care visits**
- **Medicaid postpartum care expansion**
- **Workforce diversity and cultural competency**
- **All of the above**
- **None of the above**

health equity

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The Commonwealth Fund

Community-Based Models to Improve Maternal Health Outcomes and Promote Health Equity

"In the United States, high spending on maternity care does not translate to better maternal health outcomes. People of color, particularly Black and Indigenous women, are at heightened risk for negative outcomes."

"One policy option is expanding reimbursement for providers like doulas and midwives, whose care has been associated with improved maternal and infant health outcomes in some research. Other options include enhancing patient access to a broader range of services, and incentivizing health systems and providers to adopt evidence-based, equity-centered models of care."

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Access

- Support existing health programs
- Eliminate maternity care deserts
- Offer tools to navigate care

Mental Health

- Identify barriers to accessing services
- Screen for and address mental health

Comprehensive Care Coordination

- Invest in policies/programs that support basic needs
- Invest in programs that offer one-stop services
- Simplify enrollment across public benefit programs
- Fund community-based education and public health

Quality

- Train providers to address racism
- Build a more diverse workforce
- Create standardized assessments for mothers and infants
- Link payment to quality

Payment Reform

- Medicaid expansion

Data Collection and Oversight

- Standardize birth and death certificate data
- Mandate and fund fetal and infant mortality review committees
- Ensure equity in the review process

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https://www.americanprogress.org/issues/women/reports/2019/05/02/469186/eliminating-racial-disparities-maternal-infant-mortality/

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The Humana Approach

Strategies to Address Maternal Health Inequity

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Expanded Options
Access to community-based doulas, midwives, birth centers, and group prenatal care, leading to fewer complications and higher breastfeeding rates

Coordinated Care in Place
More home visits, outreach, and integrated services, as well as technology infrastructure to enable telehealth

Streamlined Payment and Funding
Medicaid expansion and extended eligibility, improving Black maternal and infant health, health coverage, maternal mortality, infant mortality, low birthweight, and preterm birth

Cultural Competency and Implicit Bias Training
New programs to diversify the Humana workforce and ensure that health professionals better reflect the communities we serve

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MAKING AN IMPACT FOR HEALTH EQUITY

Cultural Competency and the Humana Approach

Candy Magaña, MPA
Population Health Strategy Lead
Humana

@DrNwando

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Why Cultural Competence, Humility, and Congruence Matters

Results examining 1.8 million hospital births in Florida between 1992-2015 suggest that **newborn–physician racial concordance is associated with a significant improvement in mortality** for Black infants

Due to the disproportionately White physician workforce, **Black families seeking to minimize risk by using a Black physician are often unable to find care**

After adjusting for medically necessary procedures, **C-sections are more common among Black women than White women**, leading to more negative health outcomes for both mother and baby

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https://www.pnas.org/content/117/35/21194
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4194634/
https://www.americanprogress.org/issues/women/reports/2019/05/02/469186/eliminating-racial-disparities-maternal-infant-mortality/

MAKING AN IMPACT FOR HEALTH EQUITY

The Humana Approach

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Implicit bias contributes to racial and ethnic disparities in health

- Use evidence-based approaches to address bias in healthcare and expand cultural competency
- Explore mandatory cultural competency and implicit bias training for associates
- Offer learning opportunities for member-facing employees and providers on bias and health outcomes
- Monitor impact of interventions on outcomes

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Getting Started: Developing Programs to Advance Cultural Competency in an Organizational Setting

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Identify Audience

Limit your focus to 1-2 specific audiences (e.g., new hires, clinical employees, etc) to pilot the intervention before scaling

Determine Content

Select and/or develop a curriculum that meets immediate and measurable needs (e.g., implicit bias, health equity)

Consider Delivery

Explore best modalities for facilitating training (e.g., online vs. in-person, group vs. individual)

Evaluate

Vigorously evaluate the impact of the program, both in terms of knowledge and behavior change

Partner

Get creative with key partners and stakeholders, including human resource teams, clinical leads, and external organizations

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HUMANA & HEALTH EQUITY

health equity

J. Nwando Olayiwola, MD, MPH, FAAFP (She/Her/Hers)

Chief Health Equity Officer &
Senior Vice President, Humana
Adjunct Professor, The Ohio State University
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cmagana1@humana.com

Results are only as good as the lives impacted.

Let’s keep making a difference.

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Poll Question #1

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Poll Question #2

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Lynda Krisowaty, MHS

Senior Program Manager, Evidence-Based Practice
Association of Maternal & Child Health Programs

Laura Powis, MPH

Program Manager, Evidence-Based Policy and Practice
Association of Maternal & Child Health Programs

innovation hub
AMCHP | Explore. Build. Share.

Equitable Evidence Identification and Effective Programs

Health Equity in Birth Outcomes Forum

Presenter: **Lynda Krisowaty, Senior Program Manager**

Presenter: **Laura Powis, Program Manager**

September 15, 2021

AGENDA

1. What Constitutes Evidence?

   10 MINUTES

2. Overview of Innovation Hub

   5 MINUTES

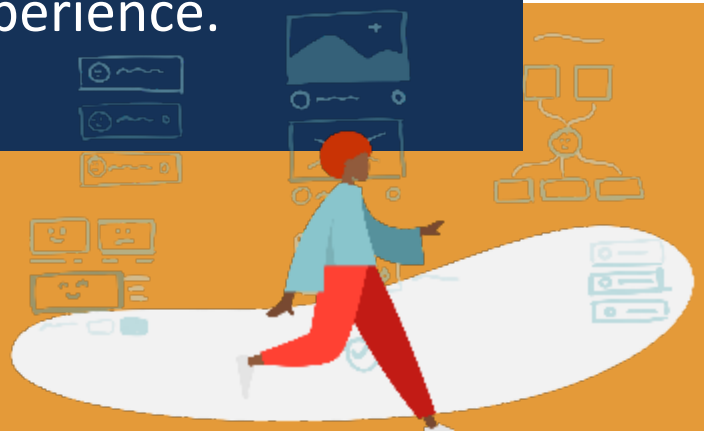
3. Overview of Strategies and Programs for Equitable Birth Outcomes

   15 MINUTES

What Constitutes "Evidence"?

AMCHP's "Evidence" Definition:

Anything that demonstrates a given initiative is having its intended impact for a specific community or population. Evidence in the public health field is inherently ***practice-based.*** What public health considers evidence is not limited to the best available scientific research evidence; it also emphasizes and values community-defined evidence and the values, needs, and preferences of those with lived experience.



Practice-Based Evidence

EVIDENCE FROM THE FIELD

- Community preferences, experiences, and input
- Feedback from those with lived experience
- Contextual evidence such as state/local data
- Input from professionals and providers
- Scientific research studies

What Works for Some, Doesn't Work for All

It amazes me that researchers and policy makers don't understand that the people we serve are experts in their own lives.

As clinicians we take a history and physical from someone and deem them competent to report symptoms and how they feel, **but not** solutions and how to address their health needs in the context of their own existence.

Somewhere along the health professions lost our way and think we know better than the people we serve, when their lived experience probably is more important than our population-based knowledge.

-Monica R. McLemore, PhD, MPH, RN

Community-Defined Evidence/Vision of Success

Environment and Organizational Context

Environment and Organizational Context

What Works

Documented Evidence/ Information

Community Practitioners' Expertise

Evidence-Based Decision Making

Content from the National MCH Workforce Development Center
Based on Community Centered Evidence-Based Practice Approach from the National Latin@ Network and Jacobs et al. 2012

Key Points to Consider

- Evidence comes in many forms, including the perspectives of people with lived experience
- Expanded development and use of community generated evidence can and should complement other forms of evidence
- To advance equity, our processes, including evidence gathering, must be equitable

EXPLORE

MCH Innovations Database

WHAT IS INNOVATION HUB?

Online platform that aims to **facilitate peer learning**, **build the MCH evidence base**, and identify and promote effective and equitable **practices and policies** grounded in evidence that will help make a collective impact on the wellbeing of individuals, families, and communities.

www.amchpinnovation.org

MAIN RESOURCES

EXPLORE MCH Innovations Database

BUILD Replication Projects, Implementation Toolkits

SHARE Database Submission Process

MCH Innovations Database

Goal: Build the MCH evidence base by identifying and sharing effective practices from the field that benefit MCH populations.

A growing repository of "**what's working**" in MCH:

- Programmatic practices and initiatives
- Collaboratives/coordinated structures
- Workforce development strategies
- Family/community engagement and partnership strategies
- Toolkits and curricula

MCH Innovations Database

PRACTICE CONTINUUM

- Addresses a need
- Benefits MCH groups
- Advances health equity
- Involves stakeholders
- Shows signs of success

- Has strong logical/theoretical foundation
- Has evaluation plan
- Identifies & uses lessons learned for improvement

- Considers biases
- Conducts continuous quality improvement
- Data shows beneficial outcomes
- Identifies & assesses unintended results

- Meaningfully engages stakeholders at all practice levels
- Disseminated via a journal, toolkit or CoIIN, external evaluation, etc.
- Replicated with similar positive results

Check out the Database!

www.amchpinnovation.org/database/

BUILD

Strategies and Programs for Equitable Birth Outcomes

Stage Setting

Healthy Beginnings and Title V

Ensure	Ensure perinatal and social determinants data are inclusive, relevant, and accessible to all stakeholders
Invest	Invest in comprehensive perinatal data systems for states and community-based organizations
Restructure	Restructure Title V funding requirements to support community-based organization and interdisciplinary perinatal providers with an anti-racist, equity-centered, reproductive justice framework
Cover	Cover the costs of necessary supports to prevent preterm birth (clinical and non-clinical – the comprehensive perinatal workforce) with public and private funds (governmental and health insurance)
Standardize	Standardize the accountability of health systems to the patient experience

Examples from AMCHP's Innovation Hub

Mothers Rising Home Visiting Program

Cutting-Edge Practice

- Innovative perinatal health support system developed for women of color by women of color using evidence-based screening tools, service models, and interventions. MRHV program approach to perinatal care is holistic, community-centered, and relationship-based
- Integrates social and health intervention methods employing social proximity, cultural congruence, MV Perinatal Health Worker training, and a 3-generation approach to yield improved perinatal outcomes and social conditions for black women, creating stability for the family unit, and improving trajectories for multiple generations and the greater community

Mamatoto Village

HealthConnect One – Community-Based Doula Program

Best Practice

- Provides support to young families during pregnancy, birth, and the early postpartum period. Dramatically increase breastfeeding rates and decrease c-section rates – by providing extended, intensive peer-to-peer support to families throughout pregnancy, during labor and birth, and into the early postpartum period.
- This program, based on the community health worker model, takes a traditional, even ancient role and integrates it into systems of care in which it is both innovative and potentially challenging.

It Takes A Village

Promising Practice

- It Takes a Village (ITAV): Giving our Babies the Best Chance is a community education and engagement series specifically designed for Native Hawaiian/Pacific Islander (NHPI) communities. The ITAV project raises awareness and educates NHPI families and community members about maternal and infant health in the context of Pacific Islander cultural beliefs and practices
- Used a community-based participatory approach to develop an innovate health promotion tool based on NHPI traditional cultural concepts.
- The ITAV project consists of four in-person, two-hour long workshops facilitated by trained community members.

Key Takeaways

- To improve birth outcomes, Black and Brown women and their communities must be central to designing and identifying solutions
- Evidence comes in many forms, including community preferences and the perspectives of people with lived experience
- Black and Brown women inherently have beautiful powerful birth outcomes
- You can't have equity in outcomes without equity in processes, and that includes evidence gathering and generation

QUESTIONS?

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Thank you.

Evidence and Implementation Team
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Laura Powis,
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Intermission

Health Equity in Birth Outcomes Forum

September 15, 2021

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Poll Question #3

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Poll Question #4

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Poll Question #5

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Milwaukee
Urban League

Eve M. Hall, PhD

President/CEO

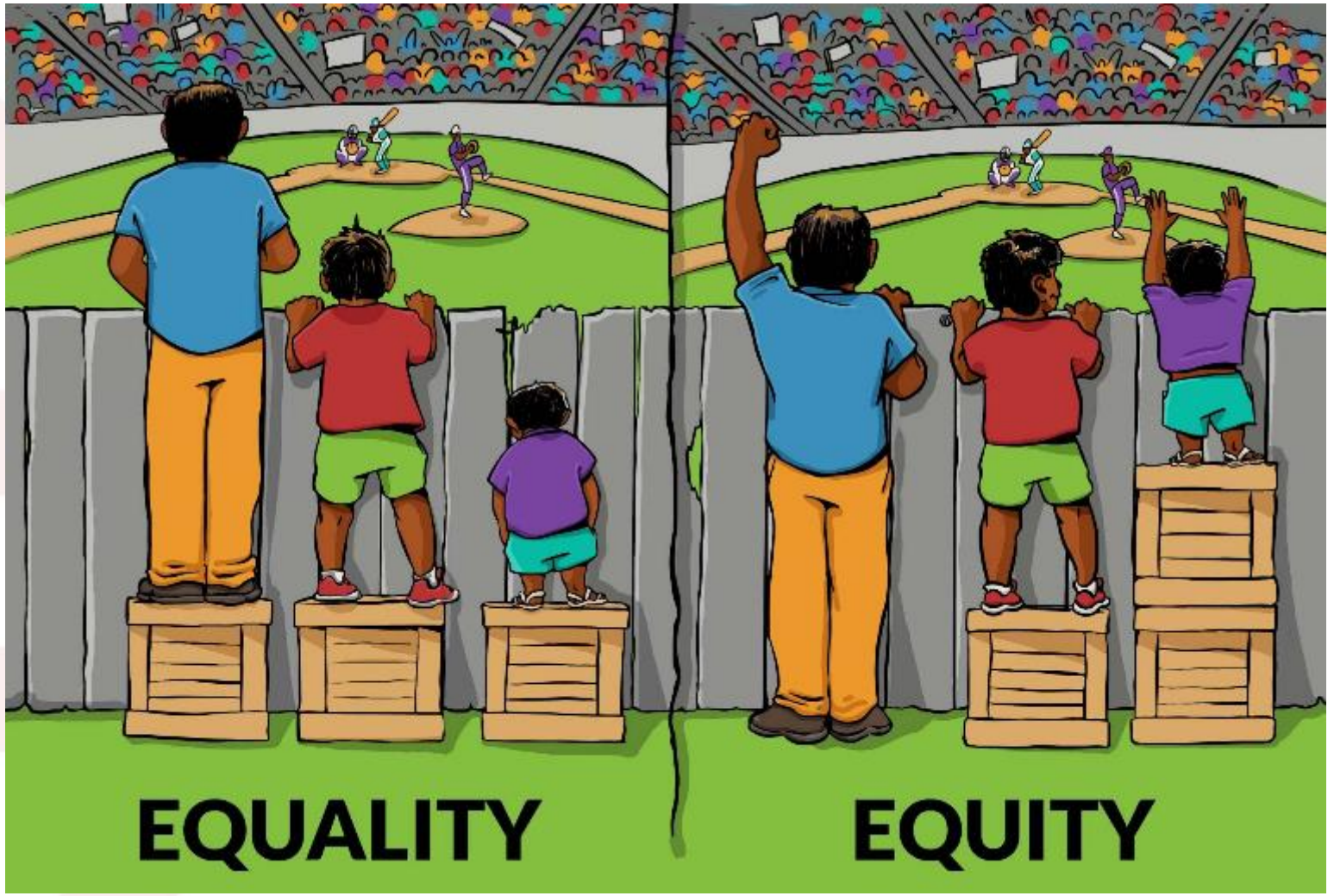
Milwaukee Urban League

Milwaukee Urban League

EMPOWERING *Communities*
CHANGING *Lives*

Welcome Back/Sponsor Remarks

Dr. Eve M. Hall
President & CEO
Milwaukee Urban League


EQUALITY
EQUITY

Jordan Wildermuth, MSW

Senior Government Affairs Manager

The National Service Office for Nurse-Family Partnership and Child First

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Director of Impact & Learning

The National Service Office for Nurse-Family Partnership and Child First

Nurse-Family Partnership

Helping First-Time Parents Succeed®

BETTER WORLDS START WITH GREAT MOTHERS.

AND GREAT MOTHERS START WITH US

Objectives

- Describe the evidence base for NFP
- Identify ways the NSO and NFP are addressing health equity to serve the unique needs of clients.
- How can NFP grow and scale in WI

Our Vision & Goals

We envision a future where all children are healthy, families thrive, communities prosper, and the cycle of poverty is broken.

Goals

- Improve pregnancy outcomes
- Improve child health/development
- Increase economic self-sufficiency

NFP Overview

Evidence-based community health nursing intervention

- For low-income, first-time moms
- With Registered Nurses
- Begins in the first or second trimester
- Ends at child's age of 2
- Visits in the home and telehealth

National and State Snapshot

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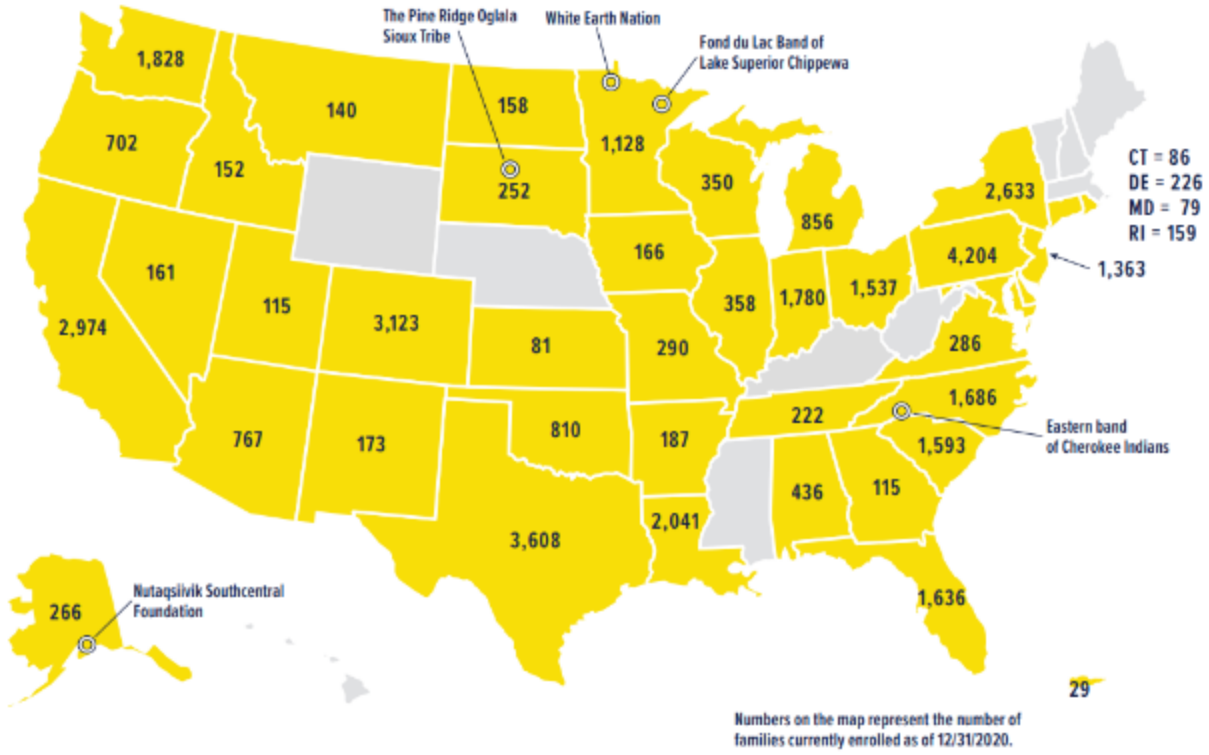
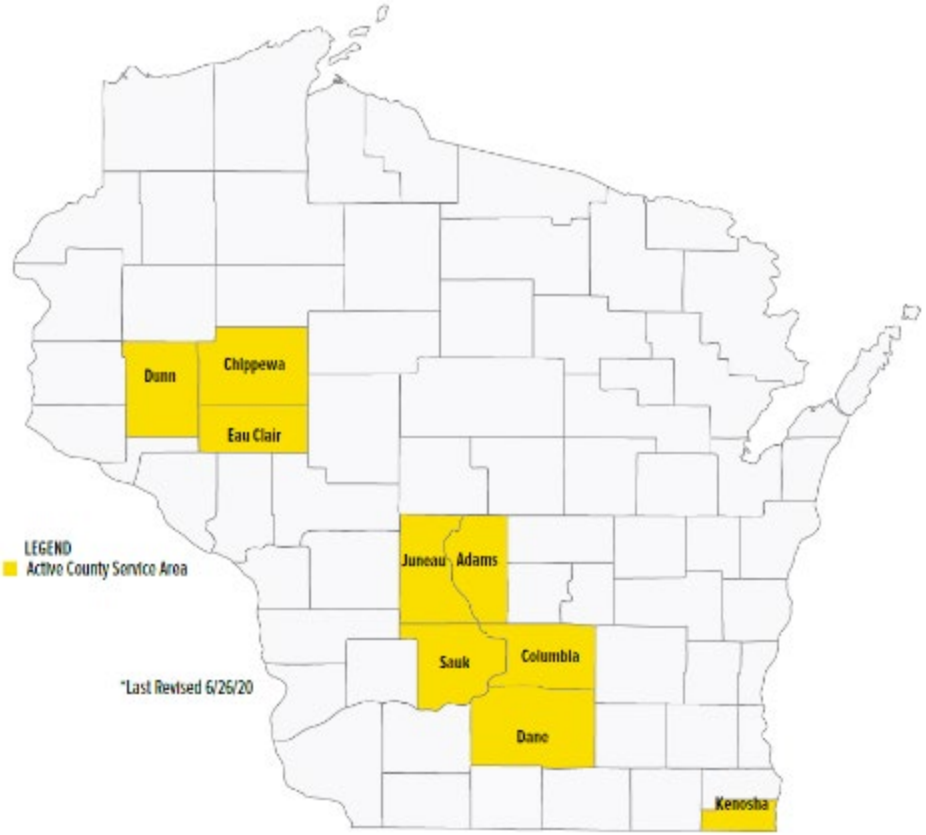
NUMBER OF FAMILIES SERVED SINCE REPLICATION BEGAN IN 1996*:	342,766
NUMBER OF FAMILIES CURRENTLY ENROLLED:	38,756
NUMBER OF NURSE HOME VISITORS AND NURSE SUPERVISORS:	2,335
NUMBER OF COUNTIES WHERE THE PROGRAM IS SERVING MOTHERS*:	758
NUMBER OF STATES WHERE THE PROGRAM IS SERVING MOTHERS:	40 + U.S. VIRGIN ISLANDS





NFP Evidence- RCTs

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Elmira, NY	1977
	Low-Income, White
	400; Semi-Rural
	Reduced: preterm births, smoking, infant ER use
	Improved child health
Memphis, TN	1990
	Low-Income, Black
	1,139; Urban
	Reduced: pregnancy complications, child injuries, subsequent births
Denver, CO	1994
	Hispanic/Latina
	735; Nurse & Paras
	Reduced: smoking, subsequent births
	Increased: birth spacing, employment, child developmental outcomes

Results

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Consistent results from the trials include:

- Improvements in women's prenatal health
- Reductions in children's injuries
- Fewer subsequent pregnancies
- Greater intervals between births
- Increases in fathers' involvement
- Increases in employment
- Reductions in welfare and food stamps
- Improvements in school readiness

20 years of follow-up studies show long term health, social and cognitive benefits for the child, & improved self-sufficiency for the parent

Addressing health equity & M3

- Wisconsin NFP Clients:
  - 55% Non-Hispanic White
  - 22% Hispanic/Latina
  - 15% Non-Hispanic Black
  - 3% Multiracial
  - 3% Asian
  - 1% American Indian or Alaskan Native

Maternal Morbidity and Mortality (M3):

- Inequities in maternal mortality and morbidity and persist across education and income levels

NFP M3 Task Force & NSO Actions

- Integrate racism and implicit bias education into National Service Office onboarding and operations.
- Cultivate a culturally and linguistically diverse nursing workforce by supporting Network Partner recruitment
- Enhance NFP education about racism, implicit bias, and causes of maternal morbidity and mortality.
- Support clinical practice enhancements for Network Partners.
- Expand NFP public policy agenda, advocacy, and communication.
- Use data to inform program improvements and increase understanding of NFP outcomes

Serving more moms and babies

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Based on a review and analysis of **more than 40 NFP evaluation studies**, Dr. Ted Miller (Pacific Institute for Research and Evaluation) predicts If NFP were to achieve scale in Wisconsin the following outcomes can be produced:

- Smoking in pregnancy ↓25%
- Pregnancy-induced hypertension ↓32%
- Closely spaced births (15 months postpartum) ↓25%

- Emergency department use for childhood injuries ↓33%
- Full immunization ↑13%
- Language delay ↓40%

- First pre-term births ↓15%
- Infant mortality ↓47%
- Moms who attempt breastfeeding ↑12%

- TANF payments ↓7% (13 years post-partum)
- Person-months on Medicaid ↓8% (15 years post-partum)
- Costs if on Medicaid ↓7% (through age 18)

Investing in NFP

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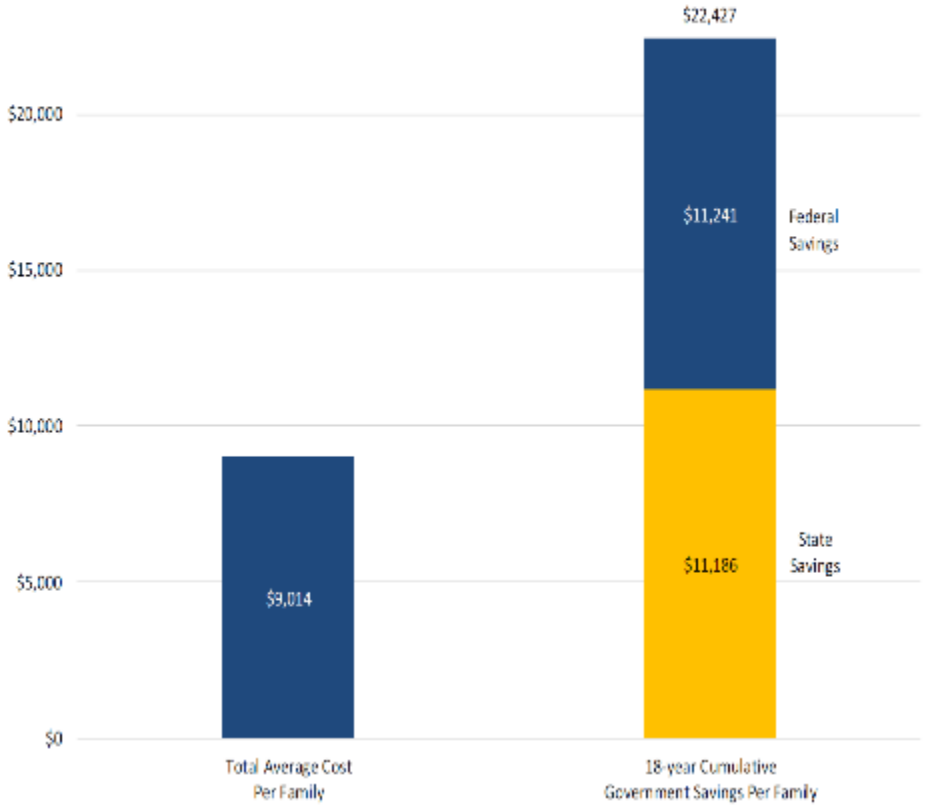
Communities choose to invest in Nurse-Family Partnership because investments can yield substantial, quantifiable, benefits in the long term

5x
$ RETURN
EVERY $1 INVESTED IN NFP SAVES $5.70 IN FUTURE COSTS FOR THE HIGHEST-RISK FAMILIES SERVED[2]

Figure 1: Total Average Per-Family Cost and Estimated Government Savings of Nurse-Family Partnership Implementation in Wisconsin (Present Value at a 3% Discount Rate)



Recommendations to scale NFP and evidence-based home visiting

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1. Continued investment in Family Foundations Home Visiting Program within Department of Children and Families
2. Utilizing 2017 Wisconsin Act 267 to implement a Pay for Success project in Milwaukee
3. Modernizing current Medicaid benefit

Current Medicaid benefit structure

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PNCC Providers
Certified case management agency employing at least one qualified professional such as a nurse practitioner, nurse midwife, public health nurse, certified nurse, health educator and others.

Duration
- Pregnant women through 60-days post-partum;
- Infants after 60-days post-partum period; duration based on risk assessment.

Services Include:
- at least one post-partum home visit
- in-person screening/assessment for risk factors
- pregnancy/infant health education
- patient-centered interventions/brief counseling
- resource referral
- ongoing care coordination/case management
- nutrition counseling
- group education/childbirth education

Note: Contracted case management agencies that provide MIECHV must ensure home visiting participants receive Medicaid PNCC and TCM/Child Care Coordination services where available.

WISCONSIN DEPARTMENT *of* HEALTH SERVICES

Extended services to pregnant women & targeted case management

Child Care Coordination (CCC) -- Extends PNCC benefit to promote positive parenting, improve child health outcomes, and prevent child abuse and neglect. CCC services:

- ❑ Include initial assessment, care plan development and ongoing care coordination and monitoring.
- ❑ Help family access medical, social, educational, vocational, and other services.
- ❑ Are available to BadgerCare Plus and Medicaid members in:
  - Milwaukee County until child's seventh birthday
  - City of Racine until child's second birthday
- ❑ Based on approved risk assessment administered within:
  - 8 weeks of child's birth if no PNCC services received; or,
  - 6 months of child's birth if PNCC services received.

PNCC services in total are limited to $896.33 provider reimbursement per member/ pregnancy.

If CCC is provided a potential $172.96 reimbursement for initial assessment and care plan development plus up to $432.40 per month for on-going care coordination.

Medicaid Financing Recommendation: Modernize Current Benefit

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Under the current benefit structure, consider:

- Extending PNCC past 60-days post-partum period through EPSDT.
- Combining PNCC and CCC into one seamless program.
- Creating provider and state agency billing efficiencies by:
  - Bundling all PNCC services under one code and all CCC services under one code.
  - Having providers bill by encounter or home visit or by client on a monthly basis rather than in 15-minute or less unit increments.
- Increase provider rates so they are in line with current COLA.

As part of future benefit structure, consider one or more of the following:

- Develop a pilot program to cover PNCC/CCC in the HMO structure, either under capitation or as an enhanced ILOS option.
- Develop a pilot program to include NFP RNs as part of the OB Medical Home Initiative service delivery team in one or more counties.
- Consider including the NFP nursing intervention in the HMO contract as part of the capitated amount with a directed payment for bundled services prenatally through infant's second birthday.

What's working now?
What could work better?

QUESTIONS?

Nurse-Family Partnership

Helping First-Time Parents Succeed®

Jasmine Zapata

MD, MPH, FAAP

Chief Medical Officer and State Epidemiologist

Bureau of Community Health Promotion

Wisconsin Department of Health Services

The Wisconsin Maternal Mortality Review Team: Historical Background and Future Directions

Jasmine Zapata, MD, MPH, Chief Medical Officer and State Epidemiologist
Bureau of Community Health Promotion, Division of Public Health

Maternal Mortality—Why it's important

- When birthing people die during pregnancy, often babies die too.
- Infant mental health is impacted by the loss of a parent.
- The same upstream determinants and causal pathways leading to maternal mortality impact maternal morbidity and subsequent birth outcomes.

By studying these causal pathways and focusing on ways to prevent maternal mortality, we can simultaneously improve birth outcomes.

Collaboration is key!

Wisconsin Maternal Mortality Review Team (MMRT)

- Established in 1997 by the Wisconsin Division of Public Health (DPH) and the Wisconsin Section of the American College of Obstetricians and Gynecologists (ACOG)

- Funded by the Centers for Disease Control and Prevention (CDC), CDC Foundation, and Title V Maternal and Child Health Block Grant

MMRT Purpose

- Collect and review case-level information about all maternal deaths to Wisconsin residents
- Make recommendations on changes in systems and practice that may result in the prevention of future Wisconsin maternal deaths

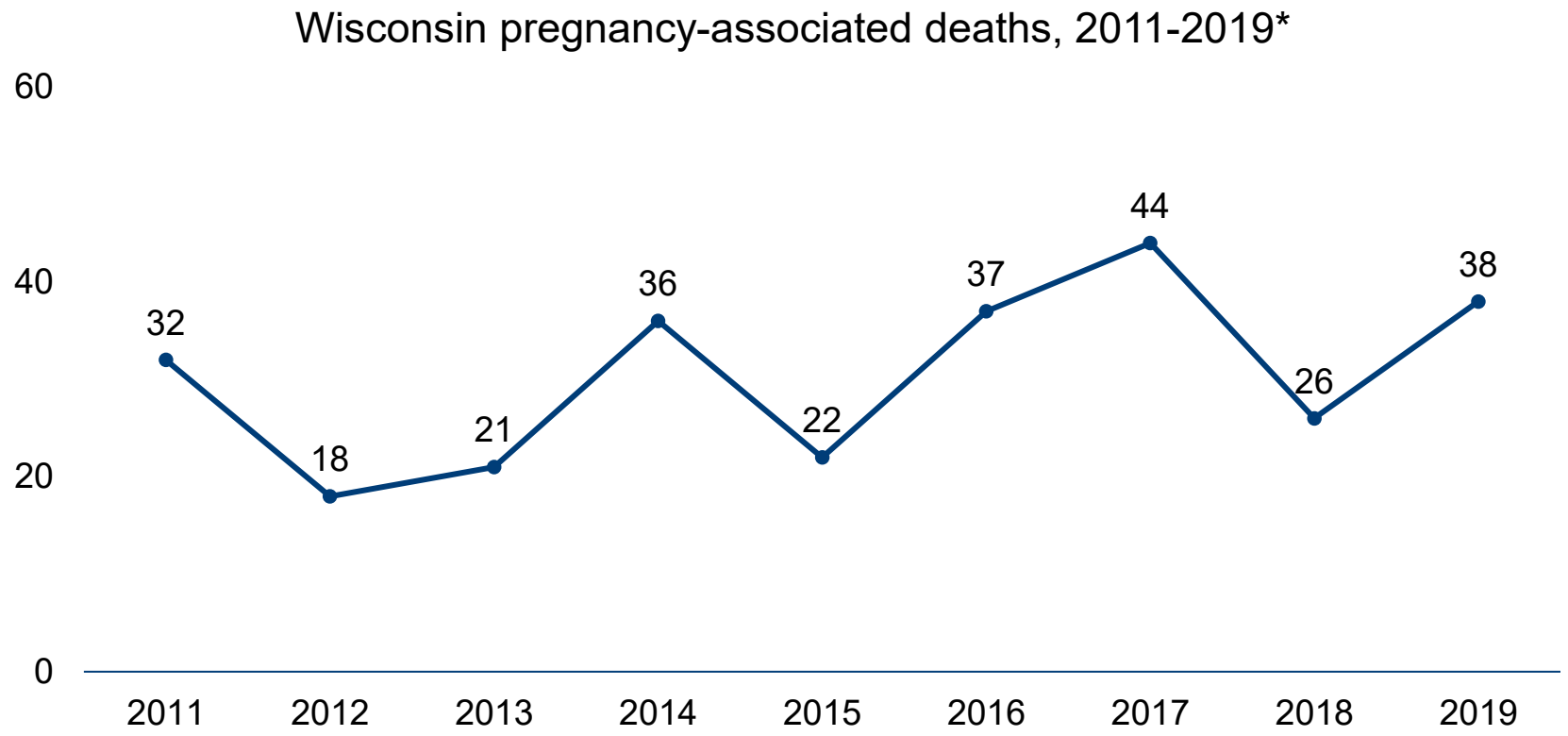
www.dhs.wisconsin.gov/mch/maternal-mortality-review-team.htm

Key Definitions

- **Pregnancy-associated death:** Death of a woman during pregnancy or within one year of the end of a pregnancy, regardless of cause

- **Pregnancy-related death:** Death of a woman during pregnancy or within one year of the end of pregnancy from a pregnancy complication, chain of events initiated by the pregnancy, or the aggravation of an unrelated condition by the effects of pregnancy

Wisconsin Data



*Due to differences in the case confirmation process at the time, not all pregnancy-associated deaths were able to be confirmed before 2016, meaning these estimates may be slightly lower than the true counts.

Wisconsin Data Cont.

In Wisconsin, the pregnancy-related mortality ratio *(pregnancy-related deaths per 100,000 live births)* for non-Hispanic Black women was **five times higher** than for non-Hispanic white women in 2006-2010.

Case Identification

- Cases are identified by:
  - Indication of pregnancy or obstetric cause of death on the death certificate.
  - Cross-referencing death records to women of reproductive age with birth and fetal death records.
- Criteria for full review include:
  - Death during or within 12 months of a pregnancy.
  - The woman is a resident of Wisconsin.

Case Abstraction

Cases are abstracted using:

- Hospital and clinic records.
- Coroner and medical examiner reports.
- Law enforcement reports.
- Ambulance and emergency response records.
- Public health and social services reports.
- Circuit court system records.
- Prescription Drug Monitoring Program data.

Review Team

- Consists of physician co-chairs representing Wisconsin ACOG and DPH
- Includes health providers and public health experts from rural and urban settings
- Meets four to six times a year to review de-identified abstracted cases
- Follows the prevention and life course public health frameworks when determining recommendations

Review Questions

1. Was the death pregnancy-related?
2. What was the underlying cause of death?
3. Was the death preventable?
4. What were the factors that contributed to the death?
5. What are the recommendations and actions that address those contributing factors?
6. What is the anticipated impact of those actions if implemented?

MMRT Recommendations—Examples from recent meetings*

- Each recommendation falls into one of these five levels:
  - Patient/family
  - Provider
  - Facility
  - System
  - Community

* Please note: these are ***not*** the most frequent recommendations, just examples of the types of recommendations made by the MMRT.

Example Recommendations

- Patient/Family
  - Individuals in motor vehicles should wear seatbelts at all times while the vehicle is in motion.
- Provider
  - Providers should educate women during routine visits on preventive health care, contraception, and early signs of pregnancy, including ectopic pregnancy.

Example Recommendations Cont.

- Facility
  - The facility should create an alert and follow-up protocol to reach out to patients who miss appointments and reschedule them in a timely way that allow women to be seen within the ACOG recommendations.
- System
  - Health systems should pay for and incorporate nurse home visits as part of the postpartum follow up program.

Example Recommendations Cont.

Community

- Community agencies should educate family, friends, and mothers on postpartum warning signs and conduct home visits within first week after delivery.

2018 Recommendations Report

- Summary of themes found in recent MMRT recommendations
- Five major topic areas:
  - Chronic disease
  - Continuity of care
  - Mental health
  - Risk-Appropriate care
  - Substance use

Chronic Disease	Women with chronic diseases often require specialty care before, during, and after pregnancy. Management of these chronic conditions should be noted during the transition periods of prenatal and postpartum care to ensure adequate management.
Continuity of Care	Special attention should be given to assure that mothers transition smoothly to prenatal and postnatal care. All women should be reconnected with a primary care physician to resume routine care after pregnancy.
Mental Health	All women should be screened for mental health issues before, during, and after pregnancy. Screening all women results in more women receiving referrals to access the services necessary to address their mental health needs.
Risk-Appropriate Care	Women should be evaluated early in pregnancy and recommended to give birth at a facility that meets their pregnancy risk level needs. All birthing facilities should complete the Wisconsin Association for Perinatal Care comprehensive and validated self-assessment of their obstetric and neonatal care levels. At the time of this report, only half of Wisconsin hospitals have completed this assessment.
Substance Use	Increased availability of care and treatment services is needed for women before, during, and after pregnancy. Referrals to family planning services and substance use treatment for women of reproductive age should be utilized to prevent substance-exposed pregnancies.

MMR Reports

- Currently available on MMR website:
  - Recommendations Report (released 2018, most recent)
  - Severe Maternal Morbidity, 2010-2014
- Upcoming:
  - Pregnancy-Associated Overdose Deaths (2016-2019)
  - 2016 Maternal Mortality Review Data Brief

Future Directions

- Diversify team membership
- Family and key informant interviews

Diversify Team Membership

- Goals:
  - Increase community representation
  - Broaden team perspective
  - Recruit intentionally by area of expertise

Diversify Team Membership Cont.

- Status:
  - Creating a standardized recruitment application
  - Identifying gaps in representation on team
  - Exploring option of creating advisory or data to action teams
  - Awaiting upcoming national Black Mamas Matter Alliance and CDC recommendations related to this topic

Family and Key Informant Interviews

- Benefits of interviews:
  - Provide context about the person's life and experiences
  - Identify gaps of information in the medical record
- Proposal for implementation has been developed, currently identifying resources and partnerships to support this project

Thank you.

Wisconsin Maternal Mortality Review

Panel Discussion

Healthy Equity in Birth Outcomes Forum

September 15, 2021

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INDEPENDENT CARE HEALTH PLAN

Lynda Krisowaty, MHS

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Laura Powis, MPH

Program Manager, Evidence-Based Policy and Practice
Association of Maternal & Child Health Programs

innovation hub
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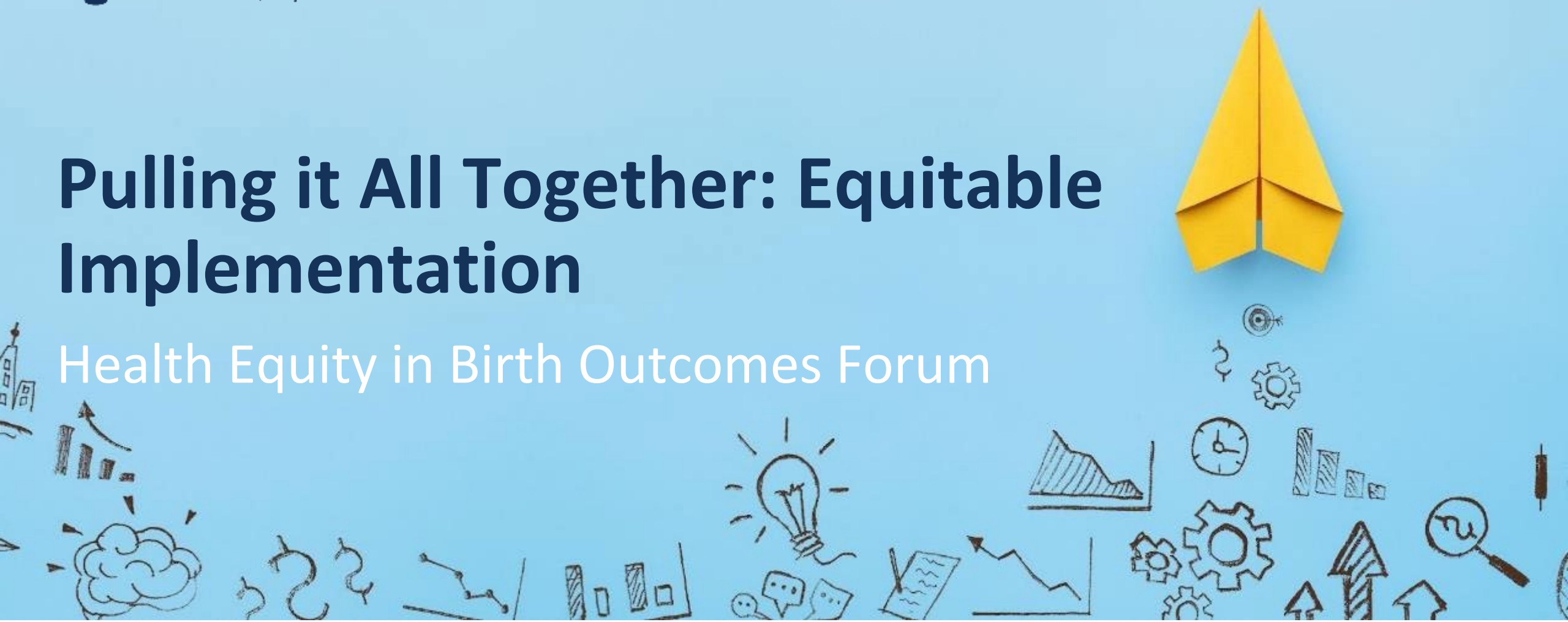
Pulling it All Together: Equitable Implementation

Health Equity in Birth Outcomes Forum



Presenter: **Lynda Krisowaty, Senior Program Manager**

Presenter: **Laura Powis, Program Manager**

September 15, 2021

AGENDA

1. Overview of Implementation Stages
   10 MINUTES
2. Overview of Adapting a Program
   5 MINUTES
3. Reflection and Next Steps
   5 MINUTES

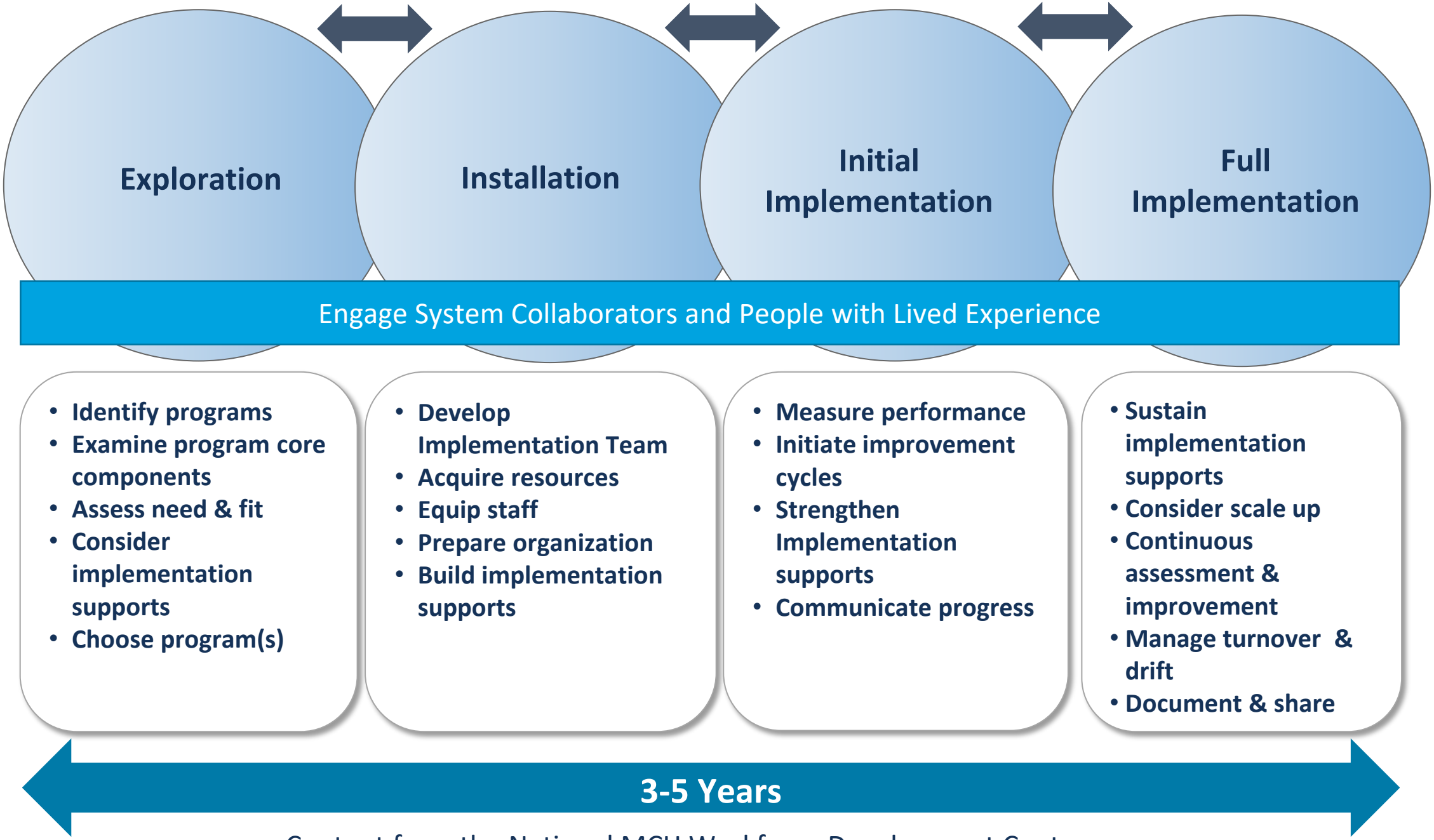
And yet…

Evidence ≠ Outcomes

What is Implementation Science?

In other words, implementation science addresses **HOW** we do our work.

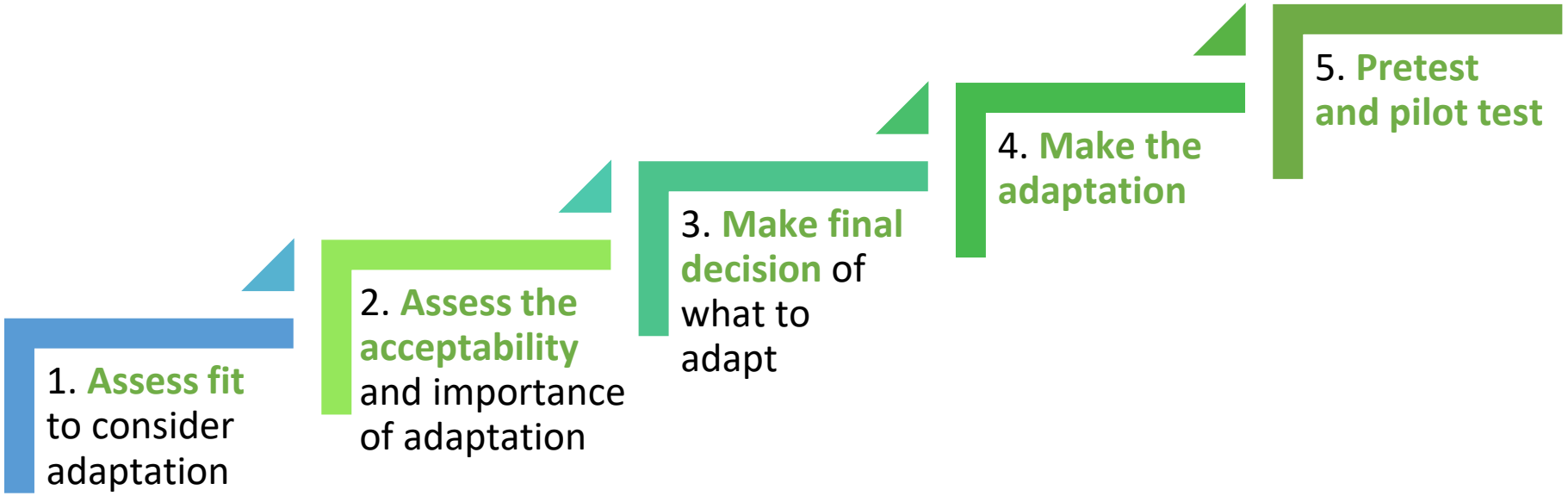
Content from the National MCH Workforce Development Center



Content from the National MCH Workforce Development Center

Adapting a Program

Steps for Adaptation



Fit, Fidelity, and Adaptation

Green Light Adaptations:

Things That Can Probably Be Modified

Minor adaptations to increase reach, receptivity, and participation

- Update and/or customize statistics and guidelines
- Customize program materials to fit the priority population. E.g., change names, pictures, wording, etc.
- Change ways to recruit and/or engage priority population

Yellow Light Adaptations:

Things That Can Probably Be Changed with Caution

Content or Methods

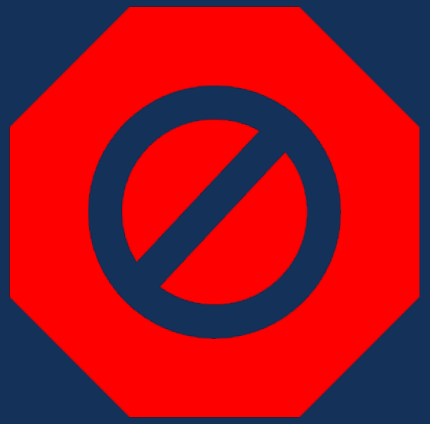
- Alter the length of program activities
- Change the order of sessions or sequence of activities
- Add activities to address other risk factors or behaviors
- Apply practice to a different population

Delivery Mechanisms

- Change delivery format/process
- Modify who delivers the program
- Change setting of delivery
- Substitute activities and/or materials

Red Light Adaptations:

Things That Probably Cannot Be Modified



Methods

- Change theoretical underpinning; mechanisms of change

Content

- Change health topic/behavior addressed
- Add activities that contradict or detract from the original practice's goals
- Delete whole sections or major activities
- Reduce duration and dose

Know Your Community

- Behaviors
- Strengths and assets
- Traditions
- Leaders and trusted individuals
- Social roles and norms
- Physical environment

Reflection & Next Steps

QUESTIONS?

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Thank you.

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Anita Holloway

- Humana Market Medical Officer
- *i*Care Board Member

Lisa Holden

- *i*Care VP of Accountable Care

Closing Comments

- Resources are available at www.icarehealthplan.org/forum21
- Thanks to our partners
- Thanks to our presenters
- Thank YOU for coming!

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Closing Comments

- Key takeaways
- iCare is taking action
- Watch your email for an evaluation

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Surprise Award

"AABN provides breastfeeding support services as well as doula support for AA women in Milwaukee area but have been expanding their work to other areas across WI. They have been receiving an unprecedented amount of requests for doula support from individuals and organizations but need financial support to continue expanding their great work. Donating to the AABN would be an excellent way to demonstrate to your Forum audience that Humana and iCare are doing their part to improve healthy births. "

Dr. Jasmine Zapata

Humana.

iCare
INDEPENDENT CARE HEALTH PLAN

Dalvery Blackwell

Executive Director

AABN

Thank you.

The Health Equity in Birth Outcomes Forum was made possible by:

- Our Speakers
- Our Partners
- Our Audience
- Our Associates

● Bill Jensen ● Tony Mollica ● Amy Hoyt ● Chrissy Willis
● Kimberly Carlson ● Rebecca Stanis ● Candice Scheibel ● Dr. Mary Ellen Benzik
● Bao Xiong ● Courtney Lentz ● Tana Tyler ● Latrice Jackson
● Kirk Heminger ● Lisa Holden ● Dr. Tom Lutzow ● Sharonda Phipps ● Kathleen Schultz

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