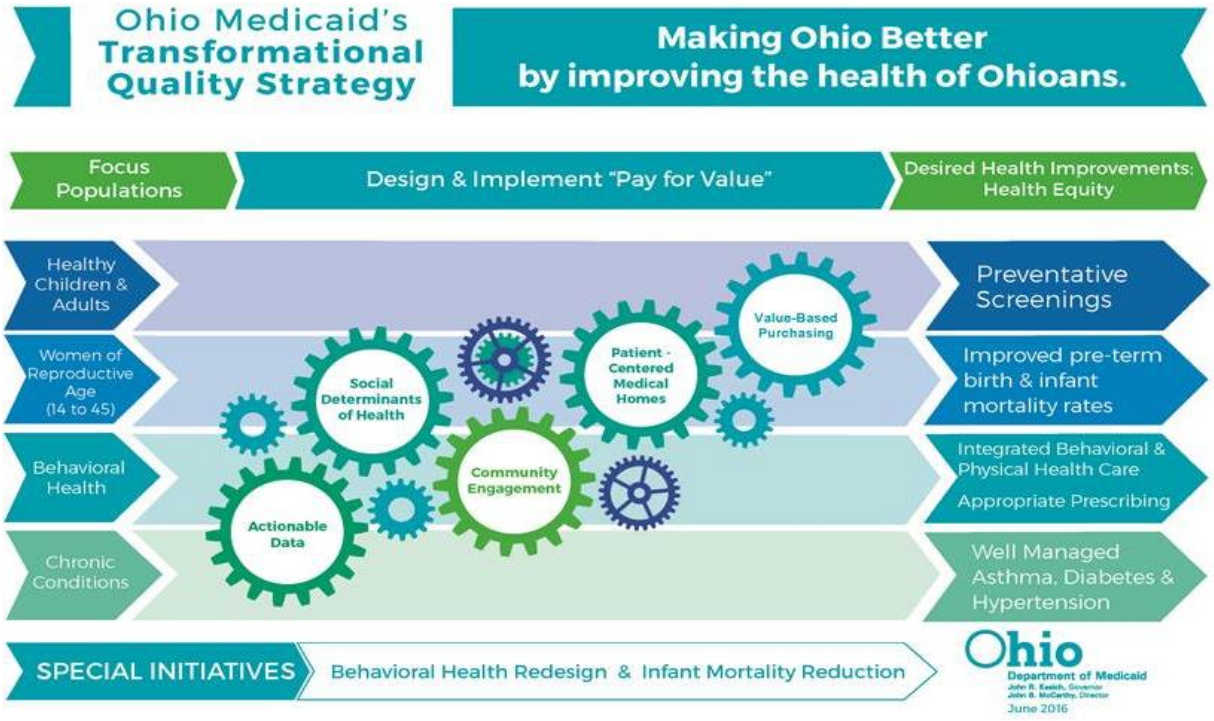
MMCP Progress in Infant Mortality Initiatives in Priority Communities and Implementing Enhanced Care Management Services --SFY 2016 and 2017 update

Introduction

Although Ohio's infant mortality rate (IMR), has declined steadily since 1990, at 7.2 infant deaths per every 1,000 live births, it remains higher than 43 other states. The infant mortality rate among African American infants is even higher. In 2015, African American infants died at nearly three times the rate of white infants (IMRs of 15.1 and 5.5, respectively).

The Ohio Department of Medicaid (ODM) serves more than 3.1 million residents across Ohio. More than 86 percent of all Medicaid beneficiaries are served through the five contracted Medicaid managed care plans – Buckeye Health Plan, CareSource, Molina Healthcare, Paramount Advantage, and United Healthcare Community Plan. ODM and its contracted managed care plans are uniquely situated to partner with clinicians, local health districts, community workers and other organizations addressing social determinants of health to collectively impact the overall state infant mortality rate. ODM's Quality Strategy focuses on reducing health disparities across the populations that Medicaid serves. Current efforts are focused on reducing the overall rates of preterm birth and infant mortality and the disparities observed in these rates among Ohio's African American population.



ODM and its contracted Medicaid managed care plans (MCPs) are pursuing several avenues to address infant mortality and its causes, including: the provision of enhanced maternal care services to women of

reproductive age identified to be at highest risk of poor birth outcomes (e.g., due to prior preterm birth or residing in a community with high infant mortality rates); collaborative efforts with community based groups that concurrently foster relationships, build community capacity and reduce infant mortality; increasing the use of progesterone statewide through a performance improvement effort resulting in standardized pregnancy notifications, retention of Medicaid eligibility during pregnancy, and removing administrative barriers to progesterone initiation; capitalizing on mobile technology for educational and connection purposes; improving transportation access through testing innovative alternatives, such as Uber and Lyft; standardizing use of the tobacco hotline for connecting smokers with counseling; and encouraging methods to improve birth spacing, such as same day implantation of long-acting, reversible contraceptives. Detailed efforts by the MCPs to improve the health of women of reproductive age and reduce the likelihood of poor birth outcomes and infant mortality are outlined below.

Enhanced Maternal Care Services

In May of 2016, ODM released guidance to its contracted MCPs with regard to the provision of enhanced maternal care services (ODM Enhanced Maternal Care Guidance). The guidance highlights ODM's expectation that the MCPs drive improvements through the following strategies:

- Using data (linking ODH Vital Statistics and Medicaid claims) to expediently identify and intervene with women at high risk of poor birth outcomes and in need of enhanced maternal care;
- Geographically targeting birth outcome improvement efforts in areas of the state with the highest infant mortality rates;
- Integrating Quality Improvement (QI) science methods into performance improvement projects to more rapidly identify and spread successful intervention strategies;
- Integrating eligibility and MCP specific information with mobile messaging to improve patient engagement and connectivity to Care Management;
- Continuously supporting state (e.g. Ohio Perinatal Quality Collaborative, Ohio Collaborative for the Prevention of Infant Mortality) and community based infant mortality reduction efforts (e.g., CelebrateOne, Cradle Cincinnati); and
- Advancing the science and implementation of evidence based care.

The MCPs are expected to use these strategies, in conjunction with investing in, and connecting women with Comprehensive Primary Care (CPCs) practices, actively collaborating with community partners, and performing expedited outreach, to systematically address modifiable risk factors and obtain measurable improvements in birth outcomes.

ODM's Enhanced Maternal Care Guidance is tailored to maternal risk level and to residence in priority communities (i.e., those with high infant mortality rates). The guidance outlines recommended services

(e.g., use of community workers Centering Pregnancy programs), communication and care management supports that women of reproductive age enrolled in a Medicaid MCP should receive. The full document can be found on the Medicaid website.

The following update provides examples of the activities the MCPs are currently undertaking to comply with this document.

Collaborative Birth Outcome Improvement Efforts in Select Ohio Communities

As part of the 2015 Executive Budget, ODM was charged with investing $26.8 million over two years to support local-level, community-driven proposals to combat infant mortality and enhance agency coordination in providing care to at risk women and infants.

In order to effectively allocate the funds, ODM and its five contracted managed care plans engaged local leaders in nine Ohio communities with high infant mortality rates, where disparity of African American infant mortality rates are significantly higher – Butler, Cuyahoga, Franklin, Hamilton, Lucas, Mahoning, Montgomery, Stark, and Summit counties – to identify and fund innovative projects to connect women and infants to quality health care services and care management.

Funding decisions for local projects were finalized in early 2016 and initial distribution of monies to the funded entities by the fall of 2016 after execution of initial contracts. Funded entities performed additional work with their sub-recipients, the local community based organizations (CBOs) undertaking many of the improvement efforts.

MCPs worked together in this effort as a single community-facing Plan to simplify communications and interactions, designating a specific plan per community as the point of contact. The funding distribution to the CBOs, which is based on each MCP's overall membership volume across the nine communities, is included in the table below.

Summary by Plan	Current Funding Allocation by Plan
Buckeye	11.75%
CareSource	55.90%
Molina	11.69%
Paramount	11.28%
UHC	9.38%

Funding entities formally represents the partnership within the community. The funding entity receives the funds and disburses them to the community based organizations participating in the intervention efforts.

Each CBO provides quarterly progress updates to the Managed Care Plan assigned to the community. Initial data submitted in January 2017 represents the project baseline. These baseline reports reflect anticipated start-up such as hiring staff, identifying partners, contracting arrangements, and engaging in staff training. Future reports, submitted in accordance with the schedule below, will provide additional data points to illustrate progress in the communities.

Reporting Period	Q1 2017	Q2 2017	Q3 2017	Q4 2017
Due date	April 28th	July 28th	October 27th	January 26th

Detailed description of funding amounts and interventions are presented for all nine communities in the section below.

Butler County

Funded Entity: Partnership to Reduce Infant Mortality (PRIM)

Total funding: $2,480,334; **SFY 2016**: $947,111: **SFY 2017** $1,533,222

MCP Lead: United Healthcare Community Plan

Initiatives funded in Butler County to reduce preterm births include: the hiring and training of additional community health workers to provide services in areas at highest risk for infant mortality; the creation of additional Centering Pregnancy Programs to provide needed social support during pregnancy; the provision of support for new fathers; and faith-based support for pregnant women and new mothers.

Funded Project Progress

Community Health Workers

Butler County received funding to train ten additional community health workers (CHWs) in basic and advanced prenatal skills (i.e., Doula and Lactation Counseling) to reach out to high risk pregnant women in Butler County.

The Community Health Worker model promotes workers, who share a cultural connection with the target population of high-risk pregnant women, and focuses on building relationships based on shared experiences. Community Health Workers focus on the social determinants of health, engaging with high risk pregnant women who might otherwise receive no or late prenatal care. Year one focuses on trainings for CHWs. In year two, Butler County will begin to move the services into the community, placing advanced prenatal CHWs at low income prenatal clinics and/or Centering practices in order to

target African American and low income, high risk women in the neighborhoods with the highest infant mortality rates.

As of January 2017, Butler County had hired 11 new CHWs; nine of the CHWs are African American. Training began January 2017 and will be completed in August of 2017. After the CHWs have completed training, they will begin engaging with the community and reporting progress measures such as the identification of women needing assistance and the number of CHW contacts made with each individual.

"Enhanced" Centering Programs

Centering Pregnancy is an evidence-based, group prenatal care model that decreases social isolation by providing expert medical care along with a peer-to-peer support group for pregnant women. Butler County's Partnership to Reduce Infant Mortality/Ohio Institute team provided start-up funding to the first Centering Pregnancy program in Butler County. Originally, the demand exceeded the capacity of this one program. Additional funding was provided for the resources needed to develop two additional Centering Pregnancy programs targeting African American women residing in areas with high rates of infant mortality. These Centering Programs provide additional services such as onsite childcare and transportation to and from appointments. Utilizing Community Health Workers and behavioral health services were proposed as methods for addressing the social determinants of health. Butler County also proposed to employ minority staff to increase the comfort level of minority women, to encourage earlier entry into prenatal care, and increase compliance.

Between the project initiation in November 2016 and the first report in December 2016, two centering sites had been identified (Primary Health Solutions and Atrium Medical Center) and staff were being trained in the centering model. Once staff are trained the Centering program can begin providing services.

Fatherhood

Involved and effective fathers are more likely to provide support for mothers and positively impact the family unit, thereby potentially decreasing infant mortality. Based on this rationale, the Celebrate Fatherhood Initiative for Butler County received funding to provide parenting and fatherhood classes, as well as a support system for potential/new fathers. The program targets African American fathers and significant others of Medicaid clients using a community based approach with male staff who work in small groups with the target population.

Between project initiation in November 2016 and the December 2016 report, 250 men have attended fathering events. Half of the attendees were African American men. There have been five community events since the program began and the average participant attended four events. Six percent of the staff match the demographics of the population they are serving.

Faith-based Support for Pregnant and Parenting Women

Faith based organizations have a legacy of serving communities especially as providers of health and social services. Faith Based organizations are vital to, and trusted by, the communities in which they are located and are increasingly becoming involved in efforts to reduce health disparities and address broader community health issues. Butler County is capitalizing upon this construct by creating an infrastructure through Families First, a faith based initiative, to conduct education classes on obesity, nutrition, physical activity, and parenting classes for women who are already mothers and/or pregnant. The program also aims to provide safe sleep education to caregivers and family members in the community and to purchase materials on pregnancy, birth spacing and optimal inter-conception health care. The church intends to offer transportation for the women to get to classes and links with the Nurturing Every Step Together (NEST) program, spiritual mentoring for pregnant women in drug rehabilitation.

The Families First service agreement was approved by the Butler County Educational Service Center (ESC) Board in November of 2016. Initial payment was sent in December of 2016. During 2016, program flyers were created and disseminated in the community. Program staff—all African-American--were hired.

The January 2017 update revealed that seventeen women, half of which were African-American, were contacted by the program since it first received funding. The average participant attended two events.

Nurturing Every Step Together (NEST) Program, an interfaith community collaborative serving recovering women

The NEST program, an interfaith community collaborative serving recovering women received funding to expand its scope to reach high-risk African American pregnant/new mothers and their families. The NEST program's goal is to address each woman's social, health and safety needs through regular innovative engagement by matching the women with well-trained and appropriately educated faith community advocates.

The NEST program received funding at the end of November 2016. By the January 2017 update, twenty-six individuals were reached and linked with other programs. Only two of the participants were African American, indicating difficulty in recruiting African American clients. In the two months of operation, the average participant attended one event.

Cuyahoga County

Funded Entity: Case Western Reserve/First year Cleveland

Total funding: **SFYs 2016 & 2017**: $4,860,000;

MCP Lead: CareSource

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Initiatives funded in Cuyahoga County to reduce preterm births include: the expansion of Centering Pregnancy to new locations; the provision of parenting guidance and support for new fathers; and expanding home visiting programs to new locations.

Funded Project Progress

Expand Centering Pregnancy Sites (NEON and Care Alliance)

Cuyahoga's Centering Pregnancy programs aim to increase the number of women participating in Centering as a way of augmenting social support during pregnancy, thereby improving birth outcomes.

Prior to funding, there were two Centering Providers, University Hospitals Case Medical Center and Neighborhood Family Practice. The two programs had limited capacity and funding supports needed expansion of services. Funding received by First year Cleveland is being used to begin Centering Pregnancy programs at three Federally Qualified Health Centers (FQHCs): NEON, Care Alliance and Neighborhood Family Practice. The program aims to serve an additional 125 women at each site for a total of 375 participants.

As of January 31, 2017, one of the three centering sites (Neighborhood Family Practice) started to serve patients. However, none of the patients have had time to complete the centering program. Neither childcare nor transportation has been requested yet.

Neighborhood Family Practice is working with NEON and Care Alliance to assist with implementation at their respective sites and will host Centering training for Care Alliance, NEON and other providers on March 1st and April 1st (capacity of 15 trainees per session).

FQHCs demonstrated progress in hiring staff: NEON filled its Centering Coordinator position; and Care Alliance recruited a nurse to support the project and is on track to implement during the grant year.

Fatherhood/Parenting (Daddy Boot Camp for New Dads)

In support of fatherhood involvement as a protective factor against infant mortality, First Year Cleveland received funding to partner with the Cuyahoga County Fatherhood Initiative to expand the "Bootcamp for New Dads" program. The program provides an opportunity for new and expectant fathers to gather in a group session and receive "hands on" experience holding, changing, and feeding a baby. They also receive parenting and communication tips. Expanding this program in community settings is intended to provide opportunities to reach more men for programming.

As of January 2017, forty-seven men attended the two scheduled events. Five additional Boot Camp events are planned over the next six months. The program aims to serve a total of 600 fathers in the targeted communities.

Home Visiting (MomsFirst, NEON OIMRI, and Birthing Beautiful Communities)

Cuyahoga County hosts a number of home visiting programs that provide services in targeted neighborhoods and have consistently proven better outcomes. First Year Cleveland proposed to increase capacity to provide home visiting services to pregnant women/teens in the targeted communities through partnerships with the MomsFirst program, NEON's Ohio Infant Mortality Reduction Initiative, and other successful programs. The program is increasing capacity by hiring Community Health Workers and Doulas from the identified high risk communities to engage, recruit, and work with women and families in those communities, thus investing in residents directly by providing job opportunities and training.

All Home Visiting Programs are still in the process of development. As of January 31, 2017, the contract with MomsFirst was still in process, thereby delaying the hiring of the newly funded positions.

NEON OIMRI has actively recruited for the Community Health Worker positions through various avenues and full staffing is expected during the 2nd quarter of 2017.

Birthing Beautiful Communities currently has nine birth workers whose training will be completed by the end of March 2017. The program has received 19 referrals, held 128 visits with pregnant women, and connected women to 221 services (approximately 2 services per woman on average)., 100% of women of the originally proposed 100 women have received at least one visit, 30% of women refused home visits, and 99.7% of participants have completed home visiting programs.

Franklin County

Funded Entity: Healthcare Collaborative of Greater Columbus

Total funding: $2,300,000; **SFY 2016**: $1,070,000; **SFY 2017**: $1,230,000

MCP Lead: United Healthcare Community Plan

Funded initiatives to reduce preterm births in Franklin County include: the expansion of Centering Pregnancy to three new locations in high risk neighborhoods; the provision of a Central Coordinated Intake program to immediately link women with care and services; expansion of the nutritional counseling and social support program Moms2B; and increasing the reach of home visiting programs in Franklin County.

Funded Project Progress

Expanding Centering Pregnancy Programs (Heart of Ohio Family Health Centers, PrimaryOne-17th Avenue, Primary One-W. Broad Street)

Franklin County's Celebrate One proposed expansion of Centering Pregnancy programs to three new locations in Franklin County in order to serve more women in neighborhoods with high rates of infant mortality.

All three of the centering sites: Heart of Ohio Family Health Centers-Whitehall; PrimaryOne Health Centers-17th Ave. -St. Stephens; and PrimaryOne Health Centers-West Broad Street are in the start-up phase with the national Centering HealthCare Institute. This includes the development of a steering team and the creation of an implementation plan. Centering Pregnancy programs required a planning period of more than six months, thus delaying implementation.

A joint Centering Pregnancy training will occur for the three new sites on April 6th and 7th in Columbus. Centering sessions will begin 45-69 days after training occurs.

Resource Specialist (Hands On Central Ohio)

The CelebrateOne Resource Specialist position was filled on January 9, 2017. Calls were scheduled to go live February 1, 2017. The next step is for HandsOn to work with CelebrateOne partners to train them on utilizing the HandsOn App and website and also gain an understanding of pressing needs. The Specialist will conduct ongoing research of community resources so that the database focusing on pregnant/parenting women and families is continually updated.

Central Coordinated Intake (Step One)

StepOne Prenatal Information and Referral Service Support is designed to link women to prenatal care after conducting an initial screen of health and risk factors; coordinating presumptive eligibility; and scheduling an initial prenatal appointment. For existing MCP members, the program will provide on-going support to the women until the MCP can begin care coordination. Support includes: confirmation of pregnancy, appointment reminders and follow up, coordination of transportation, and linkage with MCP upon enrollment.

The January 2017 report showed that StepOne is fully staffed and the provider network has been expanded to include 18 private practices. With an average wait time of 3 days, women are accessing care more quickly.

StepOne held meetings with CareSource and UHC Community Plan to discuss the coordination of care and support once women begin prenatal care.

Currently 54% of the women calling are from neighborhoods with the highest infant mortality rates in Franklin County.

A marketing plan has been finalized to target information to the eight CelebrateOne high priority neighborhoods. The marketing plan will be implemented during the first and second quarters of 2017.

Nutritional Counseling and Social Support (Moms2B)

Moms2B is a community based nutrition and social support group for pregnant and newly parenting moms. Funding provided for the establishment of Moms2B programs in four new neighborhoods,

starting in Linden (which has an IMR of 23.0%). The OSU Wexner Medical Center will provide an additional $20,000 for each established site.

As of January 2017, the first of four new Moms2B sites was being established in Linden at the New Salem Baptist Church. Over 100 people were expected to attend the open house on February 13. Additional outreach throughout the area began February 20.

Scouting for new locations in Hilltop Southeast and Northeast is also underway. The additional sites will be added incrementally in May, September and February (2018), respectively.

New staff for the Linden and subsequent sites have been hired, including a Social Worker and two interns who are African American.

Home Visiting

As of February 2017, Celebrate One received approval to increase the utilization and capacity of home visiting and other pregnancy support services to pregnant and newly parenting women. The first report will be provided at the end of the first quarter of calendar year 2017.

Hamilton County

Funded Entities: The Center for Closing the Health Gap in Greater Cincinnati;

Cincinnati Children's

Total funding: $2,837,000; **SFY 2016**: $1,469,480.00; **SFY 2017:** $1,367,520.00

MCP Lead: Molina

Funded initiatives to reduce preterm births in Hamilton County include: the provision of a Central Coordinated Intake program to immediately link women with care and services; the expansion of the community health workers and home visiting work force; and educating fathers about safe sleep practices.

Funded Project Progress

Centralized Intake (Cradle Cincinnati)

Cradle Cincinnati partnered with United Way's 211 system to centralize intake for families in Hamilton County. Funding supports the 211 line, advertising, marketing and two Cradle Cincinnati Connections Navigators.

Centralizing intake allows for a single main entry point or "front door" for families in Hamilton County to get referred to community health workers, home visitation agencies, community resources, or a

connections navigator to help them traverse the system based on a comprehensive evidenced based assessment and screening tool.

As of the baseline period report, United Way's 211, the centralized intake systems/process being utilized for this project, was scheduled to launch by March 2017. A training for the 211 operators was planned for February 2017. Cradle Cincinnati had the initial meeting with Deskey, a Cincinnati firm that will provide a marketing strategy for 211.

Community Health Workers and Home Visitors

Every Child Succeeds, Healthy Moms and Babes, Cincinnati Health Department and TriHealth Outreach Ministries received their contracts from Cradle Cincinnati in December of 2016. These organizations are collaborating to recruit 18 community health workers (CHWs) and six home visitors to reach women in the targeted Hamilton County zip codes. Every Child Succeeds will pair CHWs with Home Visitors to serve 100 first time moms from pregnancy through the first year of the infant's life. The program also aims to serve 80 second time moms. The remaining partners will work under the pregnancy pathway model of care for all women served through the first year of their infant's life.

Additionally, Health Care Access Now (HCAN), Cradle Cincinnati, and Every Child Succeeds have partnered together to assist CHWs and Home Visitors with obtaining education credits. HCAN will serve as the community hub for referral distribution of clients, received from the centralized intake, for thee partner agencies employing CHWs using the community pathways model of care.

As of the January report, 16 CHWs had been hired; five of them (31%) are African American. Seventy-eight percent of all the CHWs employed by the above entities are African American. Needs have been identified for 112 women. CHWs have been contacting women four times on average. Training of the CHWs with HCAN for the Care Coordination System was scheduled to begin in March or April.

Fatherhood (The Center for Closing the Health Gap)

The Center for Closing the Health Gap partnered with Kappa Alpha Psi Fraternity Incorporated, Cincinnati Graduate Chapter, to conduct health forums regarding safe sleep practices. As of the end of 2016, 125 men had attended both events that were offered. The male staff are 100% demographically matched to the population.

Lucas County

Funded Entity: Getting to One, Toledo Hospital Council Northwest Ohio

Total funding: $230,000.00; **SFY 2016**: $1,615,000.00: **SFY 2017** $1,615,000.00

MCP Lead: Paramount Advantage

Lucas County funded initiatives include: expanding the reach of the Toledo-Lucas County Getting to One Pathways HUB; using community dialogues to address racism as a social determinant of health outcomes; and the expansion of mental health and addiction counseling services.

Funded Project Progress

Toledo HUB & CHWs (Toledo-Lucas County Getting to One Pathways HUB)

Funding covered two new care coordination agencies being added to the HUB network in January 2017 bringing the total to 10 care coordination agencies. The first 75 referrals occurred during January and assessments began in February. Pregnancy pathways opened in February.

As of the January update, the Getting to One Pathways HUB was in process of executing contracts with seven community agencies to hire 11 new CHWs. Existing CHWs are 47% African American, 41% White, and 12% Hispanic. Training for new CHWs and their supervisors took place in January 2017. All CHWs will be certified by the Ohio Board of Nursing by the end of spring 2017.

Community Dialogues (Toledo-Lucas County Getting to One Pathways HUB)

Lucas County received funding to address racism as a social determinant of health outcomes. As of the January 2017 update, Lucas County had completed the first set of Community Racism Dialogues (6 sessions per set) and hired a full-time Community Engagement Coordinator in December of 2016.

Sixty-three percent of the attendees at Racism Dialogues were African American. The second set of Dialogues were in the process of being scheduled when the January update was submitted to ODM.

Mental Health and Addiction Counselors (Toledo-Lucas County Getting to One Pathways HUB)

The Toledo-Lucas County Getting to One Pathways HUB received funding to hire two additional mental health counselors whose primary role is to serve the maternal population in the Lucas County zip codes with highest risk of infant mortality.

As of the January update, contracts for three new Mental Health Counselors were being executed.

Mahoning County

Funded Entity:

Total funding: $2,441,747.78; **SFY 2016**: $1,115,997.03; **SFY 2017**: $1,325,750.75

MCP Lead: Buckeye

Mahoning County funded initiatives include: the hiring of centering facilitators and the establishment of two new centering sites; adding two care coordination agencies to the HUB network and community

health workers to support the agencies; hiring community health workers to support their OIMRI project; and providing transportation services for mothers participating in the county-wide programs.

Funded Project Progress

Community Pathways HUB expansion and CHWs

Mahoning County received funding to expand its fairly new Community HUB Pathways to serve additional individuals. The Mahoning County Pathways HUB is planning to become a nationally certified HUB by May 2017.

As of the January update, verbal agreement from one additional care coordination agency had been received and a contract was being developed. CHW recruitment was also underway.

Community Health Workers

The MY Baby's 1st Coalition proposed to expand effective programs in the county that employs CHWs to directly assist women at risk for poor birth outcomes due to the social determinants of health. Both of the newly hired CHWs are African American. As of January 31, 2017, five women were identified as needing assistance; all were African American.

Transportation

As of the January update, the transportation request for proposals was published in the local newspaper, posted on the MCDBOH website, and sent electronically to all partner organizations in the community. Proposals were due to the MY Baby's 1st Coalition on Feb 6, 2017. The contract was to be awarded by Feb. 13, 2017 and services were to commence March 1, 2017.

Montgomery County

Funded Entities: Dayton OEI/Montgomery Co Infant Mortality Coalition; Sunlight Village, Inc.

Total funding: $1,715,138; **SFY 2016**: $862,569; **SFY 2017**: $852,569

MCP Lead: CareSource

Funded initiatives in Montgomery County include: support and education of fathers, and provision of childcare and transportation to enhance an existing Centering Pregnancy program.

Funded Project Progress

Fatherhood (Five Rivers Dayton)

As of the January update, two community events had been held. Four organizations had participated in the two events with a total of eight male attendees. Two thirds of the attendees were African American and staff were 100% matched to the population.

Centering Pregnancy (Life Stages Dayton)

Three care coordination agencies are participating**.** 248 of 301 (82%) women who completed the centering program were African American; 12.5% of employees are African American**.** 15% of participants requesting and receiving transportation were African American. No women had requested childcare.

Stark County

Funded Entity: Canton City Health Department

Total funded: $2,968,154; **SFY 2016**: $1,679,763; **SFY 2017**: $1,288,391

MCP Lead: Paramount Advantage

Stark County funded initiatives include: the creation of an HUB in Stark County; and expanding the CHW and Home Visiting workforce.

Funded Project Progress

HUB (Akron Summit County Healthy Connections Network (HCN) Certified Pathways HUB)

As of January update, several phone calls and meetings had taken place with Akron-Summit HUB leadership to clarify roles and responsibilities of the HUB in relation to Stark County. The HUB leadership has expressed concern there may be a lack of administrative capacity to accommodate the addition of Stark County.

Community Health Workers (Canton-Stark County THRIVE)

Eighty-nine percent of the CHWs are African American. Nine CHWs have been certified through the Ohio Board of Nursing. On January 3rd, six community health workers began their employment with four care coordination agencies: Canton YWCA, Access Health Stark County, CommQuest, and Alliance Family Health Center.

The Partners for a Healthy Baby curriculum is being used to ensure that THRIVE program participants receive information that is appropriate based on the timing of the home visit (1-3 trimester, postpartum). The CHWs, public health nurses and leadership have gone through the Partners for A Healthy Baby curriculum training (an evidence based home visiting model developed by Florida State University). The CHWs and nurses will be evaluated based on the model fidelity.

Centering

There are currently 20 care coordination agencies. One new site, the Alliance Family Health Center (AFHC) was undergoing its site certification by the Centering Healthcare Institute when the program provided its January update. As of the January update, the Centering Pregnancy programming was anticipated to begin during the 1st quarter of 2017. Two CHWs have been employed by AFHC to assist at-risk pregnant women.

Home Visiting (Canton-Stark County THRIVE)

As of the January 2017 update, two CHWs had been certified by the Ohio Board of Nursing; both are African American. Fifty-five women have enrolled in the program; 100% are African American.

Summit County

Funded Entities: Charisma Community Connection; Akron Summit Community Action; Summa Health System; Charisma Community Connection

Total funded: $2,968,154; **SFY 2016**: $1,679,763; **SFY 2017**: $1,288,391

MCP Lead: Buckeye

Funded initiatives in Summit County include: expanding the reach of the Akron Summit Community Action HUB, the use of the Centering Pregnancy model for prenatal care; and providing fatherhood support.

Funded Project Progress

HUB (Akron Summit Community Action HUB)

As of the January 2017 update, the Akron Summit Community Action HUB had connected to 8 care coordination agencies and employed eight health workers (88% African American). Twenty-seven women had been assessed using a comprehensive assessment tool (89% African American). An average of 5 pathways had been opened for each African American participant (compared to 3 for white participants). Six women both initiated and completed a contraceptive pregnancy pathway.

Centering Pregnancy (Project Ujima/Summa Health Equity)

Project supported by infant mortality funding in the Akron area include the facilitation of weekly wellness circles for expectant and new parents; the coordination of facilitators' training for racism dialogues through Everyday Democracy; and coordinating and facilitating support for pregnancy centering circles for the Summa Center for Health Equity.

As of the January 2017 update, the Centering Pregnancy project had connected to eight care coordination agencies. Four women had entered centering pregnancy since the program began in

October of 2016, but none had time to complete the program. The one woman who requested childcare was provided with the service. Four women requested and received transportation.

Fatherhood (Charisma Community Connection/Fame Fathers)

Charisma Community Connection / Fame Fathers is an established local fatherhood initiative aimed at promoting responsible, committed, and involved fathers - primarily in Summit, Stark, Trumbull and Mahoning counties. Charisma Community Connection / Fame Fathers seeks funding to partner with local organizations and agencies to ensure that fathers are playing an active role in the fight against infant mortality.

As of the January 2017 update, 349 men had completed "fathering" events (Fathers walk, coaching, boot camp, outreach parade and grilling event) since the project received funding; 319 (91%) of the participating men were African American. Ninety-nine men completed "parenting" events (family baby shower, parenting sessions, safe sleep sessions, and a parade); 82 (83%) of the participants were African American.

Faith-based support (Mount Calvary Baptist Church)

The five Medicaid MCPs funded Mount Calvary Baptist Church's Minority behavioral health group to engage in extensive community outreach within the 44320 and 44307 zip codes. Efforts include educational opportunities to churches through nursing outreach.

Over four hundred individuals were reached by Mount Calvary Baptist Church during the first few months of project funding. Nearly 100% of individuals reached by Mount Calvary Baptist Church were African American. Eighty individuals had completed the program as of November 2016; 74 (93%) were African American.

Statewide Initiatives in High Risk Infant Mortality Communities

Funding was also received by organizations with a statewide focus for activities such as Medicaid provider cultural competency, fatherhood engagement and safe sleep, and public awareness.

Cultural Competency Training

Funded Entity: Performance Consulting Services

Total funding: $400,000

MCP Lead: Molina

Performance Consulting Services began providing cultural competency training in March of 2016. As of November 2016, 5 community training sessions had been held with a total of 89 participants from 23 different provider offices. All trainings reported to the Ohio Department of Medicaid were held in

Columbus. Future trainings will occurring the spring of 2017 in the Lucas County area with invitations sent to over five area health systems, including but not limited to: Hospital Council of Northwest Ohio, ProMedica and Nexus Healthcare Systems, Toledo Health Department, and several Independent Neighborhood Practitioners.

Fatherhood and Safe Sleep

Funded Entity: Columbus Kappa Foundation

Total funding: $294,645; **SFY 2016:** $165,345; **SFY 2017:** $129,300

MCP Lead: Molina

The goal of the Kappa Safe Sleep Fatherhood Initiative is to assist in education and awareness activities around SIDS and other sleep-related causes of infant death. The goal is to communicate the important role men have teaching other men such as fathers, grandfathers, uncles, brothers, and other community stakeholders about methods to reduce SIDS and other sleep-related causes of infant death.

Kappa Alpha Psi received funding to conduct 20 community health forums throughout the State of Ohio in conjunction with the SID Network of Ohio, with an effort to improve birth outcomes for all Ohio residents. The Columbus Alumni Chapter is collaborating with the East Central Province of Kappa Alpha Psi, the regional governing body and with alumni of the chapters in the geographic areas of the state with the highest infant mortality rates, including Cincinnati Dayton, Akron, Youngstown, Cleveland and Toledo. This collaborative aims to inform the community of the disparate statistics and the impact infant mortality has on the nation, state and their community has a whole.

As of the most recent update in January of 2017, 3,108 men had attended the statewide fatherhood/parenting events. Male staff match the population 100%.

Marketing

Funded Entity: Murphy Epson

Total funding: $1,700,000; **SFY 2016**: $1,000,000; **SFY 2017:** $700,000.00

MCP Lead: United Healthcare Community Plan

Murphy Epson was hired by the MCPs to conduct a public awareness initiative in all target communities. After numerous meetings with the MCPs and ODM, the Our Babies Count (OBC) marketing campaign was developed to focus on direct engagement with moms-to-be, dads-to-be, community members, influencers and more in the nine most at-risk areas in Ohio. Murphy Epson utilized a boots-on-the-ground approach in taking the message to the streets of how families could achieve better birth outcomes. This was done by going to where the people are in their communities and providing opportunities to engage the public to become community ambassadors. This communication has been

achieved through the OBC website, community events, public awareness building, infant mortality coalition and beauty salon/barber shop engagement, and diaper bag distributions.

Quality Improvement (QI) science-based Progesterone Improvement Project (PIP)

In October 2014, ODM received approval from the Centers for Medicare and Medicaid to redesign its improvement projects to include current quality improvement science methods focused on rapid cycle quality improvement and statistical process control. These approved methods allow for more efficient testing of intervention strategies to determine what works.

The current MMC PIP is focused on removing barriers to the initiation and continuation of Progesterone in order to prevent preterm birth. This area was chosen as a state-wide PIP due to Ohio's high rate of infant mortality and the large disparities that exist in black and white infant survival. The PIP is able to address disparities through partnerships with clinical sites located in areas of the state with greater disparities in birth outcomes.

Initial clinical partners were high risk Maternal Fetal Medicine (MFM) clinics within Academic Medical Centers. These sites were located in seven of the nine communities that are considered to be at highest risk for infant mortality: **Akron**--Akron General Medical Center and Women's Health Center at Summa Akron City Hospital; C**anton**--Aultman Physician Center OB/Gyn Clinic; **Cincinnati**--Center for Women's Health University of Cincinnati Medical Center; TriHealth Faculty Medical Center Good Samaritan, Mercy MFM Clinic; **Cleveland**—MacDonald Center for Women's Health, Maternal Fetal Medicine Clinic at Hillcrest Hospital (Cleveland Clinic), and MetroHealth; **Columbus**--Doctors Hospital Women's Health Center, Grant Medical Center, OSU McCampbell Clinic Center for Women's Health, OSU Martha Morehouse MFM, Riverside, and Mt. Carmel West and Mt. Carmel St. Ann's; **Dayton**—Five Rivers Health Centers Center for Women's Health (Miami Valley Hospital); **Toledo—**Promedica Center for Health Services (Promedica Toledo Hospital). Additionally, four federally qualified health centers (FQHCs) participated in the initial effort (the Cincinnati Health Department - Elm Street Clinic, the Erie County Community Health Center, Valley View Health Center and Lorain County Health)

The project identified best practices to facilitate timely provision of progesterone. These included: the development of one standardized pregnancy communication system (as opposed to the six that previously existed) to be used for all five managed care plans and fee for service, managed care plan notification of the county job and family services on the woman's behalf in order to prevent loss of Medicaid coverage during pregnancy, removal of prior authorization, a main contact point at the provider and MCP levels for resolution of problems, and a centralized call center for progesterone candidates at the home health agency level.

During the improvement project, these interventions were largely manual. To facilitate spread of best practices statewide, ODM, the MCPs, contracted home health providers, county pregnancy related

services coordinators, the Ohio Board of Pharmacy, the Government Resource Center, Duet Health, Hewlett Packard Enterprises, and the Department of Administrative Services have been collaborating to create an online pregnancy notification system. This online system, known as the PRAF 2.0, which will be housed on Duet Health's Nurture Ohio website is being designed to allow providers to simultaneously help their patients maintain Medicaid eligibility, notify MCPs of needed services and supports, and in the case of women who are candidates for progesterone to prevent preterm birth, create a progesterone prescription and a referral for home health services for women who prefer to receive their injections at home rather than in their provider's office. This online system will facilitate spread of best practice communication and collaboration with Medicaid providers in the nine communities and then statewide.

Mobile Technology to Improve Patient Engagement

Text4baby, a joint effort between the MCPs, ODM, and CMS, aimed at improving patient engagement and connectivity to Care Management launched in 2014. Ohio MCPs and ODM began working with the Centers for Medicare and Medicaid to collaboratively develop a set of standard, state-specific text messages that all pregnant women in the state of Ohio can receive once they sign up on their phones. Each MCP added customized messages with information about its specific maternal programs. The MCPs promoted this program in member materials and through additional promotional mailings, telephone calls, and promoting enrollment opportunities through their care management program at community events.

Support of State and Local Infant Mortality Reduction Initiatives

Statewide Collaboratives: All five Medicaid MCPs commit senior level and care management staff to attend learning sessions and quarterly meetings hosted by the Ohio Perinatal Quality Collaborative and the Ohio Commission for the Prevention of Infant Mortality (OCPIM), respectively.

Representatives from MCPs serve on OCPIM committees dedicated to addressing the causes of and racial disparities associated with infant mortality. MCPs have actively contributed to the discussion regarding infant mortality by examining billed claims to determine the predictive impact of severe mental illness on infant mortality (CareSource) and how to use reproductive life plans and systematic inquiry around pregnancy intent to promote inter-pregnancy health (Buckeye).

Community Pathway Hubs: Each of the MCPs have developed their own relationship with the Community Health Worker Hubs in Toledo, Cincinnati, Athens and Mansfield who reach into the community to identify and engage pregnant women. The MCPs are furthering these efforts through the above-mentioned infant mortality funding initiatives.

MMCP Progress in Infant Mortality Initiatives in Priority Communities and Implementing Enhanced Care Management Services --SFY 2016 and 2017 update

Our Babies Count: The Medicaid Managed Care Plans in collaboration with the American Academy of Pediatrics, Black Doctors of Ohio, ODH and ODM created "Our Babies Count" to support the many local groups working to save Ohio babies. The website provides resources for pregnant women and those who care about them and provides information on what individual Ohioans can do to reduce infant mortality. It connects individuals to Medicaid health plans and provides instructions in regard to obtaining insurance. In addition to connecting users to insurance and local programs available in their communities, the website educates users around pregnancy health topics, such as preterm birth, smoking during pregnancy, and safe spacing. Resources are organized by Ohio region, allowing users to quickly identify services available in their communities.

Advancing the Science and Implementation of Evidence Based Care

MCPs use evidence based practice guidelines when making utilization management decisions related to Medicaid covered services. Feedback can be offered to individual providers on their adherence to evidence-based practice guidelines and care variances from standard clinical pathways that may impact outcomes or costs. These type of plan activities are being taken to scale across the state through two transformational efforts: 1. a perinatal episode of care in which the MCPs are providing reports on newborn delivery performance including quality metrics and costs; and 2. Comprehensive Primary Care, an infrastructure of patient centered medical homes that by design may provide financial gain at the practice level for women and low birth weight for infants.

Through participation in quality improvement projects aimed at improving care by incorporating clinical expertise and quality improvement science to identify intervention effectiveness, by increasing member engagement in health care decisions, and by remaining flexible and open enough to test new ways of doing business even when they do not have an immediate financial benefit, Ohio's MCPs assist in the advancing of evidence based care. As the MCPs continue to collaborate closely with Ohio's academic medical centers, providers who are nationally renowned for having clinical expertise, provider associations, and quality collaboratives, the opportunities to promote quality care that is inherent to evidence base practice will continue to expand.

Conclusion

As state-supported, community based efforts gain momentum and mature, process measures will be available for each of the nine communities, allowing a more detailed examination of investments. . Process measures for each of the nine communities will fall into the following categories: infrastructure coordination and continuity, health equity workforce investment, social determinants of health, and engagement.

ODM is also currently creating data dashboards for observing longer term outcomes (e.g., progesterone usage, preterm birth, infant mortality) by community, down to the zip-code level. Although, there will be a substantial delay between the initial implementation of community interventions and ultimate infant outcome, having this as a tool for observing changes over time at the discrete zip-code level will assist in tracking quantitative progress. However, these data which are based on claims and vital statistics birth data, will not provide the more intimate portrait of enhanced relationships between community members, providers and the MCPs or the foundation that has been lain for stronger, more coordinated community efforts that is also expected to be achieved through these efforts.