



## SEM PQIC MEETING

Minutes  
April 10, 2018  
1:00 – 4:00 p.m.

### 1. Welcome and Introductions

Vernice Anthony opened the meeting. Introductions were made of all the members. New attendees included:

- Aaron Almasy – McLaren
- Kristine White – Great Start Oakland

### 2. Update on Healthy Baby At Home (HB@H)

Alethia Carr updated the members on the Healthy Baby @ Home (HB@H) Initiative by discussing the approach the team will take to meet our goals. Carr gave an overview of the program's background, including goals, objectives, and strategy. She shared results from the LOCATE Survey In-Person Interview Findings. They are as follows:

#### Mental Health Areas:

- Postpartum depression screening assessed on all
- Mental Health issues referred to social worker
- Minimal community resources for referral
- Lack of continuity with Medicaid coverage

#### Social Disparities Identified:

- Transportation
- Low income
- Lack of family support
- Lack of trust as a barrier/fear of baby removal
- NAS babies
- Education level
- Housing/homelessness

#### Other findings:

- Hospitals had lactation consultant access
- Mentioned WIC, BF Network and BF peer groups
- Referral for home assessments was uncommon
- Social worker make referrals – LPH & HV

Carr shared the team's progress from January to March of 2018, including the identified program partners and the results of the focus group held in February. The Focus Group, which included both women (29) and a man (1) who have experienced home visiting, was organized to help identify the ways in which home visiting programs can be improved by looking at specific needs within the community and by helping to reframe attitudes towards the program to better assist mothers and infants. First, the Focus Group addressed what Home Visiting is and is not. Then the group identified Pros and Cons of Home Visiting. They are as follows:

#### Pros:

- Bonding
- Learning
- Caring Social Workers comes more than the nurse
- Supportive

#### Cons:

- Not one-on-one
- Not professional
- Rescheduled too much
- Nurse comes only about 2-3 minutes
- Nurse is not as caring
- Very cynical and judging
- Not asking questions regarding parent/child
- Not an easy or controlled transition
- Not willing to come to a family's home
- Parent feeling disappointed
- Have a feasible time and limits

The Focus Group also offered some suggested changes and improvements:

- Being consistent
- Staying with the same person
- Being more compassionate
- Being more mindful
- Just because it's a state program, doesn't mean I am in need
- Everyone should be treated the same (i.e., whether someone has a dirty vs. clean home or is in need vs. not in need)
- Home visitor should brush up on their knowledge and be able to answer questions. It is not helpful for them to Google things related to client questions. The client can do this themselves and it doesn't instill confidence in the program.
- Home visitors can be judgmental regarding the food in the home, the living conditions, and how clients discipline and interact with their children.
- Some parents were made to feel like they were being judged on everything and could not be comfortable around their children in the presence of the home visitor.
- Home visitors should understand that families may not want to have people in their homes and may be more comfortable meeting elsewhere.
- They should respect the privacy of the families.
- Some people that come to the homes don't have children, but they judge your parenting

During the discussion of the Focus Group results, a number of attendees shared anecdotal evidence which supported many of the findings. One particular story included a Home Visitor FaceTiming a baby to their friend while speaking in a language not known by the mother. This particular story stands out for a number of reasons, including an invasion of the family's privacy, among many other identified issues. The Focus Group also spoke on specific communication needs and methods, as this area is barrier to the overall success of Home Visiting. They are as follows:

- A lot of mothers may feel overwhelmed once they come home with a new baby and don't want to talk on the phone
- Texting (15 people raised hands)
- Emails (many hands raised, emphasis placed on idea that email addresses rarely change)
- Social media was least popular response
- Mixed responses were given on whether or not a home visiting program should call or if clients should call them when and if they are interested
- Communication needs to be strategic due to some women who may be in domestic violence situations

Overall, it was felt that the Focus Group was beneficial in helping to direct the work of HB@H. Additional concerns about HV programs were brought up by the coalition. Lack of funding for the programs, including assistance for those that may need more than the allotted visits, was identified as a major concern. Consistency of support was also an issue – women expressed a need to not be looked down upon but to be treated with dignity, respect and compassion. A need for a friendly, knowledgeable relationship between mother and Home Visitor was expressed by the Focus Group.

Following this discussion, Iris Taylor provided an update on data collection for HB@H. Hutzel Women's Hospital (Inpatient) was identified as the primary hospital for the program. Baseline data is 2018 1<sup>st</sup> Quarter admissions to NICU or Special Care Unit. The process is to auto generate HV referrals for all mothers with babies in NICU or Special Care Nursery with the intent to develop a default referral in EMR. The data elements are as follows for newborns admitted to NICU/Special Care Nursery:

- % that receive referral to home visiting (MIHP)
- % that accept MIHP services
- % that completed care plan
- % with referral for SDOH support
- % accepting referral (enrolled in MIHP)
- % completing care plan

In addition to this, specific protocol and data elements were set up Hutzel's Outpatient (PNC), as well. Baseline data would also be from the 1<sup>st</sup> Quarter but for referrals to MIHP for prenatal clinic patients. The process is to auto generate home visiting referrals for all Medicaid prenatal clients. The intent is to make HV referral a standard of care. The data elements for all Medicaid clients in prenatal clinic are as follows:

- % that receive referral to home visiting services
- % that accept home visiting services (MIHP)
- % completing the care plan
- % with referral for SDOH support
- % that accept home visiting services
- % that completed care plan

Additional data collection will come from Blue Cross Complete Medicaid Health Plan. Baseline data will also be in 1<sup>st</sup> Quarter 2108 for referrals of pregnant women to home visiting services in zip codes 48221 & 48238. The process is to improve demographic information of Health Plan referrals to MIHP (data scrub). The intent is to improve the use of MIHP resources to engage referrals. Data elements for all pregnant mothers in zips 48221 & 48238 are as follows:

- % with incomplete demographics (no phone)
- % referred for home visiting (MIHP)
- % that accept home visiting services
- % completing care plan
- % continuing home visiting services post-partum
- % referred for SDOH support

The program's process was discussed. It is as follows:

- Data is reported from partners weekly using a data collection tool
- Data will be summarized into a monthly report to MDHHS
- Implementation changes will be reviewed throughout project for lessons
- Weekly follow up to occur with partners to identify points for adjustment
- Working with WSU-College of Nursing for partnership

Additional program partnership successes and needs were discussed. Including that UnitedHealthCare Community Health Plan began making referrals of pregnant members in 48221 & 48238 to HB@H's MIHP partner (AMC). The team is examining ways to capture this impact. There has also been a sincere community interest in the program and that Focus Group participants are interested in continuing dialogue with SEMPQIC. The team is also working with Wayne Home Visiting (GS) to identify areas of collaboration for sustainability.

### **3. Fetal Infant Mortality Care Review Team Recommendations**

Yolanda Hill-Ashford, MSW, presented the FIMR-CRT to the coalition. Detroit's FIMR-CRT consists of a diverse group of individuals from various backgrounds including healthcare, academia, social services, public health, law enforcement, and health plan providers. FIMR recommendations are tied into the 9 goals from the state of Michigan. The team meets monthly and reviews abstracted case summaries and maternal interviews that detail life and death circumstances of infants who died in Detroit, Michigan. The FIMR-CRT team works to identify items delineated in relevant categories specific to each case which include (*but are not limited to*) preconception/interconception care, medical status of mother and infant, family planning,

substance use, prenatal care/delivery, pediatric care, environment, social support, transportation, and chart documentation. Based on the 21 cases reviewed, we compiled relevant themes when present in at least two cases, including the following:

- Late entry to prenatal care
- Homelessness, frequent moves, and/or extreme housing instability
- First pregnancy at age 18 or under (*this infant or past pregnancies*)
- Lack of provider referrals to home visiting agencies, WIC, or prenatal care (*when pregnancy was confirmed at Emergency Department*)
- Involvement of CPS for mother of deceased infant as well as for parents/family of mother
- Untreated mental health issues
- Sleep-related deaths occurred in homes with a safety-approved sleep environment, but infant was sleeping elsewhere at time of death
- Pregnancies were spaced less than 18 months apart
- Lack of financial or emotional support from father of infant
- Tobacco and substance use (most frequently prescriptions and marijuana)

Hill-Ashford presented key FIMR recommendations, specifically the first 6 as she felt that they deal with things happening in Detroit. They are as follows:

1. Whenever a pregnant woman enters an ED, this event should trigger follow-up to ensure entrance into or continuation of prenatal care, as well as referral for home visiting and other appropriate resources	ED staff/intake, hospital social workers/case managers, peer manager, nurse, or other designated hospital staff
2. Family planning method/prescription referral and birth spacing counseling at discharge from hospital	Birth hospitals, OG-GYNs
3. More complete and standardized client information gathered by providers at intake	Intake nurses, physician assistants, intake staff
4. Depression screening and mental health assessment at all prenatal, postpartum, and Well-Woman visits	Intake nurses/PAs, OB-GYNs
5. Provider referrals to home visiting programs (i.e. MIHP) for ALL pregnant women, not only women who “seem” eligible	Intake nurses/PAs, OB-GYNs
6. Ensure that safe sleep education is provided before delivery and provide tailored safe sleep education for younger populations (teen parents, siblings, etc.) and low-literacy populations (below 3 <sup>rd</sup> grade reading level with more pictures, audio/video messages)	DHD, MDHHS, MPHI, local health departments

Hill-Ashford identified some anecdotal support for the top 6 recommendations, as well as some additional information including that, when interviewed, the father’s recollection of events more closely aligned with the abstracted cases than the mother’s. Because of this, it has been decided to target men more closely in this instances. She also expressed that many times these deaths are preventable, and that sometimes that it could be a matter of education and resources regarding safe sleep. The coalition brought up a number of concerns, including that providing information isn’t always the best and that many parents express the desire for a centralized place to find information and resources, such as a Twitter. Hill-Ashford also stressed the need for more people to come to the table to assist in this efforts, including the need for mental health providers.

Mildred Johnson then presented. Johnson conducts the interviews with the mothers and fathers that help to construct the FIMR recommendations. She shared a story about a 17 year-old mother she interviewed, her first ever, that lost her baby due to a safe sleep issue. The next interview was with a woman with 8 children who had been evicted, and shared a bed with her newborn and 2 of her children. After trying for a long time to get in contact with this woman, Johnson went to the home and the father answered and asked her “What about me?” She made the decision to talk with the father, who gave her more information than she thought possible. She knew that he was also hurting.

Johnson shared her personal experiences with Home Visiting, after having severe depression after her having her youngest child. She recalls having the women being judgmental towards her because of the state of her home at the time of the visit and that she still remembers the look the woman gave her to this day. Johnson addressed the social determinants of health affecting these families such as transportation and affordable housing, stressing the need for improvement and collaboration to help develop and build upon the great work being done.

Coalition members thanked Hill-Ashford and Johnson for the work that they are doing, expressing how necessary it is. Support for starting home visiting when the mother is pregnant is expressed, as well as the need for continuing education on safe sleep.

#### **4. Interactive Session on Implicit Bias & Recommendations from Last Meeting**

Vernice Anthony introduces the interactive sessions, building upon the interactive session from the January meeting. Coalition members were asked to quickly read an article and past meeting minutes to help guide the discussion regarding implicit bias. Following, coalition members were instructed to break off into groups to come up with an answer to “What can I do to improve/help/deal with the issues of implicit bias that I believe is impacting the quality of care, particularly of black infants?”

##### **Group 1**

The group discussed a variety of responses from individual/personal to professional/institutional and from co-worker to co-worker. All agreed that one needs to check their own biases individually and that they need to be far more cognizant of the things that they think about as they interact with clients, patients, and their teams. Professionally, it was suggested that implicit biases be addressed with staff by offering regular training and services similar to the way CPR training is done. It was also suggested that co-workers not bring their bad experience with a client to another co-worker in a judgmental way as it dictates future experiences for other individuals, and can decrease the quality of care and attention of care for that client. Systemically, it was agreed that we all need to hold each other accountable. Another group member also suggested going into situations with a sense of innocence, assuming that you do not have the whole story or picture, to not assume everything, which helps to gain more insights and answers.

##### **Group 2**

This group quickly identified that it may be difficult for people to truly know what their implicit biases simply because they are implicit. They suggested that perhaps people could make sure of apps or online quizzes that help to identify individual implicit biases. This could help to educate individuals because they may feel that their bias is one thing, but it may be something different, and they also stressed the importance of being reflective in this matter. They also brought up how adverse experiences in their childhoods go with them everywhere they go and how these experiences can dictate or shape future situations, they we all bring in our traumas. There is a need to respect that and to allow ourselves to be vulnerable in that space, to receive that, and for those that provide supervision to allow supervisees to bring that to them. The group decided to have a “trauma lenses,” which means that everyone has a trauma UNLESS they don’t. They felt that this lenses would help maintain a sense of humbleness in dealing with patients and clients, and with co-workers and everyone in daily life. They also expressed the need to be cognizant of the privilege of being able to enter someone’s home, and that others need to be educated what we do is a privilege and not a right. Just because someone has a need, it doesn’t mean that we should be disrespectful when entering their home. Humbleness and empathy are key. Client education is also important in this matter.

### **Group 3**

Diversity within the group was observed and different opportunities and roles played within individual organizations were identified. Some have the opportunity to teach and mentor physicians and health care providers; people who are public health officials; those in direct contact with communities that are considered to be high-risk for infant mortality or other issues impacting health of infants; people who work for health plans with the opportunity to work with clients in that way. There were different approaches identified by everyone in what they were going to do themselves. Language was a common theme and how that can introduce a lot of implicit bias and barriers. They discussed ways in which providers can be assisted in this area, in communication with patients and how they can be educated and work towards not allowing their implicit biases towards a patient's language get in the way of their work. Resources also came up. It is necessary to not compare different communities based on individual resources, and how best to not create judgements based on that. The group also touched upon checking one's own biases. It was suggested that individuals should learn what their biases are, admit them and then take the time to examine them and set goals towards breaking them down. It was seen that this would help towards the common goal of helping clients and patients.

### **What Was Learned**

While not necessarily new, a member stressed the need to identify one's implicit biases and to openly communicate them as a way to work towards dissolving them. That implicit bias training is more important than ever, especially in the type of work that we are doing. Also, developing a common language that we can all work from would aid in this. There is also a need to not be defensive, to be more self-reflective, and take your own responsibility.

Implicit Bias Test: [implicit.harvard.edu](http://implicit.harvard.edu)

Different tests available based on race, gender, sexuality, etc.

### **Cultural Competency vs. Culturally Humble**

When going into meeting people, one can't take what they have read about a specific group as fact and that we need to be open to engaging people as individuals, separate from what we think we know. There can also be biases within one's own race or culture, and those need to be addressed and understood as well.

### **Suggestions**

It was identified that there need to be more conversations and education around these ideas and that SEMPQIC can provide this, as well as recommendations on how to do this.

Work this topic into the conference in some way.

### **Important Dates**

August 9: IMAC in Kalamazoo

August 16: MIHIP Townhall Meeting at Henry Ford (1 Ford Pl, Detroit), 6 to 7:30 PM

**Next Coalition Meeting**

**TBA**