Welcome to the 2018 SEMPQIC Conference!

Addressing the social determinants of health on the quality of care for infants and moms

Wednesday, September 26, 2018
Focus: HOPE, Detroit
www.gdahc.org/SEMPQIC
Thank you to this year’s vendors!
Addressing the SDOH on the quality of care for infants and moms

OBJECTIVE #1
Understand the impact of social determinants of health, including racism, on the quality of care for women and families.
Addressing the SDOH on the quality of care for infants and moms

**OBJECTIVE #2**

Identify quality improvement opportunities to integrate community resources and/or referrals into existing perinatal services in Region 10.
Addressing the SDOH on the quality of care for infants and moms

**OBJECTIVE #3**

Learn of current research and data trends related to health care disparities that impact perinatal health and promote networking for impact.
Speaker bios are available online

Please visit [www.gdahc.org/SEMPQIC_bios](http://www.gdahc.org/SEMPQIC_bios) or scan the QR code in your conference packet with your cell phone to access our speaker’s biographies.
Interactive implicit bias session

This interactive portion of today’s program is being run through Poll Everywhere, a live polling web application.

To participate, please text MYGDAHC378 to 22333 from your cell phone.

Directions on how to answer will appear on the slides and answers will update on the screen in real time.
REGION 10 OVERVIEW

- Region 10 includes Wayne, Oakland and Macomb counties – approximately 41% of State’s total births and 68% of Michigan’s Black births
- 4 local health departments
- 24 birthing hospitals
- 8 Medicaid Health Plans
SEMPQIC Goal

Create a coordinated, equitable and sustainable network for perinatal care based on best practices and evidence-based strategies that will result in improved birth outcomes for all babies born in Southeast Michigan and narrow the disparity between black and white births, including maternal, perinatal and infant outcomes, including infant mortality.

Long Term Objectives

• Strengthen a Southeast Michigan (SEM) community-based perinatal system of care

• Create a coordinated network for the delivery of evidence-based home visiting services and other supports for mothers and babies

• Establish operating policies, procedures and agreements

• Create a data repository of data elements related to health outcomes for mothers and babies
SEMPQIC Recommended Strategy

Strengthen coordination of services

Promote use of home visitors as care coordinators

Home Visiting can help mothers connect with health plans and services such as WIC.
LOCAtE Survey In-Person Interview findings

-Hospitals had lactation consultant access.

-Mentioned WIC, BF Network and BF peer groups.

-Referral for home assessment was uncommon

-Social worker makes referrals – Local Public Health & Home Visiting
LOCATe Survey In-Person Interview findings

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
LOCATe Survey In-Person Interview findings

Mental health areas noted:

- Post partum depression screening assessed on all
- Mental health issues referred to social worker
- Minimal community resources for referral
- Lack of continuity with Medicaid coverage
GAP ANALYSIS POINTED TO HOME VISITING

- 41% Mi births in Region 10
- Detroit IMR ranges 11.8-16.1 infant deaths per 1000 live births
- Black IMR = 2x white IMR
- Poverty & Maternal stress contribute to IMR
- PTB & LBW contribute to IMR, Black IMR ~ 2x white IMR
GAP ANALYSIS POINTED TO HOME VISITING

• PPOR analysis of IM showed maternal chronic disease before & during pregnancy, no prenatal care, health behaviors during pregnancy (smoking, drinking, other). During infancy- sleep related deaths and illness.

• Chronic diseases – diabetes, obesity and access to health care contribute to IMR.

• Region 10 scored low for Facility Discharge care and Staff Training on mPINQ.

• Hospital CHNA prioritized diabetes, obesity and access to care most frequently.
PRIORITIZATION CRITERIA

• Work will address Gap Analysis
• Measurable – process/impact/outcome
• Evidence focused
• Does not duplicate existing efforts
• Supports existing work
• Address MDHHS IM Plan
• Address SDOH or impacts equity of care
• Value added
• Sustainable
HOT SPOT FINDINGS

48221 & 48238 zip codes

- High IMR ranging 11.8 -16.1 infant deaths/1K live births
- High sleep related infant deaths 12-15/1K live births
- More than 30% residents with incomes <$25K, high unemployment, high number of female headed households with children & w/o husbands
- More than 90% African American
- Combined population ~70K
HEALTHY BABY @ HOME INITIATIVE (HB@H)

• Improve use of home visiting programs and address SDOH for infant survival. Target women of childbearing age, caregivers, prenatal women and infants.
  • Inequity in food security and social support are SDOH
  • WIC & MIHP have both shown positive impact
  • 45.5% of eligible population use MIHP in Detroit/Wayne
  • 25% of eligible population use WIC
  • 2 Detroit zip codes selected from Hot Spot map
**Key Driver Diagram: SEMP QIC Healthy Baby @ Home Initiative** January 2018 - Sept. 2018

**Goal:** Increase the number of healthy birth outcomes and infants experiencing healthy development for the highest risk populations in Region 10 through increased utilization of quality, evidence-based home visiting services.

**Project Aim:** Two zip codes with high population density, poor birth outcomes and significant levels of the social determinants of health related to high infant mortality have been identified as 48221 and 48238. This will be achieved by assuring high quality and evidence-based home visiting programs operating in these zip codes, work with health plans, the local health department, CBOs and birthing hospitals to make appropriate home visiting services available that address the SDOH to 10 percent more eligible families in these zip codes in the next 12 months.

**Key Drivers**
- Prenatal Care Stakeholders/Birthing Hospitals, Medicaid Health Plans, Focus Hope
- Quality Home Visiting Services Delivery
- Consumer Engagement/Education
- Provider Education
- Payment Models
- Data Utilization & Management

**Interventions**
- Referral Sources
  - Policies/Practices
  - Follow up communication
  - SDOH support – Focus Hope
  - MHP-IP contract requirements
- EH-HEV Services
  - HEV agency engages well
  - HEV agency address SDOH
  - HEV agency responds to patient needs
  - HEV agency links with PH provider
- Focus Groups
  - Identify consumer resistance to HEV
- MIHHS HEV Messaging
  - Spread lessons learned for effective consumer engagement
- Medicaid Reimbursement
  - HEV reimbursement
- MIHP Data System
  - State Vital Records Data
  - HEV claims
  - Focus Hope referrals
**AIM:**

Increase the number of healthy birth outcomes and infants experiencing healthy development for the highest risk populations in Region 10 through increased use of quality, evidence-based home visiting services

Target zip codes 48221 & 48238

**Activities:**

Identify high quality, EB Home visiting services

Work with Health Plans, LHD, CBOs & birthing hospitals

Address families’ social determinants that impact health

Use PDSA for rapid quality improvement/enhancements

**Results:**

HV service utilization increases by 10% and

HV referrals from birthing hospitals increase by 10%
Areas for improving home visiting referral processes will be explored in three distinctive groups.

1. Home Visiting referrals from a Medicaid Health Plan to a MIHP agencies, (examine the completeness of demographic data (e.g. telephone number, etc.).

2. Home Visiting referral process for newly enrolled prenatal care patients

3. Home Visiting Referral process for moms whose infants were admitted to either the NICU/Special Care Nursery

**Key Partners**

All My Children MIHP, Blue Cross Complete, Hutzel Hospital, Mother’s Friend MIHP, Positive Images Inc. MIHP, United Healthcare Community Health Plan

Advisory Committee Members included Key Partners, BCBSM, WSU School of Nursing, and Wayne HV LLG. 3 meetings and a webinar were held with the Advisory Committee.
FOCUS GROUP HELD WITH HOME VISITING PARTICIPANTS

Just under 30 participants, including a Dad, mostly African American

Participants understood Home Visiting services

**Liked** Bonding, learning, and support, SWs caring

**Did not like** Short visits (2-3 minutes), rescheduling, judgmental attitudes, uncaring approach, unwillingness to go into home, unprofessionalism

**Suggested** consistent professionals, showing compassion, being knowledgeable to answer questions posed, being open to alternate sites for contact

**Contacting by email and texting were preferred** methods for contact

Participants were very engaged and expressed interest in giving ongoing input
## HB@B Snapshot

### MIHP A (Month of July)

**Prenatal Clinic**

<table>
<thead>
<tr>
<th>Action</th>
<th>Count</th>
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<tr>
<td>Woman approached</td>
<td>128</td>
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<tr>
<td>Assessments completed</td>
<td>43</td>
</tr>
<tr>
<td>Mother relocated</td>
<td>1</td>
</tr>
<tr>
<td>Woman enrolled with another MIHP</td>
<td>56</td>
</tr>
<tr>
<td>Woman not interested</td>
<td>18</td>
</tr>
<tr>
<td>Scheduled Appointments</td>
<td>11</td>
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</table>

### MIHP B YTD

**Prenatal Clinic**

<table>
<thead>
<tr>
<th>Action</th>
<th>Count</th>
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</thead>
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<tr>
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<tr>
<td>Assessment completed</td>
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<tr>
<td>Continuing Services</td>
<td>444</td>
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<tr>
<td>Care Plan Completed</td>
<td>82</td>
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### HB@B SNAPSHOT

#### HEALTH PLAN (JUNE)

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<th>Not Interested</th>
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<tbody>
<tr>
<td>Enrolled</td>
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<tr>
<td>Wrong Number</td>
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<tr>
<td>Unable to Contact</td>
<td>7</td>
</tr>
<tr>
<td>Scheduled Appointments</td>
<td>6</td>
</tr>
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</table>

#### HEALTH PLAN (MAY)

<table>
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<tr>
<th>Completed Assessment with 5 professional visits</th>
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<tbody>
<tr>
<td>reassigned</td>
<td></td>
</tr>
<tr>
<td>Enrolled appointments</td>
<td>3</td>
</tr>
</tbody>
</table>

- 26
Accomplishment 1: Coordinating data collection across multiple entities to collaborate and dedicate their resources is a mark of success.

Accomplishment 2: Increased referrals from NICU and SCN.

Accomplishment 3: Increased access to patients for MIHPs in prenatal care settings.
Barrier 1: Working through several different agencies (i.e., hospitals, clinics, health plans, and MIHPs).
- Each organization has separate reporting systems
- Changing staff
- Lack of electronic systems to track data

Barrier 2: Competing priorities prevents dedication to project
- Lack of consistency in referral process and data reporting

Barrier 3: Discharges from NICU that require skilled nursing generally do not have a referral to MIHP

Barrier 4: Approximately 40% of women at these facilities have private insurance and are ineligible for MIHP enrollment, yet they still are part of a high risk population
HB@H 2018 – LESSONS LEARNED

• Meeting with discharge planners improved referrals for NICU and SCN babies
• Perinatal stakeholders in Region 10 are thirsty for insight into addressing social determinants of health
• Personal contact in the prenatal clinic increases consideration of accepting home visiting services
• Need for coordination between prenatal clinics, birthing units and other MIHPs that mothers have already been enrolled into
• Useful to continue collaboration with agencies that support home visiting efforts – Like Wayne LLG, MDHHS, local health depts., Medicaid health plans, etc.
SEMPQIC 2019 HB@H QI PLANS

• Continue QI effort with Home Visiting (HB@H Initiative)
• Expand to another home visiting agency
• Expand to another prenatal clinic
• Continue NICU/SCN connection efforts
• Discontinue Medicaid Health Plan initiative
• Access QI/PDSA training opportunities
Q & A
Our Communities, Ourselves: Advancing An Authentic Health Equity Agenda

Renée Branch Canady, PhD, MPA
CEO, MPHI
SEMPQIC
September 26, 2018
“This above all: to thine own self be true, And it must follow, as the night the day, Thou canst not then be false to any man.”

-Polonius, Shakespeare
The journey of a 1000 miles begins with a single step...

Chinese Proverb
A Health Equity Vision of Leadership

Leaders in Public Health are:

• Generally driven by a profound and fundamental sense of **mission**.

• A sense of purpose motivates them to leave the comfort of the sidelines and wade into **controversy**

Health equity means that all have a fair and just opportunity for good health.

Health equity is the ethical and human rights principle or value that motivates us to eliminate health disparities.

-RWJF/Paula Braveman, UCSF
“This requires removing obstacles to health such as poverty, discrimination, and their consequences, including powerlessness and lack of access to good jobs with fair pay, quality education and housing, safe environments, and health care.”
“Patients” experiencing symptoms of heart disease

Shulman, et al. 1999
“Patients” experiencing symptoms of heart disease
Schulman Findings

African Americans 40% less likely to be referred for cardiac catheterization

African Americans rated as having lower income, despite the same occupation

Race and sex of patient affected referral decision, even after adjusting for symptoms

Lowest referral rates were for African Amer. Women

Suggest bias on part of provider; perhaps subconscious vs. deliberate
Self Assessment:
Getting out of our Own Way!

COMPETENCE

Unconscious Competence

Conscious Competence

Unconscious Incompetence

Conscious Incompetence
Advancing a Health Equity Agenda

• **SEEING DIFFERENTLY**
  – Look AND See

• **SAYING DIFFERENTLY**
  – Changing the Narrative

• **DOING DIFFERENTLY**
  – Authenticity
  – Risk Taking
SEEING DIFFERENTLY: A Personal Challenge to Look AND See
“SEEING DIFFERENTLY”
(A Health Equity Lens)

• Seeks out what is unfair in order to reverse or avoid it
• Aspires to apply justice in serving individuals and families
• Recognizes the impact of social resources on the care and behavior of individuals and families
• Identifies and facilitates social opportunities for individuals and families to readily/easily attain well-being
SAYING DIFFERENTLY: A Personal Challenge to Change the Narrative
FOR YOUR PLEASURE
YOU HAVE TO BUY
A TICKET TO ENTER

EQUALITY

EQUITY

CAPITALISM
DOING DIFFERENTLY: A Personal Challenge to Authenticity
An ode to Thee:

“To all the women and men who go to work each day and bring their humanity with them.

They make a contribution to their organization by doing what they do, and they make a contribution to the world (their community) by being who they are while they do it.”

Stephen Lundin & Bob Nelson
Ubuntu: An Inspiring Story about an African Tradition of Teamwork and Collaboration
You have very little morally persuasive power with people who can feel your underlying contempt.

-- Martin Luther King --
Why We Must Tackle Racism, Classism, Sexism Explicitly: Two Arguments and a Challenge

Argument #1

Race, class, and gender oppression in their contemporary forms are pervasive and insidious—each time they are identified, privilege asserts itself to diminish concern over them.

Explaining it away: “I know racism exists, but…”; “You’re just being hypersensitive.”

The fairness paradox: When we focus an intervention on a specific population (e.g. first time African American mothers), the focus often diffuses to “we have to help everyone.”

Benign neglect: an employee “just not fitting in,” certain groups “just don’t show up for our programs.”
Why We Must Tackle Racism, Classism, Sexism Explicitly: Two Arguments and a Challenge

Argument #2

In order to undo our entrenched ideas of “business as usual,” we must actively create a culture where challenges to privilege and oppression are routinely welcomed.

What would this mean?

PERSONAL: We would mutually unpack our own racist (sexist, classist, etc.) assumptions when encountered.

INTERPERSONAL: We would invite challenging analysis of interactions that may be imbued with racism, sexism, etc.

INSTITUTIONAL: We would automatically ask about the consequences of privilege and oppression in any policy/program discussion.

CULTURAL: We would establish a new “normal” for the community, by openly challenging oppression and actively working to eliminate root causes.
Why We Must Tackle Racism, Classism, Sexism Explicitly: Two Arguments and a Challenge

The Challenge

To tackle current forms of oppression explicitly, we must find ways to make conversations about race, class, and gender “tolerable” to people who experience oppression daily AND to people who have no awareness that such oppression occurs = AUTHENTIC RELATIONSHIP

Traditionally privileged group members, when made aware of the oppression of target group members, often feel an urgent need to gain immunity from participation in it.

*If they fail to gain this immunity, their next action is often to leave the conversation.*

Traditionally oppressed group members view dialogue as painful and pointless, after seeing the failure of non-target group members to grasp the truth of their experience.

*If this is not reversed, they will understandably abstain from any effort by the organization to change practice.*
Our Community, Ourselves
(For Equity & for Authenticity)

- Intent versus Impact
- Both / And Thinking
- Increase comfort with discomfort
- Incidental vs Contextual

Institutional Racism
Class Oppression
Gender Discrimination and Exploitation
“Be not weary in well-doing, for in due season you will reap if you faint not!”

The Apostle Paul
Q & A
15 Min Break
Health Systems Interventions to Reduce the Impact of SDOH on Maternal and Infant Mortality Outcomes

Led by Cynthia Taueg, DSN, MPH, BSN, Vice President, Community Health, Ascension

PANELISTS

- Marcia J. Phillips, LMSW, SSW, Case Management & Social Work Services, Maternal Child Health, Henry Ford Health System
- Char’ly R. Snow, Certified Nurse Midwife, Henry Ford Health System
- Paula K. Schreck, MD, IBCLC, FABM, Pediatrician, St. John Providence Health System
- Mercedes C. Williams, RN, BSN, MIHP Coordinator, Infant Mortality Program, Ascension
Q & A
Community Perspectives: Home Visiting Program Utilization

Led by Yolanda Hill-Ashford, MSW, Director, Family and Community Health Division, Detroit Health Department

PANELISTS
- Lakeshia Grant, Home-Base Teacher, Focus: HOPE Early Learning
- Star Rolands
- Renee Perkins
- Jenelle Washington
- Michelle Cabe
Q & A
Interactive Session on Implicit Bias

Led by Joy D. Calloway, MBA, MHSA

If you have not done so already, please text MYGDAHC378 to 22333 in order to participate in this session.

To submit answers, please follow the directions in the presentation.
Implicit Bias: A Primer

Joy D. Calloway, MBA, MHSA
Public Speaker § Corporate Trainer § Problem-Solver
Joy D. Calloway, Inc.

Advantage Health Centers Detroit
Monday, September 24, 2018
What is Implicit Bias?

- Unconscious, involuntary
- Deep-seated, despite best intentions
- Externally reinforced and perpetuated
Have you heard the term "implicit bias" before in your workplace?

Yes

No
Have you heard the term "implicit bias" before in your workplace?

- Yes: 88%
- No: 12%

Poll is full and no longer accepting responses.
How knowledgeable do you believe you are about implicit bias?

- Very: 52%
- Somewhat: 48%
- Not at all: 0%

Poll is full and no longer accepting responses.
Why does Implicit Bias Occur?

- Influencers
- Society
- Media
Consider your significant other or spouse; are they racially/ethnically similar or dissimilar from you?

Similar

Dissimilar
Consider your significant other or spouse; are they racially/ethnically similar or dissimilar from you?

Poll is full and no longer accepting responses

- Similar: 88%
- Dissimilar: 12%
Consider the neighborhood you grew up in; was it racially/ethnically similar or dissimilar from you?

<table>
<thead>
<tr>
<th>Similar</th>
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<tbody>
<tr>
<td>Dissimilar</td>
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</table>
Consider the neighborhood you grew up in; was it racially/ethnically similar or dissimilar from you?

Poll is full and no longer accepting responses

- Similar: 84%
- Dissimilar: 16%
Consider your favorite teacher in elementary school; were they racially/ethnically similar or dissimilar from you?
Consider your favorite teacher in elementary school; were they racially/ethnically similar or dissimilar from you?

Poll is full and no longer accepting responses

- Similar: 68%
- Dissimilar: 32%
Consider your childhood best friend; were they racially/ethnically similar or dissimilar from you?
Consider your childhood best friend; were they racially/ethnically similar or dissimilar from you?

- Similar: 88%
- Dissimilar: 12%

Poll is full and no longer accepting responses.
Consider your workplace; is it (primarily) racially/ethnically similar or dissimilar from you?
Consider your workplace; is it (primarily) racially/ethnically similar or dissimilar from you?

Poll is full and no longer accepting responses

- Similar: 44%
- Dissimilar: 56%
Consider your place of worship; are they racially/ethnically similar or dissimilar from you?
Consider your place of worship; are they racially/ethnically similar or dissimilar from you?

- Similar: 85%
- Dissimilar: 15%
Consider the primary source of your news; are they anchors/writer/editors racially/ethnically similar or dissimilar from you?

<table>
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<tr>
<td>Dissimilar</td>
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<tr>
<td>Unknown</td>
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</table>
Consider the primary source of your news; are they anchors/writer/editors racially/ethnically similar or dissimilar from you?

Poll is full and no longer accepting responses

- Similar: 37%
- Dissimilar: 63%
- Unknown
Consider the members of your social circle; are they racially/ethnically similar or dissimilar from you?

When poll is active, respond at PollEv.com/mygdahc378

Text MYGDAHC378 to 22333 once to join

Similar

Dissimilar
Consider the members of your social circle; are they racially/ethnically similar or dissimilar from you?

Poll is full and no longer accepting responses

- Similar: 73%
- Dissimilar: 27%
Implicit Bias Across Industry Segments

- Law Enforcement
- Education
- Business
- Healthcare
Interrupting Bias

- Awareness
- Education
- Assessment
- Questioning
When I say ______; consider the first picture that pops into your head. Does the person look and sound like you? (i.e. Same race, gender, accent, etc.)

<p>| | |</p>
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<tbody>
<tr>
<td>Yes</td>
<td></td>
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<tr>
<td>No</td>
<td></td>
</tr>
</tbody>
</table>
When I say ______; consider the first picture that pops into your head. Does the person look and sound like you? (i.e. Same race, gender, accent, etc.)

*Poll is full and no longer accepting responses*

- Yes: 76%
- No: 24%
Table Exercise

- Weight/appearance
- Age
- Sexual orientation
- Physical disability
- Political affiliation
- Marital status
Resources


- *Everyday Bias: How the Unconscious Mind Shapes Our World, Our Work* Cook Ross, June, 2014

- *Implicit Bias Review*, Kirwin Institute, 2016

JOY D. CALLOWAY, MBA, MHSA
Public Speaker § Corporate Trainer § Problem-Solver

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joy@joydcalloway.com
313-574-4088
Mother Infant Health Improvement Plan
Our Vision

Zero Preventable Deaths
Zero Health Disparities

We must bridge the gap between public health and private clinical practice to ensure that mothers and infants receive the care needed to improve health outcomes and prevent deaths.

We must remove silos between maternal and infant work to ensure that families are receiving the care needed to prevent deaths.
Southeast MI Town Hall Summary

Town Hall Meetings Provided a Platform to Collect Feedback from the Community

95% of attendees reported that the vision of the MIHIP was clear and understood the long-term goals.*

Provided an opportunity to hear from more community members

*Percentages based on post-event survey data

Key Achievements

Brought organizations together to work towards a common goal and helped spread understanding of the vision

92% of attendees envisioned themselves being a part of improving infant and maternal health.*

Opportunities for Improvement

Include information on legislative updates and legislative buy-in to the MIHIP

Facilitate discussions on how competing agencies can work together

Develop a website/app for reference

Better acknowledgement of satellite town hall participants
Implementation Plan

• Develop community specific goals
  • Select 2-3 strategies based on your community’s needs
  • Be innovative in your execution of the strategies
  • Ensure that goals are measurable

• Utilize Regional Perinatal Quality Collaboratives as backbone organizations for regions

• Targeted Universalism
  • Video link: https://haasinstitute.berkeley.edu/targeteduniversalism
Call to Action

1. Sign up for the MIHIP Newsletter

   Following the event, you will receive an email with a link to subscribe to updates.

2. Pursue partnerships and help bridge public and private work

3. Stay involved

   Continue to provide input as we draft and implement the MIHIP statewide.
Thank you for attending!

The presentation will be posted on the SEMPQIC site.

www.gdahc.org/SEMPQIC