SEM PQIC MEETING

Minutes
January 16, 2018
1:00 – 4:00 p.m.

1. Welcome and Introductions

Vernice Anthony opened the meeting by sharing a quote from the Rev. Dr. Martin Luther King, Jr. which said, "Of all forms of inequality, injustice in healthcare is the most shocking and inhumane", in honor of the King national holiday. Introductions were made of all the members. New attendees included:

- Lakisha Gwinn – Focus Hope
- Chy Johnson – Starfish Family Services
- Ayana Knox-Potts – Great Start Collaborative Oakland County
- Renee Pearson – St. John Hospital
- Sajita ___ - Meridien Health
- Kathleen Kinney – Focus Hope

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. The team has convened an advisory committee including birthing hospitals, community-based agencies, Medicaid health plans and home visiting agencies to get a deeper understanding of how the MIHPs work in southeast Michigan. The HB@H program is not an evaluation of home visiting programs. The goal is to increase participation in quality home visiting programs from the current 48% statewide by gaining a deeper understanding of the key drivers for the MIHP along with the various elements for prenatal stakeholders, service delivery, consumer/client engagement, payment methods, data utilization and management, and provider education.

The team will be working to gather data in these areas during January and February. Some additional things to consider when moving forward with the pilot include the fact that Medicaid health plans receive nearly all names of newborns in the area and refer them to local MIHPs, yet only 8% actually are enrolled. Dawn Shanafelt from MDHHS shared anecdotal information, based on home visiting programs nationwide, of the need to engage moms in quality home visiting programs during pregnancy. Once babies are born, mothers are less likely to feel the need for someone to come into their home to assist them, which attributes anecdotally to the low enrollment numbers if mothers are contacted after they give birth to enroll in a home visiting program.

The team has also started working with the MDHHS contractor to implement the Plan-Do-Study-Act (PDSA) approach for the HB@H pilot to identify metrics for quality improvement and to demonstrate impact. The team has been meeting with Focus Hope to find out where their successes have occurred so we can duplicate in our target areas.

3. Home Visiting Listening Session – MDHHS wants to hear your voice!

Robin Jacob, consultant from University of Michigan' Youth Policy Lab working for the MDHHS held a listening session with the Coalition. The work of the Youth Policy Lab goal is to conduct applied researched aimed at helping agencies and nonprofits use data and research to do a better job at achieving their missions. The Lab is currently partnered with MDHHS on a project to increase access to home visiting programs across the State. So far, the Lab has studied geographic and demographic trends for individuals enrolled in home visiting programs as a baseline for piloting interventions that may help increase enrollment. The team is also studying what people are doing to address this issue in other areas in the country. They are currently placing emphasis on three different approaches to increasing access to social services like home visiting:

1. Communication and Outreach – involves broad, mass communication campaigns (e.g., billboards, PSAs, etc.) Research also suggests that in-person outreach works significantly better and ensuring warm handoffs when agencies are making referrals work best.
2. Canvassing – involves training individuals in the target populations to serve as ambassadors for a particular health issue and charge them with the responsibility of sharing information within their own social networks. This is one of the most effective way to target the most at-risk population.
3. Addressing social determinants including ways to reduce personal and cultural barriers (e.g., transportation, implicit bias, etc.).

Comments from the coalition included:

- The coalition should look at the current research information the Lab is doing to help guide us so that we are not reinventing the wheel and wasting time coming up with something new if that is not necessary.
- There is a need increase connections between other organizations/services to increase the likelihood of a warm handoff.
- Health Needs in Boston uses undergraduate students to sit in practices to help screen all patients for social needs and ensures a warm handoff. Rebecca Onie hosts a TED Talk on this topic called "What If Our Health Care Kept Us Healthy? Kellogg approached them with concerns about why the medical world is unaware of social service resources that would benefit patients.
- We should focus on asking what women think. Women are having bad experiences and associate home visiting with something negative. Some organizations have stopped using the term home visiting. They call them One on Ones or contacts instead.
- There is not a rating system for MIHPs for mothers to be able to know which ones are good and which are not. The use of technology can help increase awareness and participation. This would be helpful for hospitals to have since they don't allow solicitation in their clinics. This would help providers to know/understand the programs that are available and which are the best.
- Thought to have a singular access point so mothers only have to answer one time.
- MDHHS is coming together with a Maternal Infant Strategy group and coordinated the first Statewide Maternal Infant Health Conference March 5th pulling everyone together to cross pollenate efforts.
- Misconceptions – What are you really doing here? Fear. It is important to cater to them to build a relationship before asking to enter the home.
- Think outside of the box – where do these moms congregate?
- Focus Hope does door to door canvassing and invites people to community events to help connect them to services.

4. Impact of Implicit Bias on Quality in the Perinatal Environment

Dr. Iris Taylor led the discussion on implicit bias and how it may affect the quality of care given to babies. The discussion centered around a study led by researchers at Stanford University entitled Racial/Ethnic Disparity in NICU Quality of Care Delivery. Researchers analyzed quality of care for 19,000 infants in 134 NICUs across California (90% off all units in the state) from 2010 and 2014. The study based its analysis on a composite index known as Baby-Monitor Nine measures of quality of care for infants, which included whether the babies or their mothers received specific treatments before or during their stay or developed harmful conditions after leaving the unit. Asian American and white infants received the highest overall quality of care according to the scoring system followed by African Americans receiving slightly lower quality of care and Hispanic and American Indian infants receiving significantly lower quality of care. However, the disparities were not consistent. In some units African American and Hispanic infants quality of care scores were higher than the white infants. In general, the hospitals with higher quality of care delivered better care to white infant. The higher proportion of African American or Hispanic infants in a NICU, the lower the overall quality scores. The study implies that implicit bias is at play.

Further discussion centered around an online article written by a Neonatologist in Chicago entitled, " I've Unconsciously Contributed to the Racial Gap in Infant Mortality. Not Anymore". The physician working in a NICU wrote the article in response to the Stanford University School of Medicine study and acknowledges her own

implicit bias behaviors in the delivery of services. She admitted straying away from mothers with portable video interpreters or spending more time with mothers who were present during morning rounds than those mothers who only visit in the evenings. This physician who is Japanese stated that even as someone who knows what it is like to be discriminated against, she unintentionally practiced medicine with implicit bias, and therefore anyone could be doing it.

It is important to understand that most implicit bias is not recognized as we run on auto pilot. What can we do about it? Individulally? As a Coalition?

Small Group Discussion Questions and Report Out:
Question #1: What is your reaction to the implication that implicit bias has impacted the study results?

- Patients are uncomfortable speaking to providers when they feel the provider is displaying bias toward them- don't know what questions to ask, or how to address it as it's happening
- Many individuals felt like implicit bias was commonplace and were not surprised by the results of the Stanford University study
- Everyone brings their own set of values with them into their everyday work environments and it is important to recognize that not everyone's values are the same as yours while still being able to provide the same standard of care to everyone without passing judgement
- Minorities take their own cultural competency for granted
- What are checks and balances around applying the standards of care to patients?

Question #2: What are your recommendations to reduce the negative impact of implicit bias?

- It is important to do self-reflection and give yourself permission to be human along with understanding that others are human too and may need someone to guide them in the right direction when it comes to eliminating bias
- Organizations should create a non-judgmental environment for people to share their feelings about this issue in an effort to help make appropriate changes
- Providers need education on implicit bias and health equity and the training should be mandatory
- We cannot be afraid to consistently call out the behaviors in our peers when we are in a position to do so and to check our own behavior and make adjustments when we realize we are displaying bias

Important Dates

- MiAim Webinar January 29th
    - (646) 876-9923 Meeting ID: 292 936 256
- Infant Mortality Advisory Council – February 15 in Ann Arbor
- March 5 conference is full
- Membership – any events to share
- MDHHS events – Dawn Shanafelt, MPA, BSN, RN

Next Meeting
April 10, 2018
1:00 – 4:00
GDAHC Office 30200 Telegraph, Suite 105 Bingham Farms, MI