Ohio Collaborative to Prevent Infant Mortality

Ohio Collaborative to Prevent Infant Mortality

Virtual Town Hall Meeting

November 19, 2021

Addressing Systems Change: Working to Achieve Equity in Infant Survival

Ohio Collaborative
to Prevent Infant Mortality

Welcome

Dr. James Greenberg, Cincinnati Children's Hospital, Co-chair

Ohio Collaborative
to Prevent Infant Mortality

Data Collection, Analysis and Reporting (State and Regional View)

Andrea Arendt,
Epidemiology Supervisor,
Ohio Department of Health

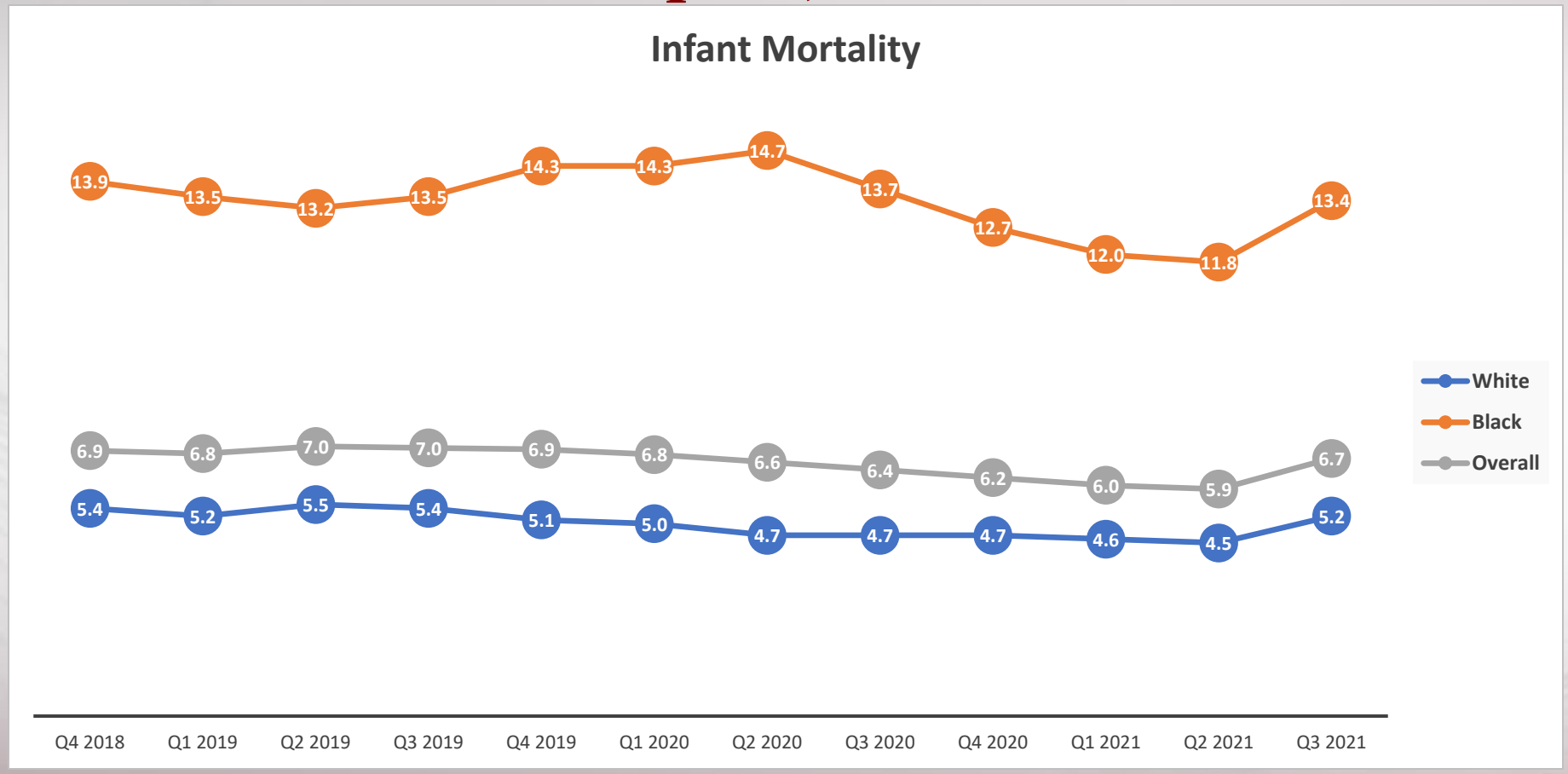
Infant Mortality Data

Andrea Arendt
Ohio Department of Health
Maternal, Child, and Family Health Data and Surveillance

Ohio | Department of Health

OCPIM Quarterly Meeting
November 19, 2021

Quarterly Rolling 12-Month Average Infant Mortality Rates per 1,000 Births



Data Source: Ohio Department of Health, Bureau of Vital Statistics.
Note: 2020 and 2021 data is preliminary.

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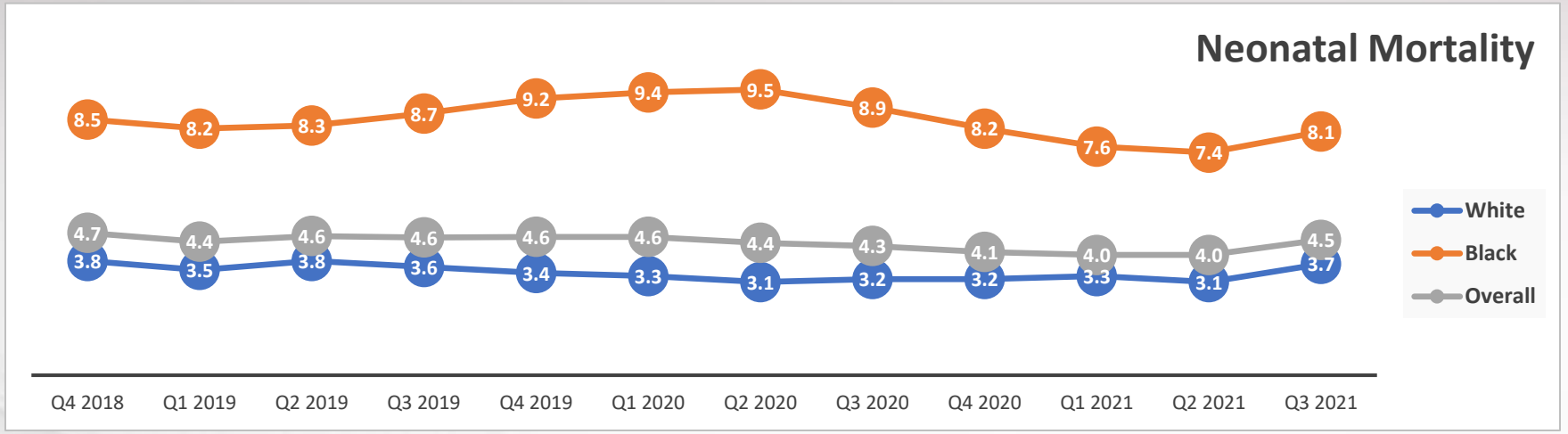
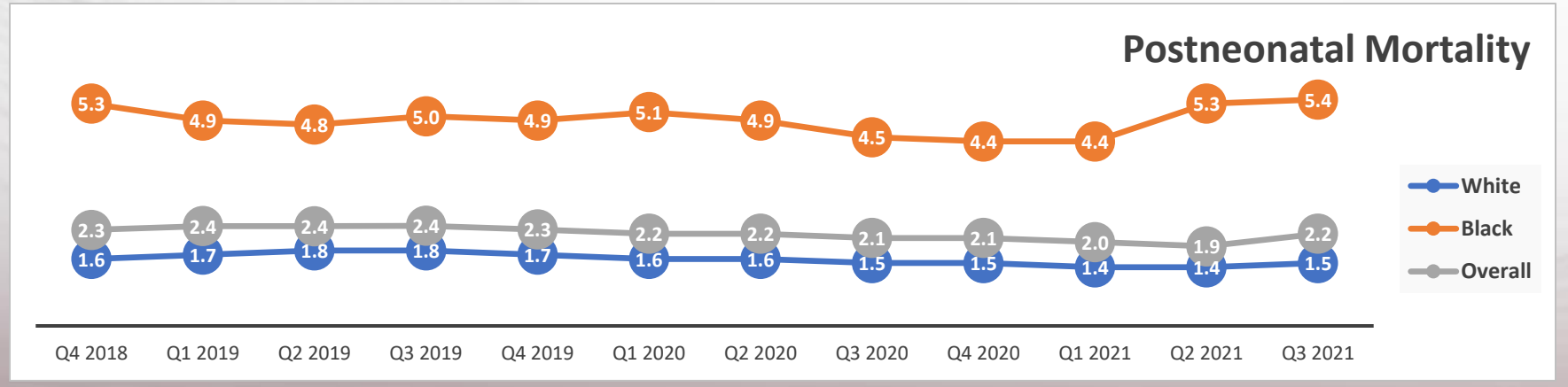
Quarterly Rolling 12-Month Average Neonatal and Postneonatal Mortality Rates per 1,000 Births





Data Source: Ohio Department of Health, Bureau of Vital Statistics.
Note: 2020 and 2021 data is preliminary.

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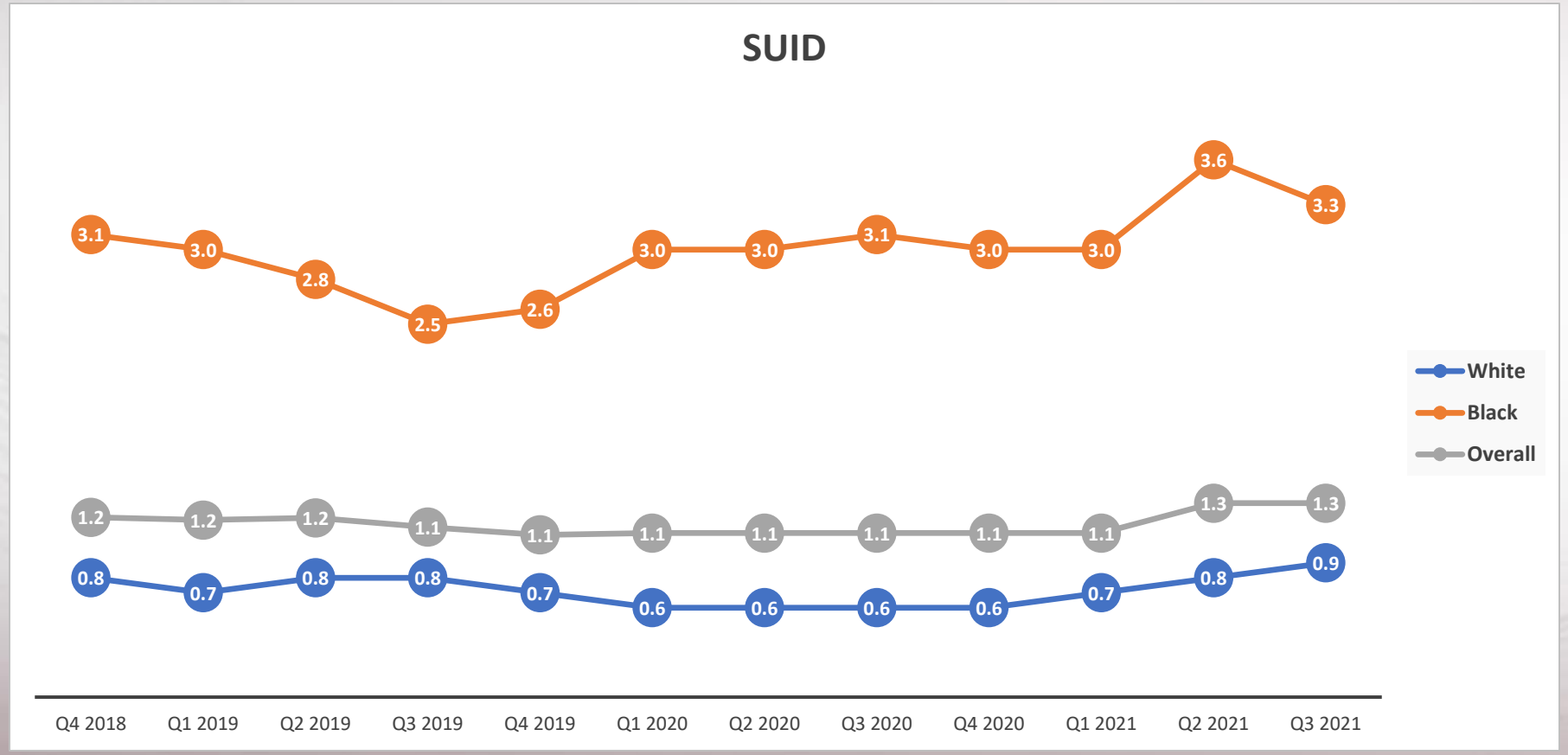
Quarterly Rolling 12-Month Average Sudden Unexpected Infant Death (SUID) Rates per 1,000 Births



Data Source: Ohio Department of Health, Bureau of Vital Statistics.
Note: 2020 and 2021 data is preliminary.

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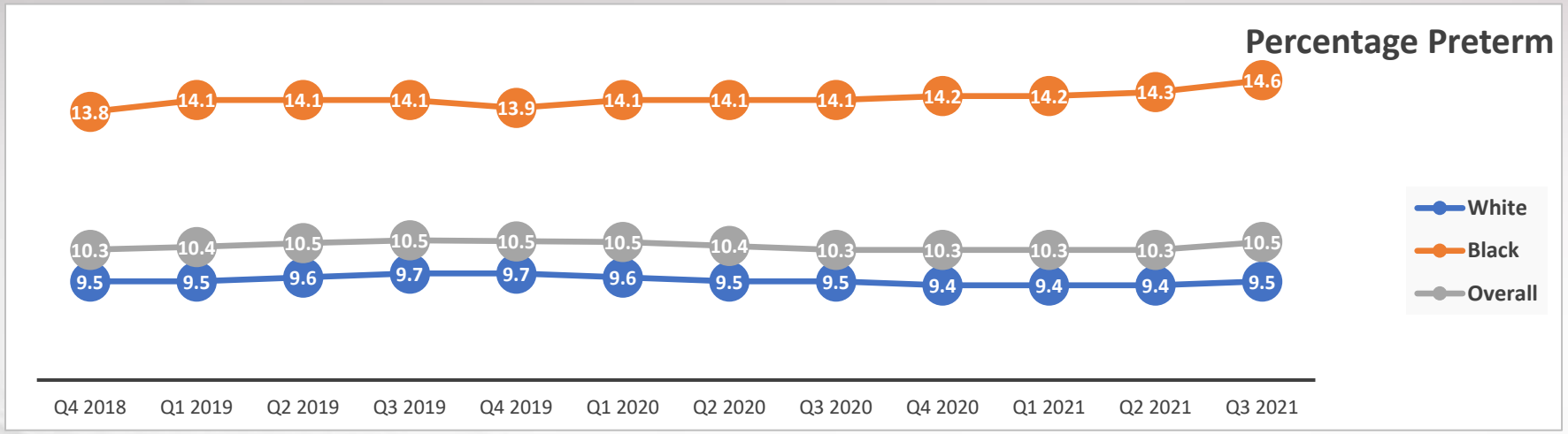
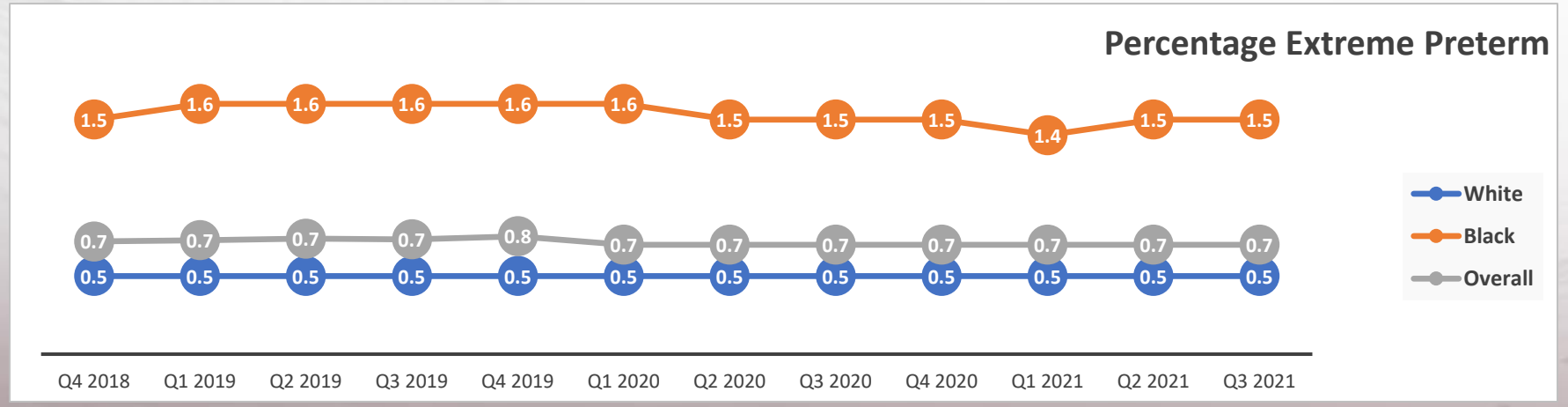
Quarterly Rolling 12-Month Average Percentage Preterm (< 37 weeks) and Extreme Preterm Births (< 28 weeks)





Data Source: Ohio Department of Health, Bureau of Vital Statistics.
Note: 2020 and 2021 data is preliminary.

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Regional Data

Quarter	Region	IMR*	NMR*	PMR*	SUID*	Preterm (%)	Extreme Preterm (%)
Q4 2020	Central	5.6	3.8	1.8	0.7	9.8	0.7
	Northeast	5.9	3.7	2.2	1.2	10.4	0.8
	Northwest	6.8	4.7	2.1	1.1	10.3	0.6
	Southeast	5.9	4.2	1.7	0.8	10.6	0.5
	Southwest	6.9	4.5	2.4	1.4	10.5	0.7
Q1 2021	Central	5.9	4.1	1.8	0.9	9.8	0.7
	Northeast	5.6	3.6	2.0	1.1	10.4	0.8
	Northwest	5.9	4.1	1.9	1.0	10.4	0.7
	Southeast	6.0	4.3	1.7	1.1	10.2	0.5
	Southwest	6.7	4.3	2.4	1.4	10.6	0.7
Q2 2021	Central	5.8	4.1	1.7	1.2	10.0	0.7
	Northeast	5.5	3.6	1.9	1.3	10.5	0.8
	Northwest	5.9	3.8	2.1	1.3	10.4	0.7
	Southeast	6.3	4.4	1.9	1.3	9.9	0.5
	Southwest	6.3	4.1	2.2	1.5	10.7	0.7
Q3 2021	Central	6.4	4.7	1.8	1.1	10.3	0.7
	Northeast	6.5	4.3	2.2	1.4	10.7	0.8
	Northwest	6.9	4.2	2.7	1.4	10.5	0.6
	Southeast	7.5	5.2	2.3	1.1	9.9	0.5
	Southwest	6.8	4.4	2.3	1.5	10.6	0.7

* Rates per 1,000 births.
Data Source: Ohio Department of Health, Bureau of Vital Statistics.
Note: 12-month quarterly averages, 2020 and 2021 data is preliminary.

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Andrea Arendt
andrea.arendt@odh.ohio.gov

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Ohio Collaborative to Prevent Infant Mortality

Combating Racism: Adapting a Quality Framework, Empowering Communities to Champion Change.

Dr. Stacy Scott,
Baby 1st Network, Co-chair

Ohio Collaborative
to Prevent Infant Mortality

Panel Discussion

Jarvis Gray, MHA, FACHE, CMO-OE,
The Quality Coaching Company

Cheniqua Morales, BSN, RNC-MNN, C-EFM, C-ONQS
Empowered Clinical Solutions

Lauren Nunally, MPH, RM, BSN, RNC-OB, Q-ONQS
Synergize Consulting

Panel Discussion Questions

- What challenges have you experienced in tackling racism utilizing a quality improvement framework?
- How can community driven organizations/members be brought into the quality improvement equation allowing for a more tailored approach utilizing improvement science to improve health equity?
- What type of institutional reforms are needed to provide opportunities to advance equity initiatives committed to achieving meaningful impact, accountable care, and patient-centered services?

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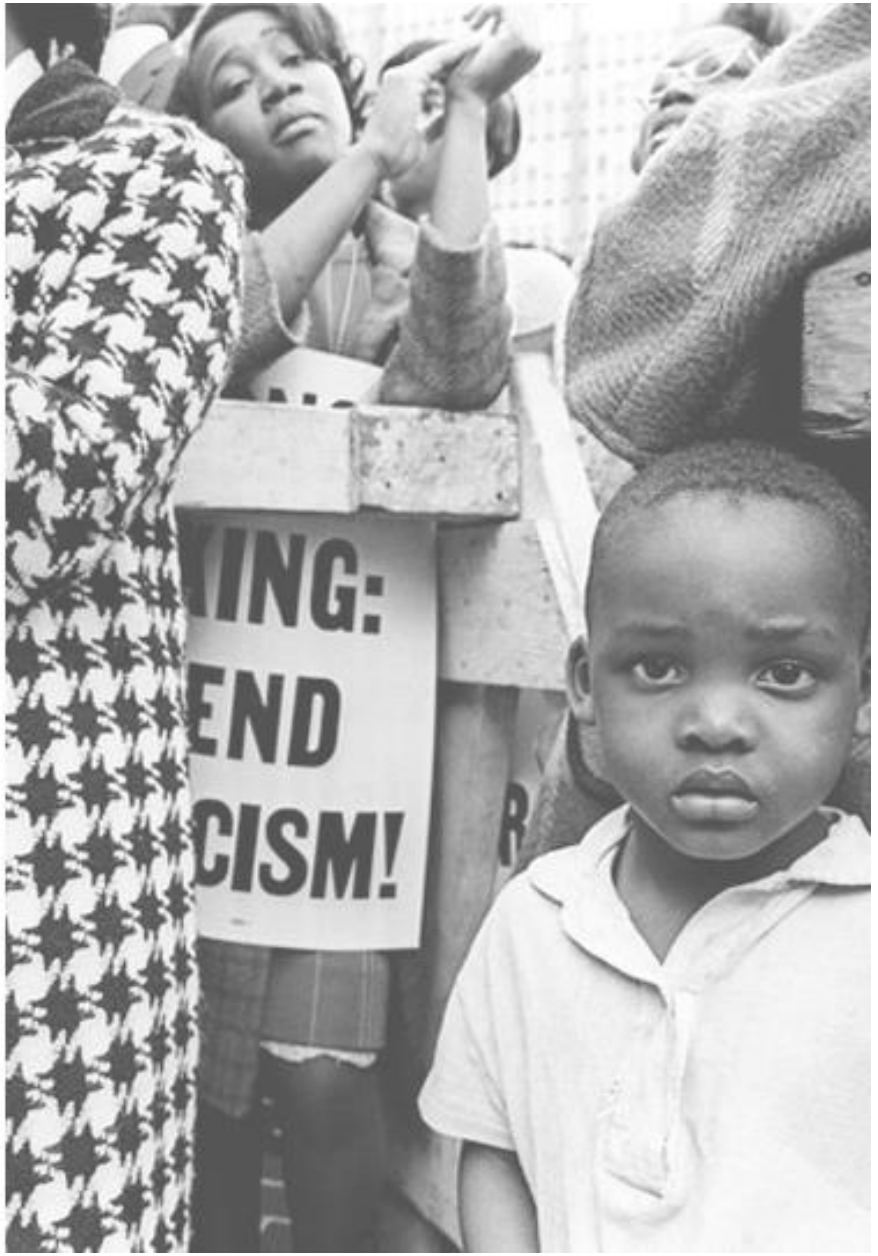
Creating an Equity Empowered System

“Driving Equitable Systems Change”

Over the course of hundreds of years, racism has been institutionalized into U.S. health care systems, propagating organizational practices and policies that marginalize and discriminate against people of color. Today, institutional racism continues to plague the health of children and families across the country leading to inequitable outcomes.



Systemic racism is a public health crisis that, until properly addressed, will continue to foster disparities and inequalities in health outcomes for people of color.

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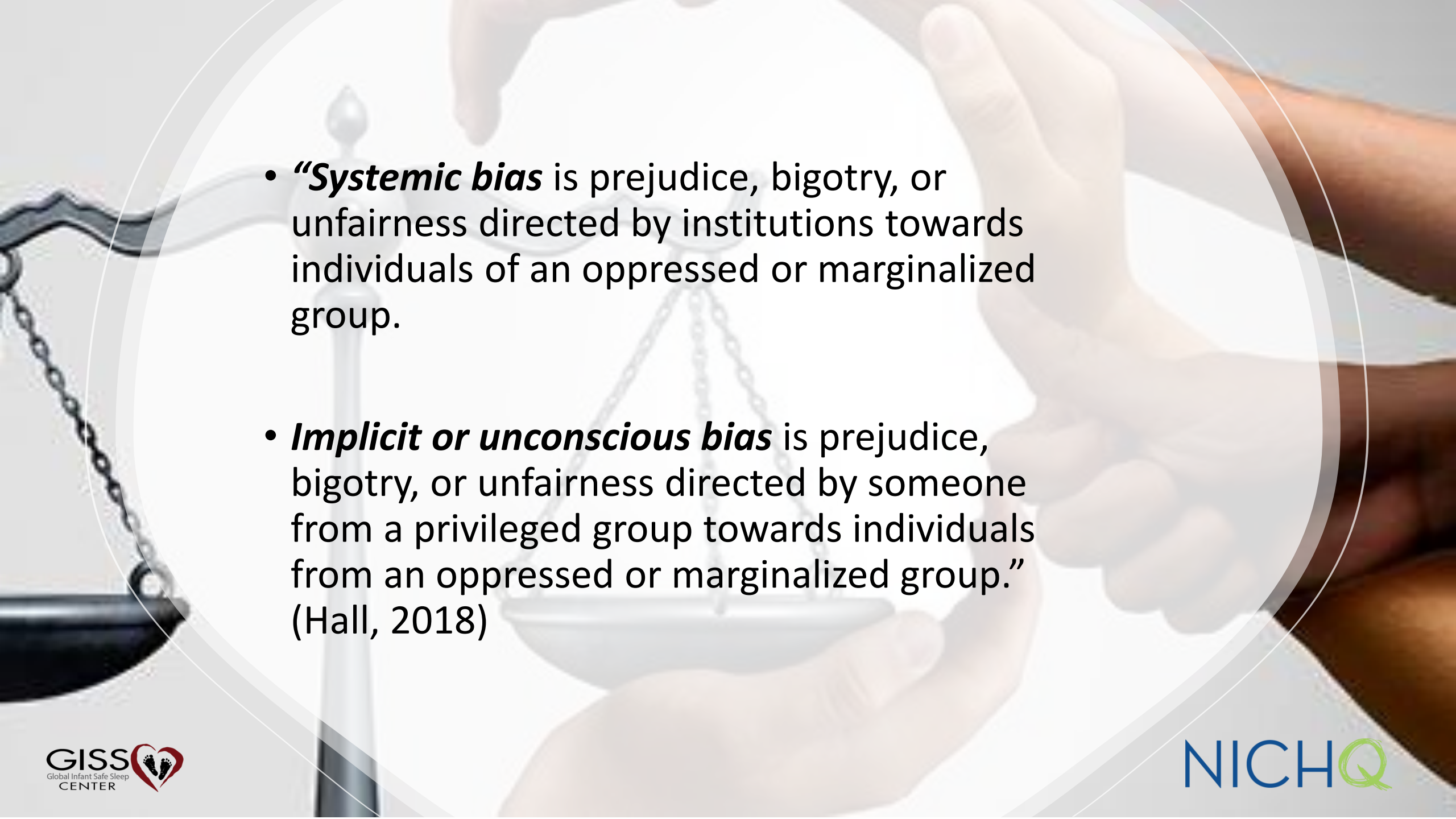
NICHQ



- *"**Systemic bias*** is prejudice, bigotry, or unfairness directed by institutions towards individuals of an oppressed or marginalized group.

- ***Implicit or unconscious bias*** is prejudice, bigotry, or unfairness directed by someone from a privileged group towards individuals from an oppressed or marginalized group." (Hall, 2018)

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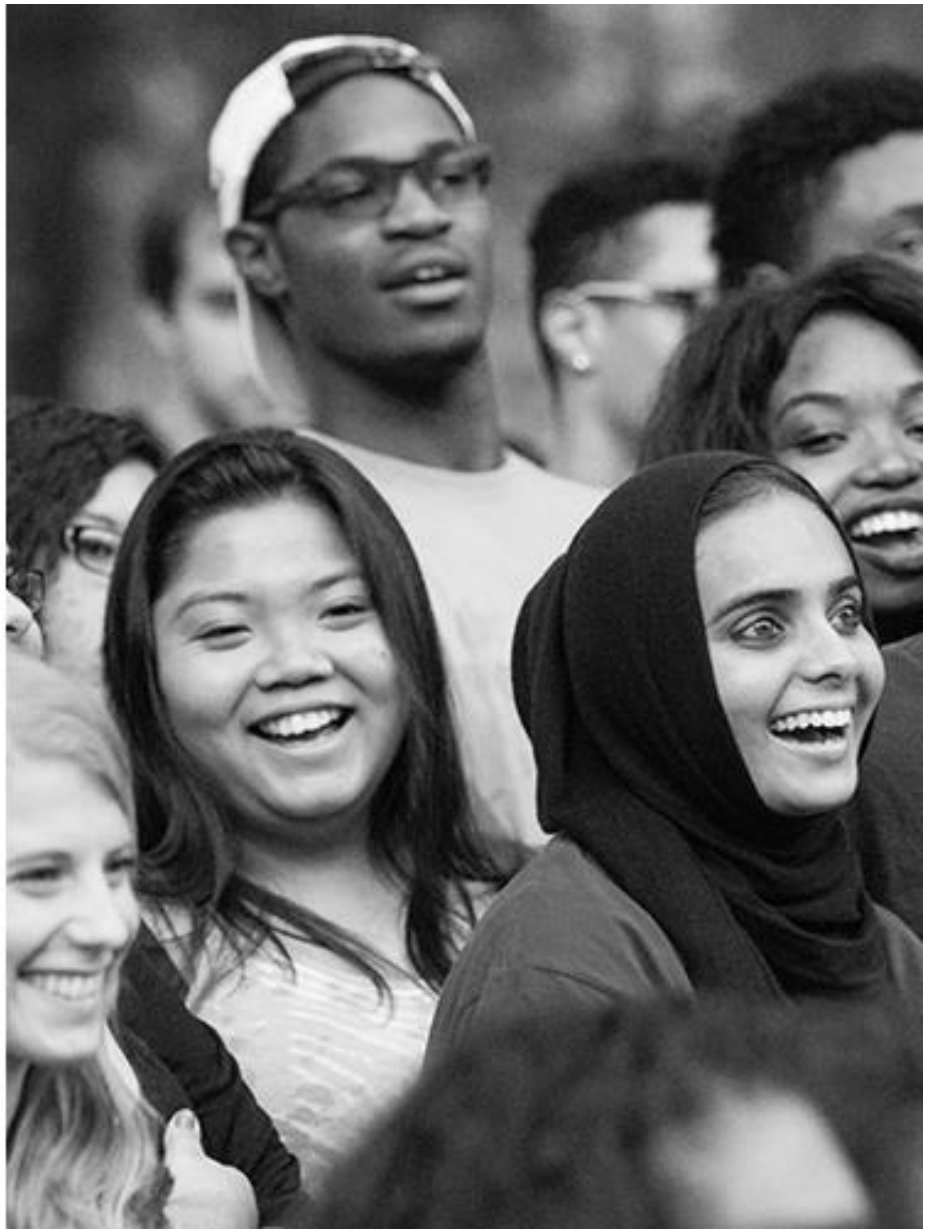
We must recognize that tackling racism and other forms of oppression must go beyond interventions at an individual level. Truly equitable health systems require purposefully reconstructing systems that are rooted in and advance equity of historically marginalized groups.



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Equity Systems Continuum

The Equity Systems Continuum is made up of four systems: *Supremist-designed*, *Savior-designed systems*, *Ally-designed systems*, and *Equity-empowered systems*

By giving each system a name and definition, an organization can

Identify where they are along this continuum,	Consider where their current approaches have succeeded and failed, and	Determine what actions need to be taken to improve along the continuum

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Supremist-Designed Systems

- Operate in indifference, which is harmful (e.g. deny that -isms exist within organization [“No one is racist here.” “No one is picking on you because you are transgender.”] despite evidence to the contrary, lack engagement and refute threats to status quo/culture).
- May be driven by motivating factors that impede equity (e.g., not focused on reducing/eliminating racial and ethnic disparities in health outcomes for the greater good but perhaps reimbursement rates).
- Fail/refuse to appropriately address instances of implicit and explicit biases and discrimination (e.g., muted, delayed, at-the-surface response, retaliation). Fail to develop new or to uphold existing policies intended to protect/support. (e.g., lack equity-promoting policies).
- Perpetuate longstanding cultural beliefs, practices, organization structures that benefit the oppressor.

Supremist enterprise, regardless of intent, is one that maintains inherent structural biases, reinforcing and perpetuating inequities that have long been entrenched in institutions, policies, and community relations.

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Savior-Designed Systems

- Do not consider the root causes and institutions that make the population vulnerable in the first place;
- Have policies and practices that harm specific racial groups while benefiting others;
- Are difficult to navigate by or on behalf of the disparity group; and,
- Are impacted by segregation and division, which often results in habits, policies, and institutions that are not explicitly designed to discriminate.

Savior-designed systems are originally designed to rescue, save, and deliver services to "vulnerable" communities by members of the oppressing community.

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Ally-Designed Systems

- Recognize that individuals' unique circumstances and social conditions affect their health, and need to be factored into to health care decisions;
- Never use individuals' circumstances as justification for providing anything less than the highest quality care;
- Reflect on lived experience, points of privilege, and oppression to inform additional perspectives needed "at the table";
- Intend to identify and challenge institutional and systematic oppression; and,
- Unite with disparity groups who are treated unjustly to create a system dedicated to dignity, respect, and equality.

Ally-designed systems are focused on building self-awareness among the oppressing group while partnering with oppressed groups to spark change.

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Equity-Empowered Systems

- Are built and governed to center on the experiences of disparity groups;
- Accept racism and other forms of oppression that adversely impact systems of care;
- Place specific emphasis on addressing unique needs and root causes of inequitable outcomes; and,
- Share power by not only ensuring diverse representation, but also redistributing resources to establish equitable decision-making, design, and implementation processes.

Equity-empowered systems are purposefully reconstructed systems that are rooted in and advance equity of the historically marginalized group.

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Ohio Collaborative
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We Need Your Help!

Please open the link in the chat

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Breakout Sessions Questions

What steps can OCPIM take to establish true authentic community relationships?

What steps can OCPIM take to ensure diverse membership across the regions?

What steps can OCPIM take to co-create solutions with formal and informal leadership?

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Results will be share at our next Statewide Town Hall Meeting

Don’t forget to submit your response

Ohio Collaborative
to Prevent Infant Mortality

Ohio Department of Medicaid

Mylynda Drake
Alternative Payment
Model Administrator

Ohio | Department of Medicaid

Maternal and Infant Support Program (MISP) Update

MISP-Related Policy Changes Effective 1/1/22

Coordinating Policy, Process and Practice

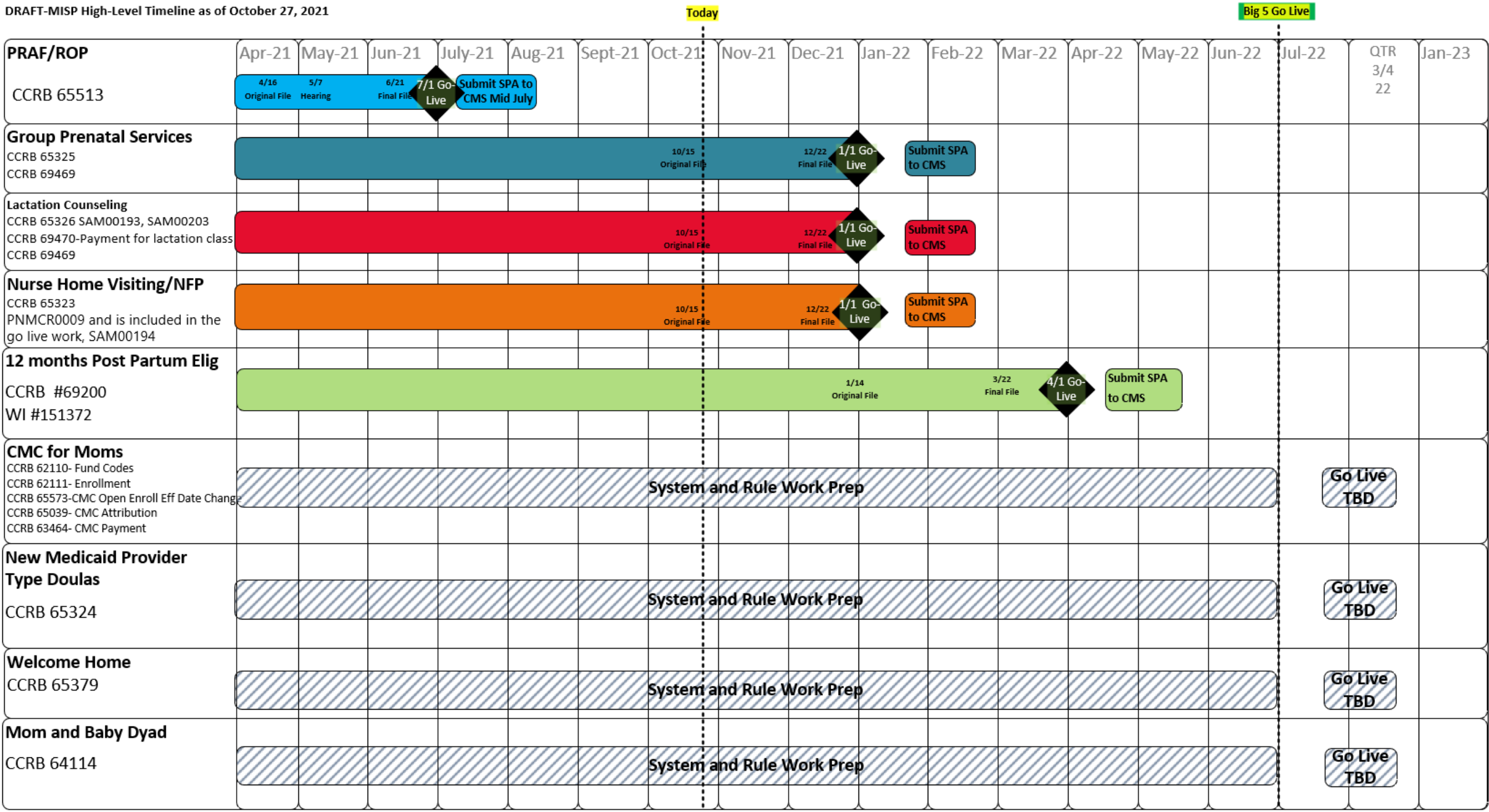
Integration of non-traditional services into the traditional healthcare system

What is the Maternal and Infant Support Program (MISP)?

MISP is the umbrella term for program changes that provide additional support to moms and babies and includes:

- Pregnancy Risk Assessment Form (PRAF) updates and increased reimbursement
- Report of Pregnancy (ROP) creation and reimbursement
- Group pregnancy services
- Lactation consultants and services, including DME updates
- Nurse home visiting
- 12-month postpartum Medicaid coverage
- Continuation of Ohio Equity Institute Infant Mortality Grants through MCOs
- Comprehensive Maternal Care
- Welcome home visits
- Doulas and doula services
- Mom and Baby Dyad

DRAFT-MISP High-Level Timeline as of October 27, 2021



Group Prenatal Care (OAC 5160-21-04)

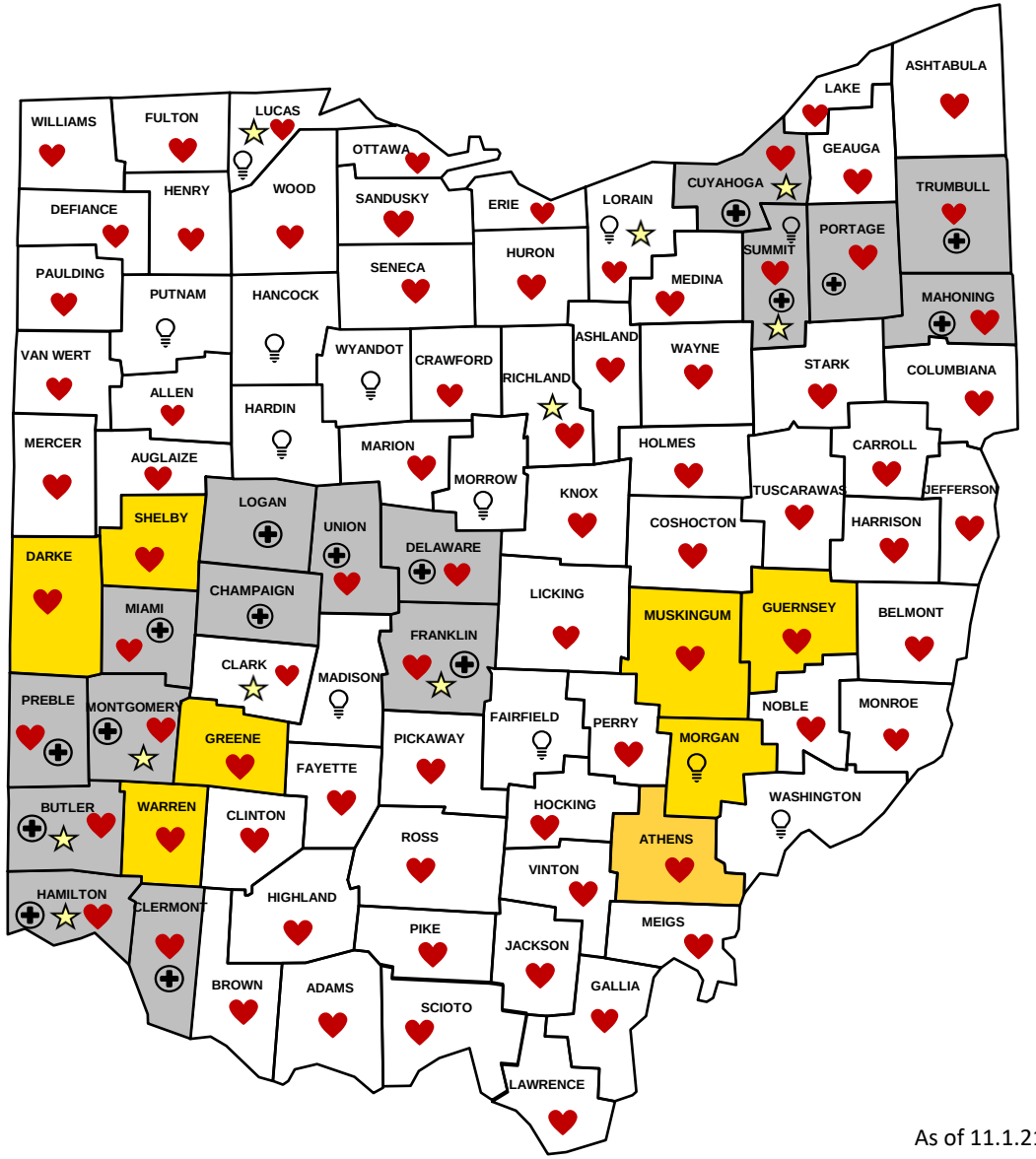
- Allows ODM and the MCPs to reimburse for group prenatal care services (e.g. CenteringPregnancy), while continuing to reimburse for pregnancy education such as Lamaze and tobacco cessation
  - » Group pregnancy care (evidence-based pregnancy education) represented by CPT code 99078 billed in conjunction with a 99211, 99212, or 99213 E&M code by a physician, physician assistant, or advanced practice registered nurse
    - Limit of six sessions per pregnancy
  - » Other group pregnancy education without the care component will bill using S codes
    - No corresponding E&M code needed
    - Limit of 12 sessions per pregnancy
  - » Coding and rate changes will be updated to appendix DD of the Medicaid payment rule
  - » A Medicaid Transmittal Letter (MTL) will be published to provide Ohio Medicaid providers coverage and claim submission guidance

Lactation Services and Breastfeeding (OAC 5160-8-42 and 10-25)

- Physicians, Physician Assistants, Advanced Practice Registered Nurses currently bill for lactation services with an Evaluation and Management Code (E&M)
- Added S9443 as a code for outpatient hospital setting billing grouped under EAPG 428 when billed alone
- Dietitians may provide lactation consulting services in accordance with 5160-8-41
- Modified breast pump coverage to cover more supplies, accessories, and frequent replacement
- Working on making the process of getting breastfeeding resources covered by Medicaid easier and more transparent, in partnership with ODH/WIC, OHA, and the MCPs
- Future work includes adding provider specialty for other licensed providers and RNs to bill for S9443 when IBCLC certified

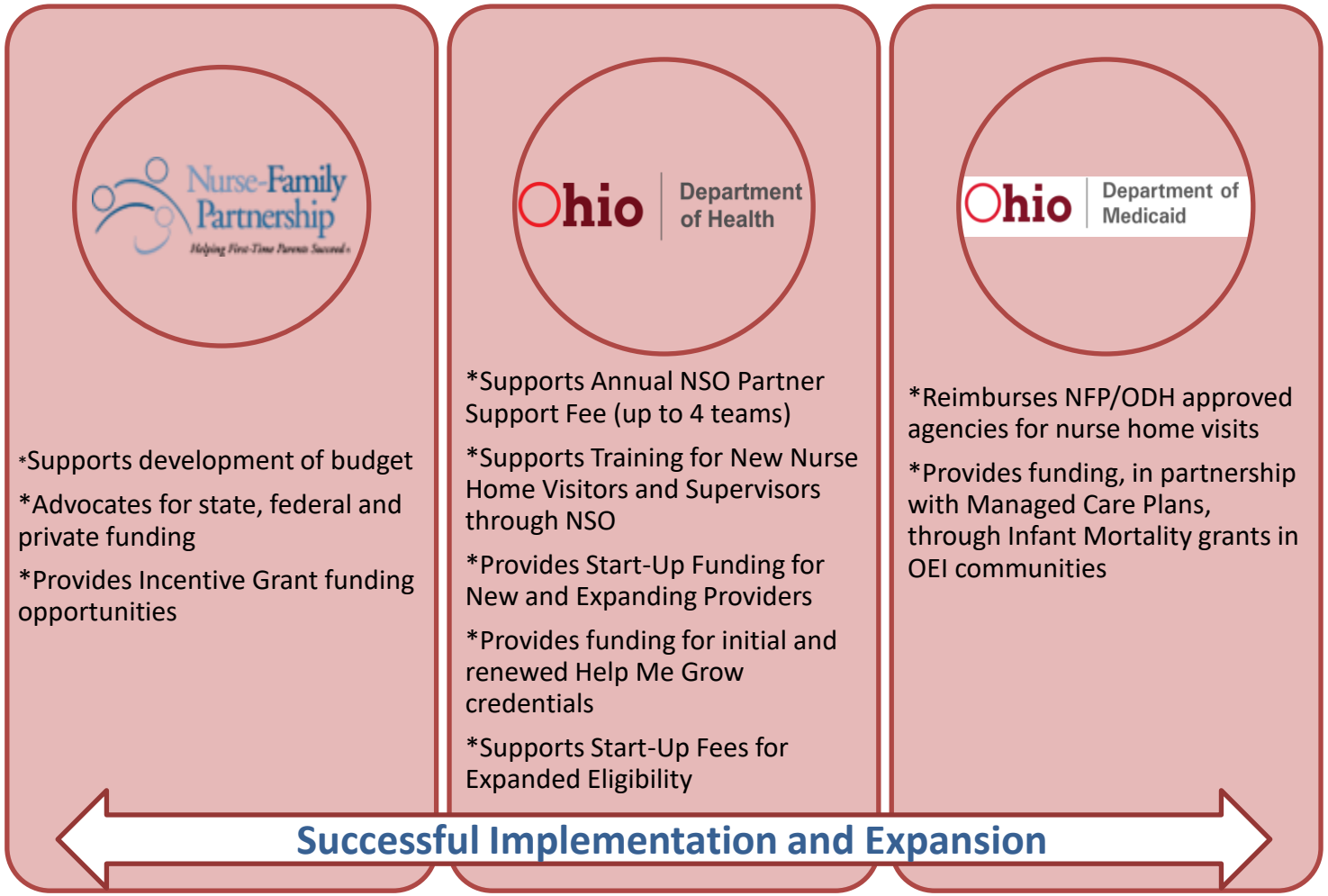
ODH Funded Models

- Moms and Babies First
- Nurse Family Partnership In Existence
- Nurse Family Partnership Hiring or Planning
- Healthy Families America
- Parents As Teachers



As of 11.1.21

Funding


Nurse-Family Partnership
Helping First-Time Parents Succeed
*Supports development of budget
*Advocates for state, federal and private funding
*Provides Incentive Grant funding opportunities
Ohio Department of Health
*Supports Annual NSO Partner Support Fee (up to 4 teams)
*Supports Training for New Nurse Home Visitors and Supervisors through NSO
*Provides Start-Up Funding for New and Expanding Providers
*Provides funding for initial and renewed Help Me Grow credentials
*Supports Start-Up Fees for Expanded Eligibility
Ohio Department of Medicaid
*Reimburses NFP/ODH approved agencies for nurse home visits
*Provides funding, in partnership with Managed Care Plans, through Infant Mortality grants in OEI communities
Successful Implementation and Expansion

Who will be funded by which funding stream?

ODM

Women must be Medicaid enrolled and meet the following:

- Asthma;
- Diabetes;
- Cardiovascular disease;
- Substance use disorder; or
- History of pre-term birth

The following provider types will be reimbursed:

- Federally Qualified Health Centers/Rural Health Centers;
- Professional Medicaid Groups (including hospital-based groups); and
- Ambulatory Health Care Clinics/Public Health Clinics

Covering services until baby turns 1 or mom loses eligibility, whichever comes later

ODH

Women who are not enrolled in Medicaid or do not have one of the conditions identified by Medicaid in rule;

Organizations that are not Medicaid providers identified in rule, including:

- Educational Service Centers; and
- Local Nonprofit Organizations

Services for families after baby turns 1 where mom loses Medicaid eligibility

Nurse Home Visiting Providers and Services (OAC 5160-21-05)

- ODM is creating a new provider specialty of Nurse Home Visitor (38/386)
  - » Enrollment began 10/4/2021
- Nurse Home Visitors will need to be certified to provide nurse home visiting services in alignment with ODH's Help Me Grow rules in OAC 3701-8 (specifically, Nurse Family Partnership certification)
- NHVs must affiliate with an ODM billing provider (e.g. MetroHealth)
  - » FQHCs and RHCs are paid their encounter rate
- Pregnant individuals are eligible for 30 visits per year
  - » each visit must be at least one hour in length
  - » additional visits can be provided with prior authorization as medically necessary
- Only women and the infants of women deemed "medically complex or high risk" as defined in rule will be eligible to receive reimbursement for services through Medicaid claims
  - » Risk of pre-term birth, asthma, diabetes, heart conditions
- ODH will function as a trading partner for NHV services using OCHIDS
  - » Providers will all still need to enroll with ODM/MCPs to receive payment
- Rule effective 1/1/22, ODH OCHIDS release scheduled for end of February

Upcoming MISP engagement in 2022

- HB 142 doula bill
- CMC stakeholder engagement
- NextGen work post 7/1/22 go-live
- Continued lactation support
- ODM dashboards of MISP activities
- Ongoing OEI IM grant support

Questions?

Ohio Collaborative
to Prevent Infant Mortality

Ohio Department of Health

Dyane Gogan Turner,
Chief for the Bureau of Maternal,
Child and Family Health

Ohio Collaborative to Prevent Infant Mortality

Bureau of Maternal, Child and Family Health

Dyane Gogan Turner, MPH, RD/LD, IBCLC
Chief, Bureau of Maternal, Child, and Family Health
Ohio Title V Program Director
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Ohio Department of Health

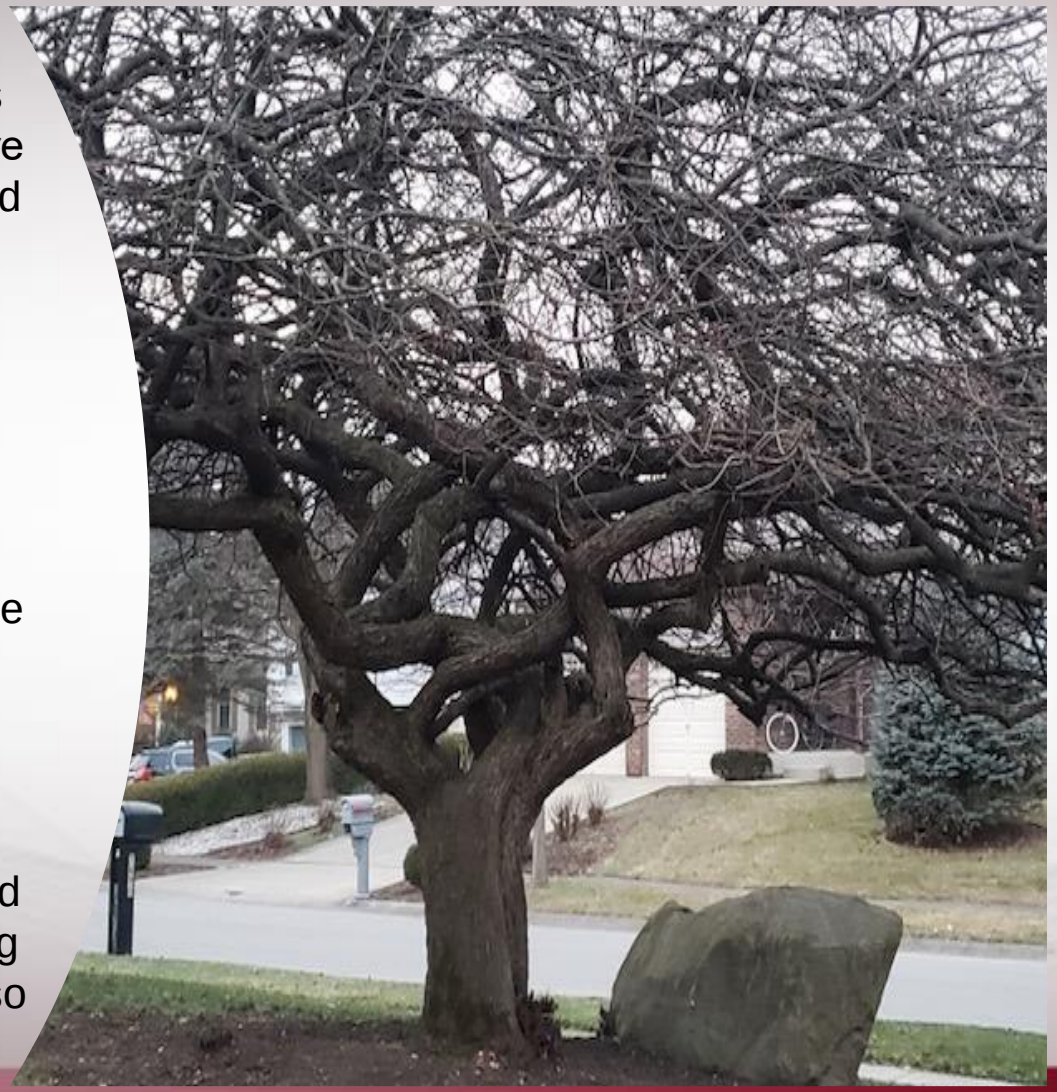
We are all connected!

The State Health Assessment/Title V Needs Assessments comprise the “trunk” and ensure there is a strong foundation for identifying and addressing priority MCH issues.

All our bureau programs, regardless of funding, make up the interconnected branches. Many branches connect to each other, but ALL of them connect to the trunk.

With true inter-connectiveness like these branches, there are no silos. We can leverage shared goals and take collective action to improve health outcomes, and most importantly, eliminate health disparities.

Title V gives us the opportunity to share our great work and encourage many partners and stakeholders to be involved in action planning and implementation – making our branches so full!



Title V MCH

- Title V Maternal and Child Health Block Grant (MCH BG) is one of the largest federal block grant programs.
- Promotes and improves health of all of nation's mothers and children, including children with special healthcare needs.
- $22 million in funding to Ohio and $67 million in state match and maintenance of effort.
- Beyond acting as funding source for staff and programs, also provides framework for identifying maternal and child health needs, selecting priorities, developing a state Action Plan, engaging partners, and measuring progress toward improving outcomes.

Ohio Title V MCH Guiding Principles

- Alignment with the State Health Improvement Plan (SHIP).
- Beyond managing MCH BG Action Plan and reporting requirements, using framework to engage in partnerships to improve outcomes for MCH populations.
- Focus on equity.
- LifeCourse approach.
- Engaging families and communities in work.
- Using:
  - Public Health 3.0.
  - Collective Impact.
  - Results Based Accountability.

What shapes our health and well-being?

Many factors, including these
3 SHIP priority factors*:

Community conditions

- Housing affordability and quality
- Poverty
- K-12 student success
- Adverse childhood experiences

Health behaviors

- Tobacco/nicotine use
- Nutrition
- Physical activity

Access to care

- Health insurance coverage
- Local access to healthcare providers
- Unmet need for mental health care

How will we know if health is improving in Ohio?

The SHIP is designed to track and improve these
3 SHIP priority health outcomes:

Mental health and addiction

- Depression
- Suicide
- Youth drug use
- Drug overdose deaths

Chronic disease

- Heart disease
- Diabetes
- Childhood conditions (asthma, lead)

Maternal and infant health

- Preterm births
- Infant mortality
- Maternal morbidity

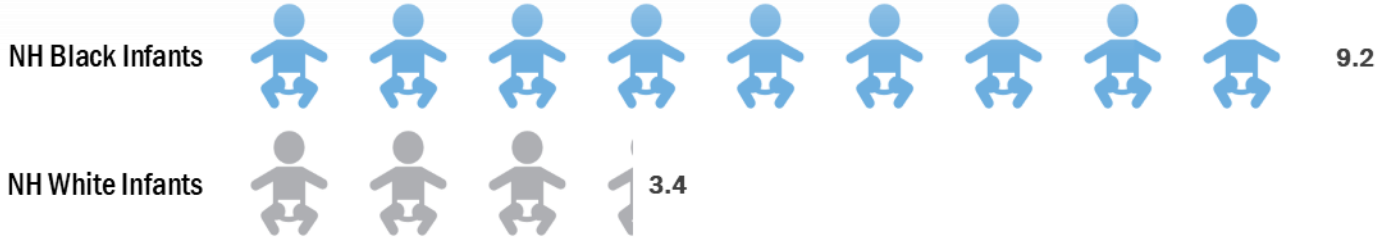
All Ohioans achieve their full health potential

- Improved health status
- Reduced premature death

There is a Black Infant and Maternal Mortality Crisis in Ohio.

Non-Hispanic Black infants are almost 3 times more likely to die than non-Hispanic white infants.*

Rate per 1,000 live births



Non-Hispanic Black women are almost 3 times more likely to die than non-Hispanic white women from pregnancy-related causes.**

Rate per 100,000 live births

*Infant mortality rates from 2019.

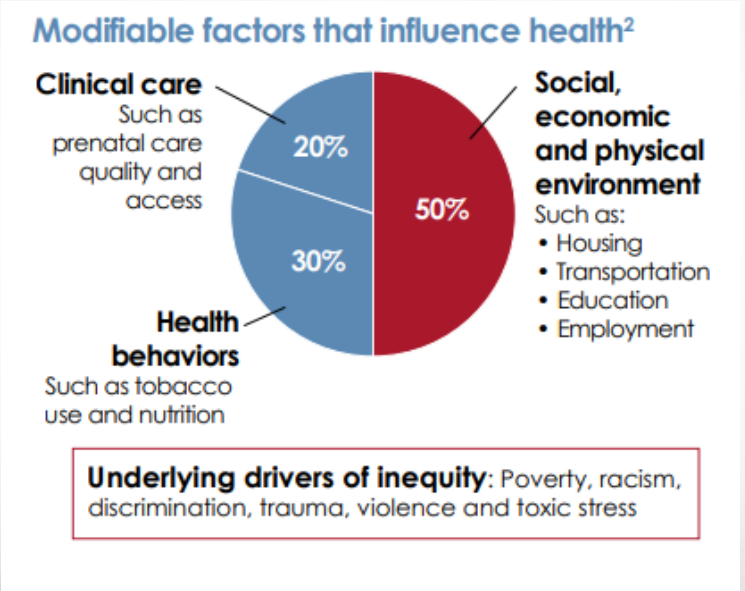
**Pregnancy-related mortality rates from 2008-2016.

Ohio | Department of Health

Why is this happening?

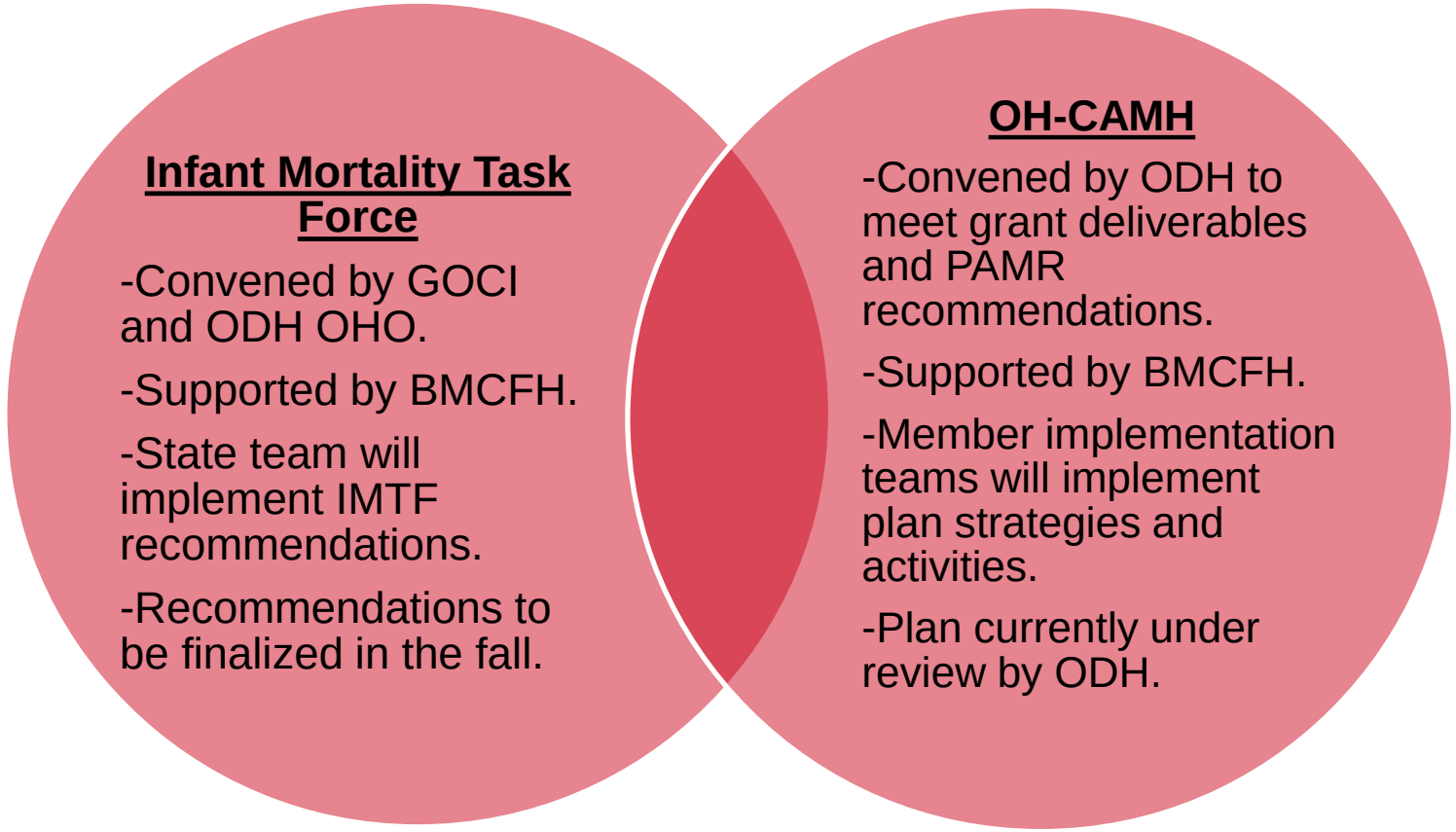
Access to healthcare is necessary, but not sufficient. Improvements to factors beyond medical care are needed to achieve infant mortality reduction goals.

- Researchers estimate that of the modifiable factors that impact overall health, 20% are attributed to clinical care (e.g., healthcare access and quality) and 30% to health-related behaviors. The remaining 50% are attributed to the types of community conditions highlighted in the pie chart.
- During the past few decades, Ohio's efforts to reduce infant mortality have focused primarily on medical care and interventions for pregnant women. These strategies focus on some — but not all — of the underlying causes of infant death, and may not be enough to improve maternal and child health in a widespread way.



Citation: A new approach to reduce infant mortality and achieve equity: Policy recommendations to improve housing, transportation, education and employment. Prepared by the Health Policy Institute of Ohio for the Ohio Legislative Service Commission Dec. 1, 2017.

Aligning Infant Mortality Task Force Recommendations With the OH-CAMH Strategic Plan



Eliminating Disparities in Infant Mortality Task Force

- To provide Governor DeWine with actionable recommendations on how to eliminate the racial disparity in the infant mortality rate.
- To create a road map that guides Ohio to meet the Healthy People 2030 goals for ALL babies (5.0 per 1,000 births).
- To engage Black women, families, and communities throughout the process to ensure that recommendations are grounded in reality.
- https://odh.ohio.gov/wps/portal/gov/odh/know-our-programs/eliminating-racial-disparities/welcome-to

Ohio GOVERNOR'S CHILDREN'S INITIATIVE

Timeline

March

- First Meeting.
- Schedule local sessions.

April-Mid-May

- Family listening sessions.
- 30 held between May 1 and May 15.

May-July

- Task Force meetings.
- Draft ideas/ Recommendations.

July

- Refine draft recommendations.
- Partner survey.

August

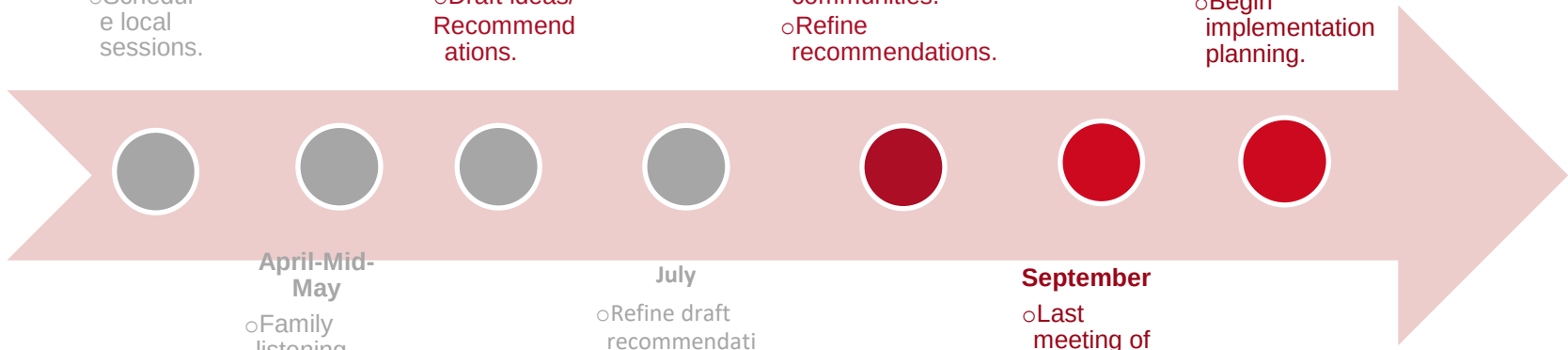
- Share draft recommendations with local communities.
- Refine recommendations.

September

- Last meeting of Task Force.
- Finalize feedback from Task Force members.

October

- Complete recommen-dations.
- Draft final report.
- Start approval process.
- Begin implementation planning.



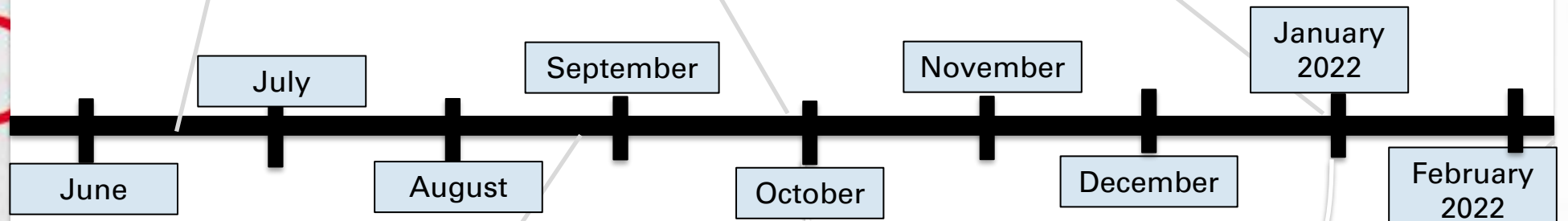
Ohio GOVERNOR'S CHILDREN'S INITIATIVE

OH-CAMH Timeline

June 29 OH-CAMH Meeting:
- The assimilated draft plan was shared with OH-CAMH at the June meeting and after the meeting we continued to solicit feedback regarding the draft plan via email.

Sept. 28 OH-CAMH Meeting:
- Overview of implementation teams.
- Implementation Process Technical Assistance Presentation.

Dec. 31
Each implementation team submits stage-based checklist with relevant documents.



Aug. 27 Lead/Co-Lead Meeting

Between October 2021 and December 2021:
- Implementation team leads convene teams, set up regular meeting schedule, and begin working toward completing the exploration phase of the implementation process using the Stage-based Implementation Checklist as a guide.

February OH-CAMH Meeting:
- Implementation Teams report back to OH-CAMH membership on progress and plan for implementation over the next year.
- Installation phase should begin by January 2022.

Data to Action: Ohio Council to Advance Maternal Health (OH-CAMH)

Eliminating Racial Disparities in Infant Mortality Task Force

DRAFT OH-CAMH Strategic Plan

Strategy 1: Implement provider education and accountability.
Strategy 2: Redesign and prioritize funding for community-based organizations.
Strategy 3: Diversify the racial and ethnic and professional makeup of the perinatal workforce.
Strategy 4: Expand access to post-partum health insurance coverage.
Strategy 5: Institutionalize evidence-based quality improvement interventions to improve maternal safety.
Strategy 6: Improve data collection and quality measures to further examine the maternal health crisis and inform solutions.
Strategy 7: Increase provision of appropriate health services for domestic violence, intimate partner violence, and human trafficking survivors by promoting organizational shifts in culture that support a trauma-informed approach to clinical and public health services.
Strategy 8: Invest in maternal mental and behavioral health services.
Strategy 9: Invest in services for maternal substance use and mental health disorders.
Strategy 10: Increase multidisciplinary communication and collaboration between clinical care providers, community-based organizations, and public health service organizations.
Strategy 11: Improve access to health education for pregnant and parenting individuals to improve health outcomes.

OH-CAMH and IMTF Membership

There are currently 179 individuals across 83 unique organizations in OH-CAMH.

- 19 (23%) of the 83 organizations in OH-CAMH are also part of the Infant Mortality Task Force (IMTF). A list of these 19 organizations can be found below. The following slide shows the individuals from those 19 organizations that are in OH-CAMH.

1. American College of Obstetricians and Gynecologists-Ohio Section
2. Cradle Cincinnati
3. Ohio Commission on Fatherhood
4. Ohio Perinatal Quality Collaborative/Baby's First Network
5. CelebrateOne - City of Columbus
6. Ohio Department of Job and Family Services
7. Ohio Department of Medicaid
8. Ohio Department of Education
9. Ohio Association of Community Health Centers
10. Ohio Collaborative to Prevent Infant Mortality
11. March of Dimes Ohio
12. Stark County
13. Children's Initiatives Office of Governor Mike DeWine
14. Ohio Department of Health
15. Ohio Commission on Minority Health
16. GroundWork Ohio
17. Ohio Department of Mental Health and Addiction Services
18. Ohio Department of Developmental Disabilities
19. Ohio Association of Health Plans

Ohio Collaborative
to Prevent Infant Mortality

Don’t forget to submit your responses from the Breakout Sessions

Ohio Collaborative
to Prevent Infant Mortality

Thank you!

Remember to honor Native American Communities at Thanksgiving

Check Link in the Chat