

## Models of Women-Centered Care

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**Derek Mitchell:**

Judy, you now have the floor.

**Judy Bigby:**

Thank you, Derek, and welcome, everyone, to our last webinar of this series. We're looking forward to sharing the information we have with you today. Next slide, please. Today's topic is Women-Centered Models of Care, as it relates to improving postpartum care. What we're going to do today is hear a welcome from the Center for Medicaid and CHIP Services to give you an overview of this initiative very briefly. We'll hear about why we want to discuss women-centered models of care to improve postpartum care. We'll hear from a Medicaid managed care organization about their initiative to address equity and improve medical outcomes for high-risk postpartum women using a team-based approach. We'll hear from Montana Medicaid about how they implemented a group care model. And, finally, we'll hear from Minnesota about their work to reduce maternal and infant health disparities using a very comprehensive model of care, that includes doulas.

We'll have time for questions and discussion at the end of the webinar, and if time permits, we'll have time for questions after each presentation. Next slide. I'd like to turn now to Kristen Zycherman from CMCS, who will give us an overview of the initiative and present a welcome.

**Kristen Zycherman:**

Hi, welcome. I'm Kristen Zycherman from the Centers for Medicare and Medicaid services, and on behalf of CMS, I want to welcome you all, and thank you all for joining. This is our third webinar in our three-part series; as for our first learning collaborative, a new phase of the maternal and infant health initiative. As many of you have been on the previous webinars, I don't want to repeat all the information. But I did want to share for anyone that hasn't been on one of our previous webinars that this is our first in a three— a set of three learning collaboratives that we have planned in the coming year. This one is obviously postpartum care and going forward we have our next learning collaborative planned for well-child visits, as well as our final planned one currently, which is our low-risk c-section NTSV learning collaborative that we expect to come out in the next year.

So thank you all for joining, and we look forward to hearing what our presenters have to say today. Thank you, Judy.

**Judy Bigby:**

Thank you, Kristen. Before we move into the next topic, I just want to alert the audience that you'll see that you have some links in your chat window. Those are links to information about the learning collaborative, and the affinity group that we'll talk a little bit about at the end of the session. Next slide. As I said, women-centered models of care are important for improving postpartum care. This article that appeared in the Kaiser Health News very recently highlights how the COVID epidemic has really accentuated the need for women-centered models of care. A woman in this article is quoted as saying that she wants to use a midwife. She's considering a home birth, and part of her reason for doing that is

because she wanted to feel cared for. There are many definitions of women-centered care, but the features include being holistic, making sure there's a focus on women's needs, and addressing gender and racial bias in the delivery of care.

Women-centered models of maternity care employ medical and non-medical personnel to support women, including women of color, through pregnancy, labor and delivery, and in the postpartum period. Next slide. In this slide, I very briefly review some of the positive outcomes that women have experienced by engaging in some of the models of care that are considered to be women-centered. You'll see that for the postpartum visit rates, the models up the top there— group appointments, team-based care, doulas, midwives, have been associated with improved postpartum visits. There also are reports of increased breastfeeding, less postpartum depression due to better screening, and an attention to more access to contraception, and better transition to primary care, as well as addressing social issues. And even though this is not exactly relevant for postpartum care, several of these women-centered models are associated with fewer cesarean births, which means that women will have fewer postpartum complications.

Next slide. I'd like to turn now to our next presenter who is Susan Beane from Healthfirst. She's going to present on a project that they did to improve equity and improve medical outcomes for high-risk postpartum women, and it's a partnership that she did with other partners in New York City. Susan will be joined by Rashi Kumar when they start to take questions. So, Susan, thank you for joining us, and I'll hand it over to you.

### Susan Beane:

Thank you so much. First slide. So we really appreciate the opportunity to share in this important forum. We are, as Judy said, a Medicaid managed care program serving about 1.16 million New Yorkers in New York City and surrounding counties. We do have other programs, including Medicare Advantage, long-term care plans, qualified health plans, and so on. And it's really our aim to make life better in terms of health for the New Yorkers and their communities that we serve. Next. And the vision for how we operate begins with our leadership. I'll just highlight the fact that Pat Wang during this really difficult year made a couple statements that drive our thinking around how we serve our communities and our members. First of all, we must be clearly about the business of battling disparities, as well as improving outcomes, and, in addition, as a health plan, we must be about providing access to the optimal quality care to ensure the best medical outcomes. Next.

And because of that, this work that we had a chance to participate in around disparities in postpartum outcomes was really a fit for us. You can see in this slide that women of color, specifically, Black mothers, having a higher rate of mortality, postpartum mortality, and maternal mortality, is not a new phenomenon for the United States. In fact, we began tracking Black to White maternal mortality ratios in 1915, and these ratios have shown an increased likelihood of Black mothers dying for that whole period of time. So not only was it an opportunity to think about and implement an intervention to attempt to address the quality issue of gaps in postpartum care. But from our point of view, we were very interested in what makes women high-risk for mortality, and particularly for women of color, stress. Next. So I'm just going to talk about that for a minute, because I think it is important to frame our discussion in terms of that reality.

And, frankly, women of color know that they are stressed. And if any of you have ever participated in a focus group or heard commentary from Black and Brown women on this topic, you will see that these participants understand that poverty, food insecurity, lack of access to education, unsafe environments,

are significant life stressors for them, and for their children. And, frankly, in this group of women who were Puerto Rican, and assessed for these stressors, they did explore the perceived discrimination based on race and ethnicity, and the impact of that stress on families and communities, and especially maternal health. Next. So it's very difficult for us to put our finger on what that is. So here I present a very brief case study on one of our heroes of the civil rights era, Anne Moody. Anne Moody was a woman who participated with other students from Tougaloo College, who were integrated, in a peaceful, legal sit-in at a Woolworth's lunch counter in Jackson, Mississippi, in 1963.

And you can read online, the group was attacked. One young man was kicked by the mob until he was unconscious and bleeding. Moody herself suffered several indignities, including being pulled by her hair, along with another friend. She was slapped, she was thrown against a counter by a worker, and I think the worst indignity was this picture, which shows she and her fellow students being doused with condiments at that lunch counter by this mob. However, what's notable here, and one reason that this is of interest to many, many observers of the civil rights movement, is look at her face. It shows almost no emotion. If we go to the next slide, she passed away in 2015, and her sister commented on her last years, which she spent back at home in Mississippi. And what really impressed me was that her sister described that, you know, even more than 30 years later, she never felt at ease in her home state. This sense of not being at ease, lack of ease.

You know, if we talk about racism and structural racism, there are many domains that apply, including, you know, civil rights, laws, and racial discrimination, segregation, housing discrimination, police violence, mass incarceration. All of these are critical issues that symbolize structural racism. But maybe for women of color, this sense of lack of ease is bringing forward to us in the healthcare delivery system, and help for organizations, something around the stress that she is experiencing. Next. So I couldn't find one of our equity pictures with women, but I like the concept, which is at the end of the day, what we were attempting to do in our project, in our study, was to develop programs designed to reduce health disparities, and bring about equity. And you can see that brown box in the picture. And as I present this data, I hope that you'll keep in mind that, you know, we sometimes are finding that women have their own lunch counter experience.

And my mom, who's 89 and lived through this era, said to me, "Stress is not something you visually can see. It is an inner feeling that is demonstrated in other ways. Frankly, stress will kill you." So with that, let me launch into the actual intervention. Next. So RWJ funded this study, which was geared to supporting women in the following ways. It was an opportunity to consider the postpartum period, especially since maternal mortality and morbidity can often be identified in that period. And we also felt it was an opportunity to support women who, based on our data at Healthfirst, were less likely to get appropriate medical follow ups post-pregnancy. We felt that this was putting their long-term health at risk, and at baseline, these women, who, again, had Healthfirst insurance, and who lived in East Harlem, and, frankly, just living in East Harlem became one of the greatest risk factors that made a woman eligible for our study.

These women had a 56 percent of timely postpartum care visits, which is a HEDIS measure, versus a control group that had a postpartum visit rate of 67 percent. So there's the disparity. Next. The intervention was actually pretty straightforward. We went into an OB practice, in this case it was Mount Sinai in New York City, and we utilized a social worker and a community health worker as a team. They utilized a standard curriculum, which had been developed by our Principal Investigator, Elizabeth Howell, and her team, which supplied the tools for knowledge and self-care building for these women. It educates them about key features of being at high-risk during pregnancy, and so on. They were offered social

services to increase access to resources, reduce barriers, and they received initial contact actually at the time of delivery, right after delivery, and then phone calls in the 60 days postpartum. Next.

And our outcomes were for – actually surprisingly straightforward. So what you can see is that in the graph, or in the table, that the following outcomes were statistically significant. Postpartum visits, between 21 to 56 days, overall contact with the healthcare delivery system, up to 90 days, and outpatient care in general, up to 90 days. So in every measure of clinical contact with the delivery system in 90 days, these women had a measurable difference in their experience of care, and their access to care. And I think to speak to the women-centered nature of this study, in this chart– the sort of results from our two-week survey of these women showed that they themselves felt that the information shared was something that they would review. So 92 percent reviewed it, 99 percent of them found it helpful. And 80 percent of their partners also reviewed the partner education sheet, and 95 percent of those who reviewed it thought it was helpful. Next.

So finally, you know, this was really a positive finding, and you’ll hear today in all of our work, it takes time to get to sustainability, and bring these kinds of successful projects to scale. But we’re very encouraged because the New York State Task Force on Maternal Mortality and Disparate Racial Outcomes published the results of the expert panel on postpartum care. I participate on that panel, and one of the policies that they’re recommending is actually that this intervention should be brought to scale throughout New York. Where we’re trying to develop stress-free zones, and make sure that wherever possible, women have access to insurance coverage and benefits. And that I think is the last slide. Yes, absolutely. Thank you so much for your attention.

**Judy Bigby:**

Thank you very much, Susan. I did not see any questions that came through in the Q&A. Are there questions anyone in the audience wants to drop in right now? We have a few minutes to– okay. So one question we have. “How can programs like this be linked to quality improvement projects?”

**Susan Beane:**

Absolutely. I think that the intersectionality between disparities and quality improvement is really, really important. And I think that what we learned here is that you could actually implement a clinical solution that demonstrates the same results in HEDIS, as it does at the EMR level. So, thank you for that question. There’s another question– “Are outcomes among women of color of grave concern even when they are not low income?” May we address that question as well?

**Judy Bigby:**

Yes, please go ahead.

**Susan Beane:**

Okay, Rashi, do you want to take that question?

**Rashi Kumar:**

So, we totally agree that outcomes for women of color are totally an issue because of systemic racism. I think the perspective that you saw in our slides is the fact that we are a Medicaid plan. So our members are dually impacted by poverty and race. Dr. Beane, you’d like to add anything?

### Judy Bigby:

I think that the question is really important because I think what the questioner is asking is even if you take away poverty, women of color, Black women especially, still have worse outcomes than other groups. And, so, acknowledging that factor is important when thinking about how can we design interventions to improve outcomes for women of color. So I think that we need to acknowledge not all Black women are poor, and all poor outcomes are not because of poverty.

### Susan Beane:

Yes. I think the other thing I would say is that we did not ask any women their income to create an eligibility standard. The only criterium was that you lived in East Harlem. We had community-level data that suggested that the majority of the women were likely low income. I think that's where I spent some time talking about stress, and, as Rashi said, the impact of systemic racism. So thank you so much for raising that and making sure we're all really clear about the risk to women, Black women, regardless of income.

### Judy Bigby:

So the next question has to do with– it's very relevant to the focus of the initiative. And that is, "State Medicaid programs, what can they do to improve postpartum outcomes?" And the person who submitted the question said that, "Sometimes states are reluctant to work at the point of care, and what do you recommend about promoting that type of partnership?"

### Susan Beane:

I know we're going to hear from the State of Minnesota later. But I will say in New York State, we took a statewide– our Department of Health took a statewide view of this, and part of what they wondered in terms of making policy was what standards should we have for how we educate health professionals? Should we have principles around how women are treated? How do they have access to education, etc? So there are both woman-centered initiatives. In this case, we used our influence as a managed care plan, together with an OB practice for this particular work. But my recommendation to states is that you really set policy and standards, and to the extent that you're willing to call out maternal morbidity and mortality for women of color, especially Black women, as a bar that must be– you know, the care for those women, must reach a certain standard on our bar performance. I think it will drive quicker performance improvement and improved outcomes.

### Judy Bigby:

Okay, another question has to do with the events that take place, or the conditions that are outside of the healthcare system that contribute to the disparities. And 'What is the role of insurers and the healthcare system to address these?'

### Susan Beane:

I think, again, the example we showed, the lunch counter example, is absolutely what you're raising. The fact that women are facing the accumulation of stressors that finally manifest, unfortunately, in – through their health, and, you know, maybe even progress to their demise. So I think that this is a time of, first of all, accepting and understanding that this poor outcome is driven not just by the immediate experience in the prenatal and postpartum care, which should be managed, and should be improved, and we should hold

ourselves accountable. But as you're saying, you know, all the institutions, including some of the ones that I raise in our presentation, you know, criminal justice, you know, the legal system, etc, have to be accountable to the impacts far beyond the specific person being, you know, encountered. But, rather, these stressors actually accrue to communities, and women are part of those, often are part of those, communities.

**Judy Bigby:**

Another question we have, Susan and Rashi, is to provide a little bit more information on what types of social services were offered to the pregnant and postpartum persons?

**Susan Beane:**

Rashi?

**Rashi Kumar:**

To be honest, I don't have that detail. But I think there was a lot of need around transportation in order to get to the postpartum visit that was the most common reflection of what women were needing in order to stay connected to care. But they were well connected to all the social service organizations in that community serving East Harlem, so there were an array of referrals that could be made.

**Susan Beane:**

Housing, food, are some of the other common ones that I believe were addressed. I would say that the researchers were really interested in early detection of depression, to try to mitigate the issue of stressors. So if you're in touch with us, we can find that detail for you.

**Judy Bigby:**

So we're going to move on to our next segment. Thank you, Susan and Rashi, and thank you for all the people who submitted questions. There was one question about the study in Connecticut. These slides will be available on the registration site after the webinar has ended, and the reference for that study is actually on the slide where it was mentioned. I'd like to turn now to Mary LeMieux from Montana Department of Public Health and Human Services. And we're going to spend a few minutes just doing a little Q&A about the group care model that Montana implemented. Next slide, please. So, Mary, welcome.

**Mary LeMieux:**

Hi, thank you so much.

**Judy Bigby:**

Can you tell us a little bit about the Montana Promising Pregnancy Care Program, and how it supports maternal health?

**Mary LeMieux:**

Yes, so Montana Medicaid's Promising Pregnancy Care Program was developed in partnership with the Early Childhood and Family Services Division of Montana's Public Health Department. The program offers group pregnancy care to women and their partner, or support person, and is based on a system called centering. Centering is an evidence-based healthcare delivery system created in the 1990s by

Sharon Rising, a nurse-midwife. The services must be provided by a qualified physician or mid-level practitioner who is centering certified, or the Department must approve the provider's curriculum to ensure that it follows the model of the program. This model of group healthcare supports maternal health by incorporating three major components; assessment, education and support. It takes the mom out of the exam room and into a more comfortable group setting where she can learn from other participants and their questions.

**Judy Bigby:**

Thank you, Mary. Can you explain how Montana implemented this program and is able to use Medicaid funds?

**Mary LeMieux:**

Yes, Montana submitted a state plan amendment to CMS to include the Promising Pregnancy Care Program as a preventive service. It took about three months to receive CMS approval. I think we received just one informal request for additional information for clarification purposes. And the state plan was approved as a program effective July 1st, 2017.

**Judy Bigby:**

Great, and can you give us some insight into how providers are paid for the group care?

**Mary LeMieux:**

Sure, providers can receive \$30 for each Medicaid member per class. The \$30 class time payment is meant to allow coverage for the extended time of the providers, and to purchase books for each of the class participants. The providers can submit charges to Medicaid for both the obstetric visit and the class time. And then for providers who are reimbursed through an all-inclusive rate system, they're reimbursed for the class outside of their all-inclusive rate for the prenatal visit.

**Judy Bigby:**

And tell us a little bit about what outcomes you're tracking and what you hope to see, especially in terms of maternal health. We know that there are also impacts on infant outcomes. But tell us a little bit about the maternal health outcomes that you're looking at.

**Mary LeMieux:**

Sure, all providers who are participating must report on certain measures. Of course, we collect the demographics of the patients. But the pregnancy-related measures are looking at how the patient confirmed their pregnancy, the estimated due date, when their prenatal care began, and at what gestational week. Previous gestational history, their BMI prior to pregnancy, tobacco use, gestational diabetes, the screening and results, their weight gain, and if there were any pregnancy complications. The delivery method, of course, the cesarean section or induction, or spontaneous delivery are things that we want to be reported. The gestational age at delivery, the birth weight, and breastfeeding at the time of discharge. But some specific things to postpartum would be the postpartum visit attendance; did they make their appointment or not? Family planning method, that was chosen at postpartum, and then are they continuing to breastfeed at the postpartum visit? And a very important one would be the postpartum mental health screenings.

Judy Bigby:

Okay, Mary, is there anything else you want to say? We have a question for you, but anything else you want to say about the PPC program?

Mary LeMieux:

Just that it's just meant to be a fun learning experience for the women. Taking them, like we said, out of the exam room, and learning from others that may have questions that they never thought of in these class-like settings.

Judy Bigby:

So we have a question from the audience. What counties in Montana is this program currently active?

Mary LeMieux:

Currently, it's only active in the Lincoln County area, which is up by— if you're familiar with Montana, Kalispell, the Northwestern corner of Montana.

Judy Bigby:

Okay, and I want to thank you, Mary. I know that you just took over this program, and your willingness to come on to share your insight for this webinar is very much appreciated.

Mary LeMieux:

Oh, thank you so much. Glad to be here.

Judy Bigby:

Can we go to the next slide now? So, next, I'd like introduce Nathan Chomilo, who is the Medicaid Medical Director in Minnesota. And he's going to describe a comprehensive model of care in Minnesota to address maternal and infant disparities. Nathan, thank you very much for joining us.

Nathan Chomilo:

Thanks for having me, Judy. You can go to the next slide. So in Minnesota, roughly now one in four, to one in five Minnesotans are actually covered by Minnesota Care, or Medicaid. And we know that in certain populations, coverage is even more notable. And, so, when we look at our mothers, birthing persons, we look into our Black community, eight out of ten Black birthing persons are insured by our program. And nine out of ten Native American birthing persons are insured by our programs. And so when there's talk of addressing disparities, of which, in Minnesota, we have some of the worst racial disparities and gaps between our White and Black, Indigenous and other populations of color. It's really important and critical, and it's recognized for some time that we need to engage our Medicaid programs to do something. Next slide, please.

And, so, one way that we've been trying to address that since 2014 was a doula services coverage through Medicaid. And so we became only the second state after Oregon to cover doula services as part of our Medicaid benefit in 2014. And the doulas provide, you know, guidance, and physical-emotional support to pregnant women, and the covered services that we provide, up to seven sessions of childbirth education and support, including one delivery visit. And we've had in 2019 an effort to increase the rates, because



we found that even though we offered this covered benefit, the reimbursement rate was a barrier to actually having providers that could sustain this benefit for our members, and our neighbors. And, so, in 2019, that rate was increased. Next slide.

But I think probably the most innovative program that we have to address these gaps is our Integrated Care for High-Risk Pregnancies Program. And so in 2015, the legislature directed our Department of Human Services via our Medicaid program since to implement the Integrated Care for High-Risk Pregnancies Initiative. And the goal is to set up a perinatal care collaborative with grant funds to promote integrated care and enhance services to women at risk for adverse outcomes of pregnancy. Next slide. And so the goal, really, was identifying that because of these large disparities that we knew about, African American and American Indian birthing persons in particular were at risk. And so working with the community to co-create and co-lead this approach to perinatal care that helped really mitigate psychosocial, integrate, and strengthen pathways and partnerships between mothers, community organizations, clinics, community health workers, and doulas. Next slide.

And, so, there was initially two arms, and we call the program for short, ICHRP– the African American ICHRP, and a Tribal ICHRP. The African American ICHRP was focused on Ramsey, Hennepin counties, which is where Saint Paul and Minneapolis sit, because that's where the largest concentration of African Americans in the state are. And then, there were five different tribal nations, Fond Du Lac Nation, Lake Superior Chippewa, Leech Lake Nation of Ojibwe, Lacs Nation of Ojibwe, White Earth Nation of Chippewa, and Red Lake Nation of Chippewa Indians which were all engaged to setup the Tribal ICHRP. Next slide. So for the African American ICHRP, with the help of consultants from the community, the African American ICHRP gathered a community-led advisory board that first facilitated conversations with mothers experiencing gaps in care, to identify barriers and solutions.

And together they developed a model with several areas of focus: strengthening community, enhancing pregnancy and family support, including fathers, then promoting healthy babies. Next slide. So this work resulted in what we call the Hub of Wellness model to link African American ICHRP work between the community, medical professions, and the grantees in a way that really centered culturally appropriate care. And, so, we had a separate grantee, the African American Babies Coalition, that really helped with a lot of the community engagement that was part of this model, and getting the message out about where you can access this type of care, what are healthy pregnancies looking like? What are healthy parenting models? What are healthy relationship models, and how do you engage fathers as well? Next slide.

So the clinical care, we have three different grantees that are all federally qualified health centers. And so they use a variety of methods and ways to engage mothers in care that, again, were led by the African American Advisory Council. And so they had specially trained doulas and community health workers that served as patient care navigators, or cultural connectors. There was an offering of centering visits, or group care, that you've heard of in some of the other models previously. Specific case management, and so all women would go through and do a specific psychosocial screen, and based off of that, they were kind of put into different tiers based on the risk factors that were identified, and the potential needs. And then they were connected with services like home and community-based visits, and then after a baby arrived, your breastfeeding support.

They even had rounding at the hospitals that most moms delivered at, and then with the COVID-19, they did transition to do telehealth visits as part of this as well. Next slide, please. And, so, the federally qualified health centers that we worked with include Open Cities, and Minnesota Community Care, and their programs, DIVA – sorry, DIVA Moms, and Nu' DIVA Moms on the previous page. Northpoint was

another federally qualified health center that we are working with, and this kind of demonstrates how they had a referral network both internally. And so the community health center, they have many different social support services that they connect their members to. And so whether you're coming in contact through their African American Men Project, their food shelf, their OnPoint program, you are identified as, you know, either an expectant father or mother, you are referred into the ICHRP program.

And then externally, they also have developed connections with other clinics and hospitals in the area of your neighborhood to say that even though your members might get their medical care and continue to get their medical care at that clinic and that hospital, but you can get the ICHRP psychosocial screening and those other services, you know, through us. And so developed relationships to kind of have both internal and external referrals. Next slide. Tribal ICHRP was a little different in that it was set up to either form or enhance existing collaboratives that focused on pregnant mothers specifically suffering from substance use disorder. And, so, they with us worked together to have three overall program objectives of screening and assessments, joint accountability and shared outcomes, and services for pregnant women, substance-exposed infants, and their families. Next slide.

And so each tribal nation had approaches that varied to meet their own resources and strengths. But there were some overlapping essential features of all the programs. They helped ensure cultures at the core of policy, programming and daily interactions. They utilized peers with lived experience. So peers who were in recovery and who'd been through pregnancy to connect with. It really aims to keep and treat families as a unit and prevent the trauma of family separation. Eliminating the stigma associated with substance use disorders. So not only within the medical setting, but within the legal setting, and the county and social support services setting. And trying to break down silos through improved coordination and collaboration and having the support of tribal leadership from the very start.

And, so, you'll actually see a quote from our legislative report in 2019 about the impact of making those connections, particularly with peers, and how it doesn't even feel like a referral. It's more like an invitation to, you know, ongoing relationship. Next slide. So ICHRP has really been a truly co-designed, community-led collaborative care model that has demonstrated success in mitigating psychosocial risks during pregnancy for at-risk Native American and African American women. Improving care model for women and their spouses. Successful birth outcomes. Less family disruption. And authentic community engagement and awareness. Next slide. Moving forward, we're looking at exploring Medicaid funding for paraprofessional services via our federally qualified health center clinical encounter rates. And so trying to capture and sustain the program through some of our FQHC rates, looking to increase funding, so to expand it to scale to other locations. And so more women can access it. Right now, it was funded as a pilot project, and, so, there wasn't even really funding for evaluation. And so we wanted to also look at how we can continue to evaluate the impact, really help our community advisory boards create a structure to become self-sustaining. So our African American ICHRP council's looking to become an independent 501(c)(3), so they can obtain both public and private funds, and continue to expand that way. And then, really important to continue the community relationships that have been built to really allow time necessary to repair the trust that's been broken due to historical trauma, and structural racism, like we've talked about earlier in this talk. And, really, the goal is for ICHRP to become the standard of care for all African American and Native American women in Minnesota. So no matter whether you're on Medicaid or not, you can be referred into these services and get those supports.

Thanks again for having me here, and I look forward to any questions or conversation.

**Judy Bigby:**

Thanks very much, Nathan. You obviously presented two models that have many different components. Some of them are supported by a grant from your Medicaid program. Can you describe how Medicaid payment supports other aspects of the programs?

**Nathan Chomilo:**

Yeah, so, when seen by, you know, Medicaid providers, whether they be physicians, other clinical providers, you can bill for those services. And obviously, if there's any care coordination, those services that are billable are billed for through Medicaid, currently. And then, we're exploring a way to kind of capture the services that are provided by the community health workers, and the specially trained doulas, around some of the other social supports in the FQHC encounter rate. And seeing if it makes sense for our partners to kind of be able to capture that when they're making their calculations for their encounter rates.

**Judy Bigby:**

Okay, we had a couple of questions about the doula care in Minnesota. One is to clarify whether Medicaid currently pays for doula care beyond the prenatal and postpartum doula service. Do you pay for birthing support? And the other is to give an overview of what the penetration of the use of doulas is in the Medicaid program, and whether or not the doulas are culturally congruent with the families in Medicaid.

**Nathan Chomilo:**

Yeah, so – and, so, for the doulas, a couple things. They must be providers who are under the supervision of the physician, nurse practitioner, or certified midwife. They did have to apply to get in our registry to our Department of Health and be certified through an approved organization and pay a \$200 fee. And then they're eligible to get reimbursed, rates that were increased in 2019, it went up to \$47 per prenatal, or postpartum visit. And then \$488 per birth. And, so, it has to be prenatal or postpartum. So I guess I'm familiar with doula services outside of the pregnancy and postpartum period. And then the question was about the penetration and, certainly, there's been some issues with getting our managed care organizations to even pay the higher rate that's been put through by the legislature. And that and the kind of certification and feeling the need to have supervision by a physician, nurse practitioner, or certified midwife, have all been barriers brought to our attention in getting more doulas interested in wanting to participate, and take our enrollees.

We don't have, to my understanding, any analysis of whether the doulas that do serve our enrollees are currently – you know, what their concordance is with their race, ethnicity, language, or any of those factors.

**Judy Bigby:**

Okay, there's a question in general that I think any of the presenters could answer. And it's time – if you go to the next slide, Ruth, we can go into our general discussion, and Q&A again, just put a question in the Q&A box on your screen if you want to ask a question. So there was a question from one audience member about whether any of the models that have been described here have been adapted for COVID, and what does that look like?

### Nathan Chomilo:

I can certainly start. I did mention in the talk that the model with the African American ICHRP had to adapt with COVID. And, so, that looks like telehealth visits were – our doulas, our community health workers are connecting with the mothers remotely, instead of in-person, in checking in in that way. And I believe they've even been able to do some of the kind of group classes and sessions together that way as well. There were some issues, I think, initially in the pandemic, around allowing doulas in, or paraprofessionals into the delivery rooms to kind of continue service there. But that eventually got sorted out with our healthcare systems. So those have been I think the biggest, you know, kind of service delivery ones. What we've heard from the African American Advisory Council is, you know, that the needs have continued to increase as far as, you know, housing and food in particular, for the mothers we serve in these communities. And so there's been kind of more efforts to try to, you know, connect to those resources.

### Judy Bigby:

Mary, or Susan, do you want to answer that question about COVID adaptation?

### Susan Beane:

We're just initiating our postpartum program at scale. What I will say about our other similar programs, would echo what Nathan said, that basically, these community-based organizations adapt. They are still willing to see people who are willing to be seen, if you will, using all appropriate precautions. But, generally, most of these programs have shifted to telephonic. During the pandemic, obviously, you know, women generally still deliver in-person. So it's going to be interesting to see how this, you know, adapts moving forward.

### Judy Bigby:

Okay, now there's a question for you, Mary, about the curriculum that is required for the PPC program. You answered in the Q&A, but the participants can't see that. So if you could just describe what your answer was?

### Mary LeMieux:

Sure, and I actually think it got cut off anyway. But for the curriculum, we just want to make sure that all of our topics are addressed in the classes. And those topics include nutrition, healthy lifestyle, breastfeeding, changes, body changes in the pregnancy, stress management, family planning, labor education, newborn care, shaken baby syndrome, postpartum care, and then preventing SIDs. We just want to make sure that the curriculums that the providers are going to be following meet and touch on all of those topics.

### Judy Bigby:

Okay, another question has come in about whether or not any of the model that you've described address childcare? Anyone want to answer that question? Nathan?

### Nathan Chomilo:

Ours do not explicitly address childcare at this point. For some of the centering classes, I guess there are efforts to try and have, you know, childcare available so that if you have, you know, a child, you are

participating in the class, but you can find someone, you can still participate. But pre-pandemic, I don't know during the pandemic how that's being managed. But apart from that, there are no other childcare supports I'm aware of.

**Judy Bigby:**

Okay.

**Susan Beane:**

This is Susan. I would agree. Again, we're going to take another look, but I don't believe that childcare was addressed in our intervention.

**Judy Bigby:**

Okay, another question has to do, again, with the support for birthing persons to access technology needed to use telehealth. Is there any support for internet access, use of cell phones, or tablets, so that pregnant persons can use some of the services that you've described?

**Nathan Chomilo:**

From our standpoint, there's not direct support, or, you know, funding, rather. But I know that our navigators, our doulas and our community health workers do try and connect mothers with support and are quite attuned to all the different community-based organizations in what they're doing and there's been several that have been providing those type of supports to mothers that way.

**Susan Beane:**

For our program, with Healthfirst, that is something that our IT group is exploring, in terms of whether we can, indeed, offer smartphones to these members at a minimum, so that they can optimize their participation.

**Judy Bigby:**

Okay and then, there's a question about whether any of the models address addiction. Nathan, you did mention this, so do you want to elaborate on that?

**Nathan Chomilo:**

Yeah, so the initial Tribal ICHRP focused primarily on, or almost exclusively on, was women with substance use disorder. Because there's a notably high rate amongst Native American birthing persons in Minnesota that we look at, to babies being born with neonatal abstinence syndrome. And, so, that was the primary focus there, and that's the use of peer recovery coaches in connection to the community and culture— the primary goal there is that those programs are continuing, but are no longer funded directly from our DHS funds. They're actually funded through state opioid response funds now, and we're looking to kind of expand to a more comprehensive Tribal ICHRP going forward, much like the African American ICHRP. In the African American ICHRP, there is screening for it. And so your addictions, all the things that you're screened for, and then you're connected to services.

And we have seen, again, less family disruption at birth as a result of participating in that program.

Judy Bigby:

Okay, Kristen, do you have any comment you want to make about that? Or Mary?

Susan Beane:

Yeah, we're going to take another look. I know that there was an active interest in any kind of emotional or mental health, or behavioral health need. So, again, for those of you interested in our program, we'll have that information afterward.

Judy Bigby:

Okay, great. Well, I want to thank all three of you, all four of you, for participating, and presenting your very interesting work. One of the things that I observed is that you all are involved in very significant partnerships to develop these initiatives and evaluate what they're doing. And it seems like a very important part of addressing the issues that are of concern to women around women-centeredness, that these kinds of partnerships are important for making sure you're headed on the right track. I'm going to turn this over now to Ruth, who will close out the webinar for us.

Ruth Hsu:

Thanks, Judy. So, to wrap things up, the recording and slides from today will be posted on Medicaid.gov. You can find these links you see on this slide in your chat box, and the affinity group that Kristen had mentioned in the beginning will be taking place this spring. There's a fact sheet on Medicaid.gov if you'd like to learn more about it. And if your state is interested in participating, we have EOI forms available, and they will be due this Friday at 08:00 pm Eastern. And on your way out, there will be an exit survey which will appear on your browser when you leave the webinar platform. We want to encourage everyone to please fill out the survey. We're interested in hearing your feedback. And if you have any questions, please email us here at [MACQualityImprovement@mathematica-mpr.com](mailto:MACQualityImprovement@mathematica-mpr.com). Thank you for participating.