MARYLAND MATERNAL HEALTH TASK FORCE

MEETING REPORT
March 30 & April 30, 2020

This is the report from the first Maryland Maternal Health Task Force meeting that was comprised of two webinars on March 30th and April 30th, 2020. The report outlines terms of reference for the Maryland Maternal Health Task Force and reflects content of meeting presentations and substantive points from five small workgroup discussions held between the two webinars.

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ABBREVIATIONS AND ACRONYMS

CHW, community health workers
CME, continuing medical education
HRSA, Health Resources and Services Administration
HSCRC, Health Services Cost Review Commission
MPRA, Maryland Perinatal Risk Assessment
MCHB, Maternal and Child Health Bureau
MDH, Maryland Department of Health
MD-MHTF, Maryland Maternal Health Task Force
MDMOM, Maryland Maternal Health Innovation Program
MMRC, Maternal Mortality Review Committee
SMM, Severe Maternal Morbidity

WEBINAR ON MARCH 30, 2020

KEY OBJECTIVES

I. **Launch the Maryland Maternal Health Task Force (MD-MHTF);**
II. **Provide an overview of selected maternal health activities and programs;**
III. **Outline the workplan for MD-MHTF workgroups.**

STAKEHOLDER SUPPORT MESSAGES

Ms. Courtney McFadden, Deputy Director of the Prevention and Health Promotion Administration at MDH, representing the State of Maryland welcomed everyone. She acknowledged that the Governor's Office, the MDH and the entire Administration fully support this statewide MD-MHTF and its mission to improve maternal health in Maryland. She noted that the first meeting is co-coordinated by MDH with the Maryland Maternal Health Innovation Program (or MDMOM), which is a collaboration between the Johns Hopkins University, University of Maryland Baltimore County, the MDH, and the Maryland Patient Safety Center. She cited several alarming maternal health statistics in the state before expressing her hope that the first statewide Task Force centered around maternal health will be successful in addressing these and the needs of pregnant and postpartum women in the state.

Remarks by Ms. Michelle Spencer, Associate Scientist and Associate Director of the Bloomberg American Health Initiative at the Johns Hopkins Bloomberg School of Public Health, followed and noted that the situation in Maryland calls for action and for the MD-MHTF to develop a strategic plan for action that builds on recent successes at the state level and on the new funding available to improve maternal health in Maryland.

Dr. Andrew Satin, the Chair of the Johns Hopkins Department of Gynecology and Obstetrics, also welcomed the creation of a statewide Task Force centered around maternal health in Maryland. He recognized that maternal health is a global, national and state priority, and assured the audience that the Johns Hopkins Department of Gynecology and Obstetrics is ready to partner with clinicians and public health colleagues across the state to improve maternal health.

Delegate Jheanellle Wilkins brought her message of support for the MD-MHTF from the Maryland House. In her remarks, she stressed the documented disparities in maternal health outcomes in Maryland – non-Hispanic black women have nearly twice the chance of developing severe complications and nearly three times the risk of dying from pregnancy-related conditions compared with white women. She noted that on the legislative side, she and her colleagues are working to address these disparities, and mentioned several bills related to women's health from the current legislative session. These include HB286, which will ensure the Maryland Maternal Mortality Review Program reflects the racial and ethnic diversity of women impacted by maternal deaths in Maryland, and HB837, which will mandate implicit bias training for perinatal care providers in Maryland.

Next, Ms. Colleen Wilburn, Tile V Director at the MDH and the first appointed Chair of the MD-MHTF, called the meeting to order**.** She reviewed the MD-MHTF objectives, year 1 membership (Appendix B), and terms of reference.

MARYLAND MATERNAL HEALTH TASK FORCE –TERMS OF REFERENCE

MISSION & OBJECTIVES

The MD-MHTF was convened by the Maryland Department of Health (MDH) on March 30, 2020 to coordinate activities and programs aiming to improve the health and wellbeing of pregnant and postpartum women in the state of Maryland. Through collaboration and consensus building, members of the MD-MHTF will provide guidance and advisory support and will make recommendations to the Maryland Department of Health and the maternal health community to meet the following key objectives:

1) Identify state specific gaps in the following areas: maternal health data, delivery of and access to quality perinatal health care services, and relevant laws and health policies for pregnant and postpartum women;
2) Develop a 5-year Strategic Plan to improve maternal health in Maryland, building on the 2020 Maryland Title V Needs Assessment, workplans of on-going maternal health programs in the state, and available maternal health data (e.g. Maryland Maternal Mortality Review);
3) Engage, support, and monitor implementation of maternal health programs in Maryland;
4) Assist with dissemination of maternal health program findings and lessons learned in Maryland and beyond; and,
5) Develop a Sustainability Plan to ensure continuity of work towards improving maternal health in the state of Maryland.

MEMBERSHIP

The MD-MHTF aims to include a broad collaboration of stakeholders representing a variety of organizations serving pregnant and postpartum women in the state, as well as the diversity of geographies, areas of expertise, and racial, ethnic and nativity groups. At a minimum, MD-MHTF Membership should include representation from each of the following groups:

- State government
- State, county and city health agencies
- State multidisciplinary committees that review adverse maternal health outcomes
- Birthing hospital administrators, leadership and clinicians
- Epidemiologists and other scientists
- Relevant professional organizations
- Community groups and organizations serving women of reproductive age
- Payers

MD-MHTF members are invited to serve and are appointed by the MDH. Individuals invited to serve in the MD-MHTF may select a designee or alternate from the same organization they represent, should they be unavailable. The MD-MHTF terms of reference and membership will be reviewed on an annual basis or at the discretion of the MD-MHTF Chair. MD-MHTF membership evaluations will be done to ensure broad and relevant representation of all the

groups noted above and will take into consideration any newly identified needs and recommendations from the MD-MHTF as well as changes in roles and positions within the jurisdictions or organizations represented. Participation in the MD-MHTF is voluntary and monetary compensation is not offered. MD-MHTF members may choose to discontinue their participation by notifying the MD-MHTF Chair.

MD-MHTF Observers, or ex-officio members, can be invited to attend one or more MD-MHTF meetings. These are individuals who have a specific area of expertise and can make meaningful contributions to the Task Force. MD-MHTF Observers will be invited by the MD-MHTF Chair to serve in this role on an as needed basis. Observers will not be involved in consensus building or voting, if such is needed.

Both Task Force Members and Observers may be assigned to one or more workgroups with the purpose of providing specific feedback and recommendations on a specific topic, program or activity. These assignments will be based on expertise.

MEETING FREQUENCY

The MD-MHTF will meet at least 2 times per year, typically in March and September of each calendar year. The MD-MHTF Chair will decide on specific dates for Task Force meetings, send letters of invitation to meetings to all Task Force members approximately 2 months in advance of each meeting, and coordinate the meetings. In-person participation by MD-MHTF members is recommended. A conference line will be set up if in-person meetings are not possible or for members that cannot attend scheduled in person meetings. MD-MHTF meetings will be restricted to MD-MHTF members and any appointed Observers.

ACCOUNTABILITY AND REPORTING

The MD-MHTF meetings will be chaired by a representative from the MDH, appointed by MDH's MCHB Director. MD-MHTF Chair changes are at the discretion of MDH's MCHB Director.

The MD-MHTF is accountable to the MDH. MD-MHTF meeting reports drafted by selected Members and reviewed by all Members will be made available within two months after each MD-MHTF meeting and posted for the public. MD-MHTF members will have 10 business days to review and provide feedback on draft MD-MHTF meeting reports shared by the MD-MHTF Chair.

Changes to MD-MHTF terms of reference noted above can be proposed by any MD-MHTF Member or the MD-MHTF Chair and will be reviewed and approved by MDH's MCHB Director.

MARYLAND TITLE V NEEDS ASSESSMENT

Ms. Colleen Wilburn, Tile V Director at the MDH and MD-MHTF Chair, gave an update on the Maryland Title V Maternal and Child Health Services Block Grant and 2020 Needs Assessment. The grant provides funding for services that promote the health and well-being of women, infants, children—including those with special health care needs—and adolescents. Maryland receives approximately $12 million annually from the Health Resources and Services Administration (HRSA) with the state of Maryland matching approximately $8 million for the program. Every five years, states are required to complete a Needs Assessment to determine priorities for the next five-year period. Ms. Wilburn noted the components of the Title V Needs

Assessment Process, which includes, in order: a 1st Steering Committee Meeting, Public Forums, Planning Sessions, a 2nd Steering Committee Meeting, Maternal/Infant Health and Child/Adolescent Health Planning Sessions, a 3rd Steering Committee Meeting, a public comment period; and then lead to the finalization and submission of the Needs Assessment. The 2020 Needs Assessment is expected to be released in July and used to develop the maternal health Strategic Plan for the following five years.

MARYLAND MATERNAL HEALTH INNOVATION PROGRAM (MDMOM) OVERVIEW

Dr. Andreea Creanga, Associate Professor at the Johns Hopkins Bloomberg School of Public Health and the Director of the MDMOM Program**,** provided an overview of the Maryland Maternal Health Innovation Program (or MDMOM), a 5-year program to improve maternal health in Maryland. MDMOM is a collaboration between Johns Hopkins University, MDH, Maryland Patient Safety Center and the University of Maryland, Baltimore County, and funded by HRSA.

First, Dr. Creanga provided background for the MDMOM program using data from the Maryland Maternal Mortality Review Committee (MMRC), vital statistics, and other published research. She next noted the MDMOM Program objectives and workplan activities.

Objective 1: To improve availability and utilization of state maternal health data.
Key activities

- Disseminate state maternal mortality data through data briefs and other publications;
- Establish statewide severe maternal morbidity (SMM) surveillance and review;
- Develop a Maryland Maternal Health Data Center with 3 functions: a maternal health data dashboard for state maternal health data visualization, a data entry system for SMM surveillance, and a learning management platform for MDMOM trainings and webinars.

Objective 2: To promote and execute innovations in maternal health service delivery.
Key activities

- Facilitate quality improvement activities in the state through statewide quality collaboratives and hospital-level facilitation
- Develop and offer several trainings to perinatal health providers
    - recognition and management of SMM (online)
    - implicit bias (combination in-person & online)
    - substance use stigma (online)
- Coordinate a statewide perinatal telemedicine program
- Develop education materials on postpartum warning signs for use by home visiting programs in the state

Dr. Creanga also noted the expected results of the MDMOM Program – specifically, to lower the burden of preventable severe pregnancy complications and pregnancy-associated deaths; reduce racial ethnic and nativity disparities in maternal health; strengthen the culture of quality, safety and respect in maternity care; and make data accessible to women, families, health providers and policy makers not only for decision-making but also for accountability.

WORKPLAN FOR TASK FORCE WORKGROUPS

Dr. Jennifer Callaghan-Koru, Assistant Professor at the University of Maryland, Baltimore County, and Ms. Bonnie DiPietro, Director of Operations at the Maryland Patient Safety Center, described the workplan for five MD-MHTF workgroups established to create a vibrant, constructive dialogue for soliciting and incorporating taskforce members' feedback into the strategic plan. The workgroups were formed around important focus areas for maternal health in the state, and these workgroups should provide valuable opportunities for discussion to help shape the state's maternal health Strategic Plan. The five workgroups include: 1) maternal health data workgroup; 2) telemedicine workgroup; 3) quality improvement workgroup; 4) provider training workgroup; and, 5) policy workgroup. Groups were asked to provide feedback on focus areas for the development of the first draft of the strategic plan. For the data workgroup, the focus areas are the development of the SMM surveillance system and the state maternal health data dashboard. The telemedicine workgroup will provide input on the pilot perinatal telemedicine program. The quality improvement workgroup will provide input on facility-based perinatal quality improvement initiatives. The training innovation workgroup will focus on trainings for perinatal health providers supported by the MDMOM program. The policy workgroup will focus on state policies that impact maternal health, including in the areas of healthcare workforce and Medicaid. Dr. Callaghan-Koru emphasized that the focus of each workgroup may evolve over time to be responsive to changes in maternal health programs and needs, and that in the future, MD-MHTF may also see the need to change or add workgroups to more effectively contribute to meeting MD-MHTF objectives.

CLOSING REMARKS

Closing remarks by HRSA's health Scientist, Dr. Theresa Chapple-McGruder emphasized the importance of the work that the MD-MHTF embarks on in Maryland. Ms. Colleen Wilburn, MD-MHTF Chair, closed the meeting and invited Task Force Members to a second webinar to learn about workgroup discussions on April 30, 2020

WEBINAR ON April 30, 2020

KEY OBJECTIVES

I. **Present and discuss summary MD-MHTF workgroup reports;**
II. **Outline the workplan for developing the 5-year maternal health Strategic Plan.**

STAKEHOLDER SUPPORT MESSAGES

Ms. Colleen Wilburn, Tile V Director at the MDH and the first appointed Chair of the MD-MHTF, called the meeting to order**.** She next thanked healthcare providers taking care of mothers and their babies in the midst of COVID-19 and congratulated all of the Maryland organizations that contributed to local and national black maternal health week events.

Maryland Delegate, Ms. Joseline Pena-Melnyk added her thanks and encouragements to MD-MHTF members and offered her support with future maternal health legislation.

WORKGROUP INPUT PROCESS

Dr. Jennifer Callaghan-Koru, Assistant Professor at the University of Maryland, Baltimore County summarized the MD-MHTF workgroup input process and the focus of each workgroup. She noted that the process started right after the first MD-MHTF webinar with workgroups in five areas: quality improvement, training innovation, maternal health data, telemedicine, and policy; and that given the recent profound impact of the COVID-19 pandemic on all aspects of healthcare, the MD-MHTF added a sixth workgroup around COVID-19 in pregnancy. Dr. Callaghan-Koru described the process used for workgroup discussions -- MD-MHTF members were pre-assigned to a workgroup to ensure that a variety of perspectives were represented in each group. Individuals were also invited to share any additional suggestions they might have within the focus of other workgroups. Workgroup leaders for each group solicited written feedback using google documents that included background information and a series of 3-5 questions. Three of the groups also hold group (i.e. quality improvement workgroup) or individual (data and policy workgroups) calls to elicit additional feedback or seek clarification on written answers.

QUALITY IMPROVEMENT WORKGROUP REPORT

Compiled by Dr. Jennifer Callaghan-Koru

BACKGROUND

Quality improvement (QI) initiatives are important vehicles for speeding the translation of research evidence and best practices into routine maternal healthcare and services. While many hospitals and organizations are always involved in some form of QI work, there are several large QI initiatives related to maternal health. At the national level, the Council on

Patient Safety in Women's Healthcare brings together experts to develop clinical guidelines on important maternal health topics; the Alliance for Innovation in Maternal Health, a HRSA-funded program, works with states to implement these guidelines in the form of patient safety bundles. At the state level, the Maryland perinatal and neonatal quality improvement collaborative has brought birthing hospitals together to tackle topics such as early elective deliveries, reducing primary cesarean deliveries, and improving care for neonatal abstinence syndrome.

QUESTIONS AND SUMMARY FEEDBACK

Q1. What quality improvement skills training will most benefit labor & delivery implementation teams and how can this best be delivered?

- There were three themes in the feedback for this question. The first was around the categories of QI skills topics that would be beneficial for maternal health QI leaders. These included: 1) analytical skills, such as data analysis, root cause analysis and driver analysis; 2) project management skills, such as team formation, planning, and consensus building; and, 3) several specific approaches to QI, such as self-assessments and the use of simulations.
- Workgroup members made suggestions about how to approach coordination of QI initiatives and trainings. These included engaging partners, such as managed care organizations, and aligning or integrating QI work with initiatives to reduce disparities.

Q2. What other statewide resources for quality improvement in maternal healthcare would you recommend promoting or developing for Maryland?

- This question generated priority areas for QI, particularly substance use disorder, and resources available to help providers address those including from ongoing initiatives in the state, such as innovative Medicaid and behavioral health programs (e.g., MOM Model program, Medicaid home visiting program);
- There were also several suggestions to identify and promote best practices among Maryland healthcare and community organizations (e.g., Bmore for Healthy Babies, Prince Georges' Transforming Neighborhoods).

Q3. What resources are available for maternal education on warning signs of postpartum complications and how would you rate their quality?

- The discussion around this question highlighted a real need in this area, particularly felt by many mothers. The taskforce members were aware of many resources that included some educational messages around postpartum health and warning signs, that can be reviewed by MDMOM (e.g., Association of Women's Health Obstetric and Neonatal Nurses, Baby Basics, Becoming a Mom, DC Primary Care Association, Healthy Families America, Partners for a Healthy Baby).
- For the development or adaptation of resources, suggestions included attention to literacy level and appropriate for communities with different languages or learning needs; and the benefits of including local information and resources were raised. There was also an interest in postpartum resources on topics not typically addressed through postpartum education, such as substance use disorder, psychiatric care, diabetic care, and cardiovascular health.

Q4. How might home visiting programs coordinate with healthcare providers when their clients experience or have questions about signs of postpartum complications?

- Establish a direct line for home visitors to health care providers;
- Contact providers when home visitors make a referral for emergency or follow-up care;
- Use of telemedicine during home visits;
- Review new local innovations in home visiting data systems;
- An ongoing challenge for maternal health services in the community is the need to improve referral services for mental health and substance use disorder treatment.

SUMMARY RECOMMENDATIONS

- Provide trainings build providers' QI skills;
- Address needs for services in priority areas (e.g., substance use disorders, mental health, chronic conditions) in the prenatal and postpartum period;
- Leverage synergies between various partners in QI and disparities work;
- Identify and promote locally successful QI models;
- Strengthen links between community-based services and healthcare providers;
- Develop and test locally adapted materials to meet postpartum education needs for home visiting programs.

TRAINING INNOVATION WORKGROUP

Compiled by Dr. Kelly Bower

BACKGROUND

Data from the Maryland Maternal Mortality Review and analysis of SMM data demonstrate that provider and health system factors are key contributors to adverse maternal outcomes in the state and that wide racial disparities exist in maternal health outcomes. In response, key professional organizations and HB-837 in Maryland have called for maternal health care providers to receive training on implicit racial bias. Similar to the general population, individuals working in health care settings have implicit biases, defined as "attitudes or stereotypes that affect our understanding, actions, and decisions," which are activated involuntarily and without awareness. Additionally, the general public and health providers commonly hold negative perceptions of persons with a substance use disorder, particularly pregnant and lactating women – all the while, drug overdose is the main contributor to pregnancy-associated mortality in Maryland.

Implicit bias and stigma in health care can affect communication, relationship building with patients, clinical decision making, and patients' experiences. Single, stand-alone implicit bias or stigma trainings for providers will not likely lead to unit-wide culture change. Based on experiences from other states, implicit bias trainings need to be repeated and coupled with tailored reflection and facilitation activities for hospitals. Additionally, hospital-level policies and practices must be designed to identify and mitigate bias, stigma, and discrimination.

QUESTIONS AND SUMMARY FEEDBACK

Q1. Are the proposed trainings and modes of delivery meeting the needs of maternal health care providers in Maryland? Are there other critical training areas that the MDMOM Program should address or critical content to include in the proposed trainings?

- Workgroup members agreed that the current plan for training offering by MDMOM is relevant and important;
- They offered additional training topics, including best practice for the recognition and management of postpartum hemorrhage, preeclampsia, and infection; best practice for the support of normal physiologic birth and role of doulas; teamwork and communication; and, completion of Pregnancy Risk Assessments.

Q2. What potential barriers could there be for implementing the trainings proposed by the MDMOM Program? What steps can we take to avoid them?

- The potential barriers identified were all related to ensuring high hospital and provider participation. In particular there was discussion of challenges related to hospital and provider buy-in and engagement; provider availability, time, and amenability to trainings; hospital understanding of benefits of participation; and provider beliefs that they do not have biases that impact the care they delivery.

Q3. How can implicit bias trainings be designed to effectively address disparities in maternal health and ensure high hospital and maternal health care provider (obstetricians, midwives, and nurses) participation?

- To address the barriers noted in question 2 and ensure high hospital and provider participation, respondents identified a need for leadership buy-in, leadership and provider understanding of the benefits of participation, and an organizational culture that values bias training. Suggestions for ensuring provider participation included continuing medical education (CME) credits, making the trainings mandatory (e.g., state board, mandatory department meetings) and built into yearly competency, and provide incentives/rewards for providers and hospitals that participate;
- Suggestions to assure trainings are effective and providers participate centered around the use of engaging strategies. It was suggested that trainings use online formats with opportunities for in-person follow-up, and that online modules be interactive;
- Respondents also pointed out that training efforts are best when they are sustained and engage providers through reoccurring trainings;
- For implicit bias trainings, it was noted that they should use state and hospital-level data to describe disparities and the need for the training as well as provide evidence about how implicit bias impacts care and contributes to disparities. Other suggested strategies included use a pre-training self-assessment of implicit biases, strategies that are personal and emotional in nature such as video testimonials from patients and providers about how implicit bias impacts care and examples of bias that occurs within each hospital to dispel idea that bias exists at other institutions but not one's own institution, and opportunities for reflection and interactive practice of techniques to avoid stereotypes.

Q4. How can the MDMOM Program best coordinate across the various hospital-based initiatives, including the proposed trainings and QI initiatives? What support can the Task Force provide to hospitals?

- Suggested strategies for integration and support of training and QI come from both the Training Innovation and Quality Improvement Workgroups. In particular, respondents indicated a need to integrate trainings and QI initiatives into each institution's existing training programs, existing training avenues (e.g., grand rounds), and any existing initiatives to address disparities;
- It was also suggested that efforts be made to accompany trainings and initiatives with information, tools, and consultation that provide clear steps, a plan and obvious targets to support hospital implementation. Finally, it was suggested that forums be created for reporting progress and accountability.

SUMMARY RECOMMENDATIONS

- Identify opportunities to integrate trainings into existing hospital initiatives;
- Provide clear evidence for the need and benefits of trainings;
- Use hybrid (online with in-person facilitation), highly interactive and personalized training formats;
- Provide hospitals with clear guidance and support for implementation of training and QI initiatives;
- Provide CME credits and other incentives for hospitals and providers, drawing on specific suggestions from the data workgroup;
- Consider feasibility of and opportunities for adding additional training topics.

DATA WORKGROUP REPORT

Compiled by Ms. Amy Hobbs

BACKGROUND

The aim of the MD-MHTF Data Working Group is to provide recommendations on the planning, development, and coordination of maternal health surveillance and data analytic activities in Maryland. Currently, there is no centralized and easily accessible data source for all relevant maternal health data in Maryland. This poses difficulties in the triangulation of data sources and related learning that would come from the ongoing and systematic analysis of key maternal health data. Although Maryland has existing processes in place for maternal mortality surveillance and review at the hospital and state level, there is currently no ongoing, timely, and standardized surveillance system that has been enacted to routinely collect, review, analyze, and disseminate information about SMM in Maryland. As a result, detailed information on SMM in Maryland is currently limited. A systematic and ongoing process for case identification, clinical review, and reporting is needed to identify state-wide issues and make recommendations for quality improvement.

Improved data integration through linking[1] available and applicable data sources would provide valuable new insights on temporal trends and geographic variations, determinants of health, health outcomes, and hospital performance for a broad spectrum of indicators at the hospital, regional and state levels. Ongoing reporting of aggregated data through a data dashboard would provide health care providers, policy makers, planners, administrators, and researchers with timely, relevant and quality data to facilitate systems planning, guide decision making, and enhance knowledge generation and translation.

QUESTIONS AND SUMMARY FEEDBACK

Q1. The MDMOM Program will select 6-7 birthing hospitals (levels I-IV, different practice models, wide range of annual delivery volumes, teaching and non-teaching) as pilot sites for severe maternal morbidity (SMM) surveillance and review. How should additional hospitals be involved after the completion of the pilot phase?

- After the results of the pilot evaluation, a risk assessment model for each level of hospital can be used to guide the decision as to which additional hospitals to involve. This could involve selecting hospitals that have recently had the greatest number of pregnancy-associated deaths and highest burden of SMM;
- Circulate a survey to hospitals to ascertain interest and select those willing to participate voluntarily;
- Include hospitals that are representative of maternity service delivery in Maryland, including sufficient geographic representation and hospitals that provide care to vulnerable populations by race and ethnic backgrounds or socioeconomic status);
- Incentivize hospital participation in exchange for advanced access to their data regarding key performance measures or SMM.

Q2. Following an approach developed in Illinois, the MDMOM Program will establish a statewide SMM review committee similar to the statewide Maternal Mortality Review Committee. What process should be used to establish a statewide SMM review committee? Who should be members of the SMM review committee?

- Include the SMM Review Committee as a sub-committee within the existing structure and process of the Maternal Mortality Review Committee in Maryland;
- The Maternal Mortality Review Committee could be approached to identify membership for the SMM Review Committee;
- Specify the expertise required and circulate requests for expression of interest for membership to a broad network, including to statewide and jurisdictional health departments, birthing hospitals, community and professional organizations, advocacy groups, and other key stakeholder groups. Once applications have been reviewed, membership selection could be based on the applicant's qualifications and availability;
- Ensure broad and multidisciplinary membership, including:
    - Health care providers, such as General Obstetricians, Maternal Fetal Medicine Specialists, Midwives, OB Anesthesiologists, Nurse Practitioners, and Perinatal/partum Registered Nurses;
    - Personnel with expertise in surveillance, data analytics and data interpretation, such as Data Quality Specialists, Epidemiologists, and Data Analysts;

[1] Linkages refers to matching individual- or hospital-level data sources through unique identifiers using probabilistic or deterministic methodology.

    - Leaders and hospital administrators, such as hospital directors, Managed Care Organization representatives, Federally Qualified Health Center representatives, community leaders (i.e., faith, neighborhood associations, Community Health Workers), and hospital champion leaders;
    - Patient advocates, including women or persons who have experienced SMM, and peer/birthing support persons, such as doulas;
    - Individuals with specific expertise, including: 1) a broad understanding of how preconception health influences maternal morbidity and mortality; 2) mental health and substance use, abuse, and treatment; 3) prevention of intimate partner violence; and, 4) chronic diseases in pregnancy.
- The workgroup stressed the importance of diversity in membership in terms of geographical representation (i.e. counties, rural/urban), hospital delivery volume and level of care, teaching and community hospitals, and various racial/ethnic backgrounds and professions.

Q3. The MDMOM Program will develop a maternal health data dashboard to increase data availability and facilitate data use for knowledge generation, communication, and decision making. What maternal health indicators should be prioritized for inclusion on the data dashboard?

- A few workgroup members confirmed that the indicators that were circulated (Appendix C) were sufficient for the purpose of facilitating data use for knowledge generation, communication, and decision making on the data dashboard;
- The workgroup stressed the importance of moving beyond individual-level measures of socio-economic and demographic status, such as income and education, and also ensure measurement of community-level factors, such as neighborhood social deprivation indices and wealth/income. One member highlighted that the significance of community-level measures factors on maternal health outcomes has been well established and would allow the ability to plan, develop and evaluate community-level interventions to address SMM and maternal mortality in Maryland;
- Indicators should be prioritized to ensure reporting of indicators of preconception health, prenatal care and pre-existing medical and obstetric conditions, including obesity, hypertension, diabetes, cardiovascular disease, mental health and substance use, intimate partner/gender-based violence exposure;
- For SMM, the workgroup suggested that it would be important to disaggregate SMM rates by diagnosis and procedure group codes and level of preventability;
- For public reporting at the hospital level, the workgroup identified the importance of risk adjusting indicators to more accurately compare between hospitals based on level of care and differences in patient populations;
- For indicators reporting on quality improvement efforts at the hospital level, feedback included leveraging existing indicators and measures that hospitals are already required to report on in Maryland.

Q4. What data sources should be considered for data linkages at the state level, keeping in mind feasibility, timing of release and need for data use agreements, mainly with MDH, for data access?

- Workgroup members confirmed that the data sources that were circulated (Appendix C) were sufficient for the purpose of data linkages at the state level and for facilitating data

use for knowledge generation, communication and decision making on the MDMOM Program data dashboard;

- The workgroup indicated several data sources that should be explored for data linkages at the state level, including:
    - Regulatory and reporting data sources, such as The Joint Commission and Maryland Institute for Emergency Medical Services Systems;
    - Administrative and claims data sources, such as Health Services Cost Review Commission (HSCRC) and Center for Medicare and Medicaid Services;
    - Vital Statistics Administration;
    - Surveillance systems and surveys, such as the Pregnancy Risk Assessment Monitoring System and the Behavioral Health Administration overdose and treatment program data.

Q5. How should hospitals be recognized for participation in statewide maternal health MDMOM Program activities and improvements in maternal health indicators over time?

- Several workgroup members mentioned giving kudos and recognition in the form of banners or announcements;
- Public reporting of risk-adjusted performance measures and hospital score cards to encourage healthy competition, while also establishing an environment where there is collaboration and trust;
- HSCRC expressed interest in exploring methodologies that include financial incentives to hospitals or physicians for improved performance on quality measures;
- Offer advanced access to data regarding performance in exchange for voluntary participation in program activities;
- Adding additional staffing or providing capacity building activities to birthing hospitals for the purpose of quality assurance or data analysis at the hospital level.

SUMMARY RECOMMENDATIONS

- The workgroup recommended including the SMM review committee as part of the existing Maternal Mortality Review committee, while ensuring a multi-disciplinary, geographical representative, and ethnically and racially diverse membership of stakeholders, clinicians, community and professional organizations, and inclusion of the patient voice;
- For data sources and indicators, the workgroup recommended to explore ability to link available and relevant data sources to comprehensively report on a broad range of maternal health indicators, stratified by individual and community characteristics;
- For hospital incentives, the workgroup recommended to ensure that there is an established environment of trust, collaboration and sharing of lessons learned between hospitals. Specific incentives cold include public recognition, financial or data related incentives for hospitals.

TELEMEDICINE WORKGROUP REPORT

Compiled by Dr. Andreea Creanga

BACKGROUND

In Maryland, Maternal-Fetal Medicine (MFM) services are concentrated primarily in Annapolis and Baltimore leaving community hospitals and providers in rural areas with limited access to MFM specialists and cutting-edge medical technologies. The two Level-IV hospitals (Johns Hopkins Hospital and University of Maryland) serve as referral hospitals for a majority of obstetric emergencies from 6 Level-I and 11 Level-II birthing hospitals.

Several other initiatives to offer expert consultation for obstetric emergencies in lower level birthing hospitals in the state are noted below:

- Through a 5-year (07/2017-06/2021) grant from the MDH, the Johns Hopkins Hospital provides perinatal services through on-site education and consultation in Maryland areas lacking such services, including Level I and II birthing hospitals and community health centers. The program provides 6 or more in-person, MFM physician visits each month to address obstetrical needs identified by the local providers. In addition, a nurse coordinator provides in-person, onsite outreach and education activities for nursing staff at the currently 17 Level I and Level II hospitals as well as at Federally Qualified Health Centers offering obstetric services and local health departments, giving priority to rural areas. While this outreach model establishes a level of trust and familiarity between local providers and MFM specialists and/or nursing staff, it only benefits those who receive in-person visits.
- The Perinatal Telemedicine Program at University of Maryland aimed to provide accessible MFM consultation and high-risk pregnancy management to all women in the state of Maryland. Through this program, remote consultation with an MFM physician occurred through the use of video conferencing over a secure internet connection. Types of consultations made available through the telemedicine program included: consultation for maternal medical condition in pregnancy, diabetes consultation and management, genetic counseling, HIV care coordination, preconception counseling. From personal communication with Dr. Katherine Goetzinger – the program was not funded from external sources and providers used their clinical time to offer these services.
- The Center for Peripartum Optimization in Obstetrics is a specialized perioperative center at Johns Hopkins Hospital focused on improving the wellbeing of expecting mothers. The goal of the center is to prepare for a safe and stress-free delivery through coordinating care management between anesthesia, obstetricians, and the labor and delivery unit staff. The center offers appointments for preoperative consultation for non-obstetric surgery, high-risk obstetrical anesthesia consultation, follow-up examinations and anesthetic preoperative consultation.

The most frequently cited perinatal telemedicine, telehealth or telementoring models in the country include the ANGELS (Antenatal and Neonatal Guidelines, Education and Learning System) Program, a joint program of the University of Arkansas for Medical Sciences (UAMS) College of Medicine, the Arkansas Department of Human Services and the Arkansas Medical Society; and Project ECHO (Extension for Community Healthcare Outcomes), a collaborative model of medical education and care management that empowers clinicians to provide better care to more patients close to their homes.

QUESTIONS AND SUMMARY FEEDBACK

Q1. What birthing hospitals in Maryland would benefit most from telemedicine for expert MFM consultation, genetic counseling and/or other services for pregnant and postpartum women?

- Workgroup members noted that hospitals outside of the DC Baltimore metro region, Western Maryland, Southern Maryland and the Eastern Shore are at particular disadvantage for accessing high-risk obstetric and obstetric anesthesia care and consultation;
- Nine of the 17 Level-I and Level-II birthing hospitals were mentioned by more than one work group member.

Q2. What concerns or barriers might hospitals have for adopting telemedicine for perinatal services, and how can a pilot program help address these concerns and barriers?

- There were four main categories of barriers noted by workgroup members:
    - Reimbursement issues were mentioned by all respondents. There is limited experience with coding, billing, insurance reimbursement, and no sustainable funding resource for compensating providers;
    - Technical capabilities will need to be in place for hospitals to adopt telemedicine for perinatal services –patients, providers and staff may not be familiar with the equipment and other technical resources needed for telemedicine; hospitals may not have access to equipment and IT services to support telemedicine or may not have compatible systems that would enable the needed interaction and coordination – a key example here is the use of different EMR platforms in different hospitals and the associated barriers accessing medical records.
    - There is need for providers to offer services and a clinic coordinator to support telemedicine activities.
    - On the patient side, patients' engagement will be key to the success of the program, and this may depend on factors beyond their control such as language barriers.

Q3. Are there telemedicine models that can be used to inform the design of a pilot perinatal telemedicine program in Maryland?

- A number of models have been cited by workgroup members. Most notably, the statewide ANGELS program in Arkansas. The program aims to create access to high-risk obstetric services through education and support, evidence-based obstetrical and neonatal guidelines, a call center, and telemedicine consultations;
- Also noted were the telemedicine programs at JHU and UMD, babyscripts, Maven Clinic, and Penn Medicine Heart Safe Motherhood.

Q4. What will be key challenges for developing a larger perinatal telemedicine program and how can we overcome these challenges?

- First, it was noted that telemedicine cannot replace bedside care during pregnancy and the postpartum period;

- Compared to feedback on barriers regarding hospitals' initial adoption of telemedicine services, when discussing challenges with a statewide perinatal telemedicine program, limitations with patients' engagement for telemedicine were more prominent. Technology was mentioned, especially the need for a reliable internet connection for the system to work and the use of different EMR systems, which is expected to create difficulties with documentation;
- Another key challenge mentioned was the need for a sustainable funding mechanism for a statewide program. With COVID-19, Medicaid allows phone calls, zoom, any communication to be billed. Whether this will this continue beyond the pandemic is unknown;
- Another key challenge for a sustainable telemedicine program in Maryland is selection of providers for consultation services, especially given shortage of some types of providers, for example genetic counselors.

SUMMARY RECOMMENDATIONS

- Conduct a needs assessment to identify the need for telemedicine services (MFM, ultrasound screenings, genetic counseling, postpartum follow-ups), predict workload, assess the key resources required as well as training needs for providers & staff to be involved in activities;
- Ensure access to equipment & IT services to support telemedicine;
- Establish protocols & documentation processes between hospitals outside of University of Maryland and Johns Hopkins systems during the pilot phase of the program;
- Coordinate staff and provider telemedicine trainings;
- Coordinate hiring of new, or use of existing, clinic coordinators to support the telemedicine program;
- Plan to measure patient engagement and patient satisfaction with telemedicine services;
- Consider additional funding options, such as additional grants, value-based care model(s), Medicaid reimbursement, and potentially identify an individual to serve in this key financial counselor for the program.

POLICY WORKGROUP REPORT

Compiled by Dr. Nicole Warren

BACKGROUND

Starting with the 2018 Preventing Maternal Deaths Act (HR1318), maternal health policies at the federal and state levels have created valuable infrastructure and resources and served as levers to initiate or reinforce maternal care and payment initiatives designed to improve maternal health. In Maryland, a number of maternal health-related legislative initiatives have become, or are expected to soon become, laws that will have direct implications for perinatal healthcare providers and payment for maternal health services. Several Maryland Medicaid-related policies are already in place that directly impact maternal health. Other states have enacted Medicaid policies that have not been adopted in Maryland but have the potential to improve maternal health outcomes in our state.

The workgroup recognized not only the effects of structural racism on direct patient care, but on social determinants, such as housing, employment and violence, that put women at high risk for

poor health outcomes. While newly approved legislation—such as HB837, requiring implicit bias training for all perinatal healthcare providers in Maryland—begins to address racism in maternal health care, more initiatives are needed to address racial disparities in maternal outcomes. The questions asked, priorities identified, and recommendations made in this summary are intended to address the disparities resulting from social and health inequities.

In addition, our workgroup was cognizant of complementary efforts, some ongoing or recently concluded. For example, the Maryland Health Care Commission's Study of African American Infants and Infants in Rural Areas was published in October of 2019. This study's recommendations align with the policy priorities noted by our workgroup members, such as improved care coordination and expanded and enhanced access to services. In addition, Maryland's 2020 Title V Assessment is forthcoming, and its content may further guide the direction of this policy group.

Policy related to maternal health include programmatic, legislative, and payment initiatives that have implications for each of the other MD-MHTF workgroups: data, quality improvement, provider training, and telemedicine.

QUESTIONS AND SUMMARY FEEDBACK

Q1. What are the main workforce-related, provider compensation, and policy/legislative issues impacting maternal health in Maryland?

- Workgroup members raised workforce-related issues relevant for both childbearing women and providers who make up the maternal health workforce. For childbearing women, workforce related policy is an approach to address the deleterious impact of structural racism. Specifically, employment and micro-finance related programs were proposed. The latter have been associated with improvements in maternal health and in reducing intimate partner violence, a leading cause of preventable maternal death. Workgroup members stressed the importance of paid maternal leave for childbearing women. Unstable housing and transportation, which in turn impact employment, were also noted as barriers to maternal health care;
- Workforce issues specific to maternal health care providers were focused on the paucity of providers in rural settings. One potential approach proposed was to offer loan repayment to encourage rural practice;
- Policies to ensure screening, treatment and referral to treatment for perinatal mood and anxiety disorders and substance use were stressed by workgroup members. These services should be compassionate, non-stigmatizing and non-punitive;
- Doula services were repeatedly highlighted in workgroup member feedback. Respondents acknowledged doulas' potential to improve quality of care and maternal health outcomes. The role of doulas was compared to those of community health workers (CHWs), and there was agreement that standardizing the training and certification of doulas, similar to CHWs, should be addressed by policy. This standardization could both facilitate payment for services and offer employment to women to provide support within their own communities.

Q2. What are the main Medicaid policy issues impacting maternal health in Maryland?

- Responses focused on Maryland Perinatal Risk Assessments (MPRAs). Workgroup members emphasized that drug overdose, homicide and suicide account for large

numbers of preventable deaths and noted the role of MPRAs in identifying women at high risk for such;
- Managed care organizations are mandated to follow up on MPRAs; workgroup members proposed measures to ensure accountability for this follow up, arguing that necessary referrals are currently not being made. Other workgroup members questioned the extent to which MPRAs are consistently and completely submitted and the role that late presentation to antenatal care may play on MPRA follow up. Any of these MPRA-related issues would delay and/or fragment care potentially contributing to poor outcomes;
- Importantly, workgroup members stressed the need to address continuity of care with respect to expanded Medicaid programs.

Q3. Are there state-level Medicaid policies, programs, or initiatives not currently in place in Maryland that should be discussed by the Task Force and considered by the Maryland legislature? If so, which policies and how might they be used to improve maternal health?

- Extending postpartum coverage beyond 60 days was noted as an important policy priority. Several workgroup members strongly advocated for extending Medicaid coverage up to one year postpartum. Other workgroup members noted that many women covered by Medicaid will still qualify after pregnancy and should be supported in exploring continued receipt of Medicaid benefits. For women who do not qualify, many will qualify for subsidies on plans provided by the Maryland Health Connection, the State's official health insurance marketplace. Workgroup members proposed ways to support women to transition to the State's marketplace;
- Similarly, coverage for doula services under Medicaid was proposed. Similar coverage is currently covered in six other states.[2] However, workgroup members noted that reimbursement from Medicaid will likely be contingent on buy-in from the Centers for Medicare and Medicaid Services and, to get that, doulas would need to be accredited. In addition, workgroup members raised concern that the relatively low rate of reimbursement for doula services as compared to private payors will continue to create barriers to doula services;
- The importance of screening for perinatal mood and anxiety disorders, intimate partner violence and substance use disorders was stressed by workgroup members. In addition, the workgroup noted that Maryland was identified as a state where substance use disorder and mental health treatment were covered benefits under Medicaid even if beneficiaries were only eligible for maternity care services;[3]
- Efforts to ensure continuity of care between primary and pregnancy care are needed. These efforts could be connected to existing programs to reduce non-communicable diseases in Maryland, for example, the MDH initiative to reduce diabetes. Ensuring continuity between primary and pregnancy care will decrease pregnancy risk (for example, hypertension may be controlled preconception) and morbidity later in life;
- Policies that promote breastfeeding and improved nutrition should be put in place since they benefit both the mother and the infant. Although there is federal legislation to ensure mothers have a lactation space at work, Maryland does not have a state law to that effect. Adding a state law on this issue was proposed.

[2] Mathematica. (n.d.) Inventory of state-level Medicaid policies, programs, and initiatives to improve maternity care and outcomes. Prepared for: Medicaid and CHIP Payment and Access Commission. https://www.macpac.gov/publication/inventory-of-state-level-medicaid-policies-programs-and-initiatives-to-improve-maternity-care-and-outcomes/

[3] Ibid.

Q4. Are there legislative initiatives, other than Medicaid, at the federal level or in other states that should/could be considered in Maryland?

- Paid parental leave, mental health services, transportation means and the need to prioritize housing programs for mothers made homeless due to intimate partner violence were all discussed. Need for transportation in rural areas and the need for mental health services that are not limited to the postpartum period were emphasized.

Q5. What are the practical implications of the current maternal health-related legislation in Maryland for maternal health in the state?

- Workgroup members repeatedly stressed the importance of the current HB837, which requires perinatal care providers in Maryland to participate in implicit bias training by January of 2022. Members argued that a 'one-off' training will not be effective and that the effort needs to be part of a broader cultural shift. Recommendation was made for training related to implicit bias should begin at pre-licensure levels and continue through one's professional life;
- There was concern regarding the composition of and potential for objectivity of influential bodies such as the statewide MMRC, county-level maternal mortality review teams made possible by HB 796, and the proposed statewide Severe Maternal Morbidity Review Committee. Composition of the MMRC will be increasingly diverse given HB 286. The composition of a future statewide SMM review committee should mirror this commitment by including those most impacted by SMM. In addition, re-reviews of SMM cases and maternal deaths can increase the objectivity of reviews;
- As telehealth becomes more widely used, especially in the context of the current pandemic, it is important to consider those with poor internet connectivity and/or living in shelters or group homes were access to devices and services may be limited.

SUMMARY RECOMMENDATIONS

- Pilot strategies and examine costs/benefits associated with extending pregnancy coverage through the postpartum year;
- Support efforts to articulate doula training and certification in Maryland;
- Advocate for insurance coverage, both public and private, for doula services;
- Mandate screening and evidence-based treatment protocols for perinatal mood and anxiety disorders and substance use disorders;
- Examine the role of MPRAs in addressing risks related to mental health, substance use, and violence in women;
- Create a mechanism of accountability for completion and follow up of MPRAs;
- Ensure paid parental leave;
- Pilot programs that show promise in their ability to promote financial independence among childbearing women at highest risk for poor outcomes;
- Advocate for diverse membership of SMM and maternal mortality review teams.

DEVELOPMENT OF A MATERNAL HEALTH 5-YEAR STRATEGIC PLAN IN MARYLAND

Ms. Courtney McFadden, Deputy Director of the Prevention and Health Promotion Administration at MDH, outlined the process by which a 5-year maternal health Strategic Plan will be developed by the MD-MHTF, building on the 2020 Maryland Title V Needs Assessment, the workplans of ongoing maternal health programs in the state, and informed by available maternal health data in the state. A draft Strategic Plan developed by MDH and key state partners will be shared with MD-MHTF members by August 15, 2020. Written feedback from MD-MHTF members will be due on August 30, 2020. Upon integration of all feedback received, the Strategic Plan will be presented and discussed during the 2nd MD-MHTF meeting on September 14, 2020. The final version of 5-year maternal health Strategic Plan in Maryland will be made publicly available by the end of September 2020.

CLOSING REMARKS

Ms. Courtney McFadden, Deputy Director of the Prevention and Health Promotion Administration at MDH, closed the meeting and invited all MD-MHTF members to join the 2nd MD-MHTF meeting on September 14, 2020.

Appendix A
Webinar Agendas

Maryland Maternal Health Task Force

Agenda

Webinar 1 – Monday, March 30th, 2020 (1:00-2:30pm EST)

1:00 Welcome Remarks

Ms. Courtney McFadden
Deputy Director, Prevention and Health Promotion Administration, Maryland Department of Health

Dr. Joshua Sharfstein
Vice Dean for Public Health Practice, Johns Hopkins Bloomberg School of Public Health

Dr. Andrew Satin
Chair, Gynecology and Obstetrics Department, Johns Hopkins School of Medicine

Delegate Jheanelle Wilkins
Member, Maryland House of Delegates

1:20 Maryland Maternal Health Task Force: Goals & Membership

Ms. Colleen Wilburn
Chair, Maryland Maternal Health Task Force & Title V Program Manager, Maryland Department of Health

1:35 Maryland Maternal Health Innovation Program (MDMOM) Overview

Dr. Andreea Creanga
Director, MDMOM Program & Associate Professor, Johns Hopkins Bloomberg School of Public Health

2:05 Introduction to Maryland Maternal Health Task Force Workgroups

Delegate Stephanie Smith
Member, Maryland House of Delegates

Dr. Jennifer Callaghan-Koru
Assistant Professor, University of Maryland, Baltimore County

Ms. Bonnie DiPietro
Director of Operations, Maryland Patient Safety Center

2:25 Final Remarks and Next Webinar

Dr. Theresa Chapple-McGruder
Project Officer, Health Resources and Services Administration

Ms. Colleen Wilburn
Chair, Maryland Maternal Health Task Force & Title V Program Manager, Maryland Department of Health

Maryland Maternal Health Task Force

Webinar 2 – Thursday, April 30th, 2020 (1:00-2:00pm EST)

Agenda

1:00 Welcome Remarks

Ms. Colleen Wilburn
Chair, Maryland Maternal Health Task Force & Title V Program Manager, Maryland Department of Health

Delegate Joseline Pena-Melnik
Member, Maryland House of Delegates

1:05 Maryland Maternal Health Task Force Workgroup Reports

Process to Elicit and Compile Workgroup Feedback & Quality Improvement Workgroup Report
Dr. Jennifer Callaghan-Koru, Assistant Professor, University of Maryland, Baltimore County

Training Workgroup Report
Dr. Kelly Bower, Assistant Professor, Johns Hopkins School of Nursing

Data Workgroup Report
Ms. Amy Hobbs, Research Associate, Johns Hopkins Bloomberg School of Public Health

Telemedicine Workgroup Report
Dr. Andreea Creanga, Associate Professor, Johns Hopkins Bloomberg School of Public Health

Policy Workgroup Report
Dr. Nicole Warren, Associate Professor, Johns Hopkins School of Nursing

Covid-10 Ad-hoc Workgroup
Ms. Briana Kramer, Nurse Researcher, Johns Hopkins Bloomberg School of Public Health

1:40 Questions & Answers

1:55 Process to Develop Maternal Health Strategic Plan

Ms. Courtney McFadden
Deputy Director, Prevention and Health Promotion Administration, Maryland Department of Health

2:00 Adjourn

Appendix B
Maryland Maternal Health Task Force Members 2019/2020 (Alphabetical order)

Linda Alexander, MD MPP FACOG
Medical Director, Maternal and Child Health Bureau - Maryland Department of Health

Lauren Arrington, CNM
Certified Nurse Midwife, St. Joseph's Hospital

Robert Atlas, MD FACOG
Chair, Department of Obstetrics and Gynecology - Mercy Hospital
Immediate Past Chairman, Maryland American College of Obstetricians & Gynecologists

Ann Burke, MD
Vice President Medical Affairs, Holy Cross Hospital

Sherrie Burkholder, MSN MHA RNC- OB C-EFM
Manager, Quality/Informatics - Adventist Healthcare

Katie Cabrera, MSN RNC-OB C-EFM
Clinical Nurse Specialist, Peninsula Regional Medical Center

Jennifer Callaghan-Koru, PhD
Assistant Professor, University of Maryland, Baltimore County

Keena Carter, RN MSN CCRN
Director of Nursing, Charles County Department of Health

Elizabeth Chung
Executive Director, Asian-American Center for Frederick

Andreea Creanga, MD PhD
Associate Professor, Johns Hopkins School of Public Health

Theodore Delbridge, MD MPH
Executive Director, Maryland Institute for Emergency Medical Services Systems

Bonnie DiPietro, MS
Director of Operations, Maryland Patient Safety Center

Maisha DouyonCover, MPH
Senior Program Manager, Office of Minority Health and Health Disparities - Maryland Department of Health

Dianne Feeney, MS
Associate Director, Maryland Health Services Cost Review Commission - Maryland Department of Health

Melissa Fleming, CNM
President, Maryland Affiliate of the American College of Nurse Midwives

Katherine Goetzinger, MD
Assistant Professor, Obstetrics and Gynecology - University of Maryland Medical Center

Laura Goodman
Division Chief, Office of Innovation, Research and Development, Health Care Financing - Maryland Department of Health

Kari Gorkos, MS
Senior Director, Public Education & Programs - Mental Health Association of Maryland

Maria Grant, JD
Vice President, Public Policy - CareFirst BlueCross BlueShield

Laura Herrera Scott, MD MPH
Medical Director, State Insurer Amerigroup

Nora Hoban, MPA
Senior Vice President, Maryland Hospital Association

Lee Hurt, DrPH MS
Director, Vital Statistics Administration - Maryland Department of Health

Desirée Israel, MSW LCSW-C
Founder, MotherlandCo., LLC
Collaborative Partner, The Bloom Collective

Alyson Jacobson, LGSW M. Ed.
Director of Home Visiting Services, Prince George's Child Resource Center

Clark Johnson, MD MPH
Clerkship Site Director, Obstetrics and Gynecology - Anne Arundel Medical Center Chair, Maryland Maternal Mortality Review Committee

Barbie Johnson-Lewis, MSW
Psychotherapist & Social Worker, Maryland Chapter of the National Association of Social Workers

Aliya Jones, MD MBA
Deputy Secretary, Behavioral Health Administration - Maryland Department of Health

Sandy Kick, MSPH
Senior Manager, Office of Innovation, Research and Development, Health Care Financing - Maryland Department of Health

Patricia Liggins
Doula, Birth Supporters United

Tanay Lynn Harris, BA
Founder, Mommy Up
Co-Founder, The Bloom Collective

Courtney McFadden, MPH
Deputy Director, Prevention and Health Promotion Administration - Maryland Department of Health

Dillon McManus, MSW
Coordinator of Special Projects, MIECHV Program - Maryland Department of Health

Lorraine Milio, MD
Assistant Professor, Obstetrics and Gynecology - Johns Hopkins University
Obstetrical Director, Center for Addiction and Pregnancy - Johns Hopkins Bayview Medical Center

Janice Miller, MSW LCSW-C
Director, Programs and Clinical Services - House of Ruth

Russell Moy, MD MPH
Health Officer, Harford County Health Department

Donna Neale, MD
Assistant Professor, Johns Hopkins University

Laurence Polsky, MD
Health Officer, Calvert County Health Department

Destiny-Simone Ramjohn, PhD
Vice President, Community Health & Social Impact - CareFirst BlueCross BlueShield

Tennile Ramsay, RN
Nursing Program Consultant, Patient Safety, Maryland Office of Health Care Quality - Maryland Department of Health

Gene Ransom III, JD
Chief Executive Director, Maryland State Medical Society (MedChi)

Maxine Reed-Vance, PhD (abd) MS RN
Deputy Director, Quality Assurance and Clinical Affairs - Baltimore Healthy Start

Megan Renfrew, MPA JD
Chief, Government Affairs and Special Projects - Maryland Health Care Commission

Amanda Rodriguez, JD
Executive Director, TurnAround, Inc.

Jeanne Sheffield, MD
Professor, Obstetrics and Gynecology - Johns Hopkins University Director, Division of Maternal-Fetal Medicine - Johns Hopkins Hospital

Stephanie Slowly, MSW
Chief of Staff, Behavioral Health Administration - Maryland Department of Health

Colleen Wilburn, MPA
Program Manager, Title V Program - Maryland Department of Health

Andrea Williams-Muhammad, CBD CPD CCBE
Executive Director, Nzuri Malkia Birth Collective

Becky Wimmer
Executive Director, Maryland Academy of Family Physicians

Appendix C
List of maternal and perinatal health indicators and corresponding data sources in Maryland

INDICATOR NAME[1,2]	DATA SOURCE[2]
Antepartum & Maternal Health Characteristics	
Number of Prenatal Care Visits	HSCRC & MDH VSA
Trimester of First Prenatal Care Visit	HSCRC & MDH VSA
Prenatal Care Provider Type	HSCRC & MDH VSA
Multiple Gestation (Singleton, Twin, Triplets)	HSCRC & MDH VSA
Parity (Nulliparous, Parous)	HSCRC & MDH VSA
Pre-pregnancy BMI	HSCRC & MDH VSA
Appropriate Weight Gain During Pregnancy	HSCRC & MDH VSA
Diabetes Mellitus in Pregnancy	HSCRC & MDH VSA
Hypertensive Disorders of Pregnancy	HSCRC & MDH VSA
Alcohol Use Before and During Pregnancy	PRAMS
Cigarette Smoking Before and During Pregnancy (NPM 14)	HSCRC & MDH VSA
Pregnant women who call the Quitline to access smoking cessation services (SPM 5)	MDH CTPC Quitline Data
Pregnant women who receive dental care during pregnancy (NPM 13)	PRAMS or MCHB Oral Health Data
Barriers and Facilitators to Dental Care During Pregnancy (SPM 8)	MDH Office of Oral Health Program Data
Substance Use Disorder in Pregnancy	HSCRC & MDH VSA
Intrapartum & Labor and Delivery Characteristics	
Premature Rupture of the Membranes	HSCRC & MDH VSA
Labor Induction	HSCRC & MDH VSA
Labor Augmentation	HSCRC & MDH VSA
Mother Transferred Higher Level of Care for Maternal / Fetal Indications	HSCRC & MDH VSA
Birth Attendant at Delivery	HSCRC & MDH VSA
Non-medically Indicated Early Elective Deliveries (NOM 7)	CMS Hospital Compare
Elective Delivery (PC-01, NFQ# 0469)	HSCRC & MDH VSA
Type of Vaginal Delivery (Spontaneous, Vacuum, Forceps, Forceps and Vacuum)	HSCRC & MDH VSA
Vaginal Delivery Rate	HSCRC & MDH VSA
Obstetric Trauma Rate – Vaginal Delivery with Instrument (PSI 18)	HSCRC & MDH VSA
Obstetric Trauma Rate – Vaginal Delivery Without Instrument (PSI 19)	HSCRC & MDH VSA
Perineal Trauma (3rd – 4th degree laceration, cervical tear)	HSCRC & MDH VSA
Incidence of Episiotomy (NQF# 0470)	HSCRC & MDH VSA
Vaginal Birth After Cesarean (VBAC) Delivery Rate, Uncomplicated (IQI 22)	HSCRC & MDH VSA
Vaginal Birth After Cesarean (VBAC) Rate, All (IQI 34)	HSCRC & MDH VSA
Primary Cesarean Delivery Rate, Uncomplicated (IQI 33)	HSCRC & MDH VSA

Cesarean Birth - Low Risk NSTV (PC-02, NFQ# 0471, SPM 1)	HSCRC & MDH VSA
Cesarean deliveries among low risk first births (NPM2)	HSCRC & MDH VSA
Cesarean Delivery Rate, Uncomplicated (IQI 21)	HSCRC & MDH VSA
Hospitals that integrate service practices/policies to support the reduction of low-risk cesarean deliveries (ESM 2.1, SPM6)	MDH MCHB Data & Maryland Patient Safety Center Data
Maternal and Perinatal Mortality and Morbidity	
Cause of maternal death	MDH MMRC & VSA
Cause of pregnancy-associated death	MDH MMRC & VSA
Cause of pregnancy-related death	MDH MMRC & VSA
Infant mortality rate per 1,000 live births (NOM 9.1)	HSCRC & MDH VSA
Maternal mortality rate per 100,000 live births (NOM3)	MDH MMRC & VSA
Neonatal mortality rate per 1,000 live births (NOM 9.2)	HSCRC & VSA
Number of pregnancy-associated deaths	MDH MMRC
Number of pregnancy-related deaths	MDH MMRC & VSA
Perinatal mortality rate per 1,000 live births plus fetal deaths (NOM 8)	HSCRC & MDH VSA
Post neonatal mortality rate per 1,000 live births (NOM 9.3)	HSCRC & MDH VSA
Pregnancy-associated mortality ratio per 100,000 live births	MDH MMRC & VSA
Pregnancy-related mortality ratio per 100,000 live births	MDH MMRC & VSA
Preterm-related mortality rate per 100,000 live births (NOM 9.4)	HSCRC & MDH VSA
Severe maternal morbidity rate per 10,000 delivery hospitalizations (NOM2)	HSCRC
Population & Hospital Characteristics	
Birthing Hospital	AHA
Home births - planned	HSCRC & MDH VSA
Maternal Hospital Level of Care	AHA
Place of delivery	HSCRC & MDH VSA
Total number of deliveries	MDH VSA
Total number of live births	MDH VSA
Postpartum & Postnatal Characteristics	
Birth Weight (<2500g, <1500g, 1500-2499g) (NOM 4)	HSCRC & MDH VSA
Contraceptive Care – Postpartum (NQF# 2902)	HSCRC & MDH VSA
Infants Born with Fetal Alcohol Exposure in the Last 3 months of Pregnancy (NOM 10)	PRAMS
Parents/ caregivers who receive education about developmental screening (ESM 6)	MCHB Data
Preterm Birth (Preterm <37 weeks, Early Preterm <34 weeks) (NOM 5)	HSCRC & MDH VSA
Rate of infants born with neonatal abstinence syndrome per 1,000 delivery hospitalizations (NOM 11)	HSCRC
Receipt of a postpartum visit after delivery	PRAMS
Sociodemographic Characteristics	
Maternal Age at Delivery	HSCRC & MDH VSA

Maternal Education	HSCRC & MDH VSA
Maternal Insurance (Primary Payer) at Delivery	HSCRC & MDH VSA
Maternal Marital Status at Delivery	HSCRC & MDH VSA
Maternal Hispanic Origin	HSCRC & MDH VSA
Maternal Race	HSCRC & MDH VSA
Maternal Race/Ethnicity	HSCRC & MDH VSA
Median Household Income Quartile by Maternal Residence	HSCRC & MDH VSA
Region or County of Maternal Residence	HSCRC & MDH VSA
Rural or Urban Maternal Residence	HSCRC & MDH VSA
WIC Client During Pregnancy	HSCRC & MDH VSA

[1]Indicators ordered alphabetically by domain name
[2]List of abbreviations in alphabetical order: AHA - American Hospital Association; CMS - Center for Medicare and Medicate Services; CTPC - Center for Tobacco Prevention and Control; ESM - Evidence-based Strategy Measures; HSCRC - Health Services Cost Review Commission; IQI - Inpatient Quality Indicators; MDH- Maryland Department of Health; MDH MCHB - Maryland Department of Health Maternal Child Health Bureau; MDH VSA - Maryland Department of Health Vital Statistics Agency; MMRC - Maternal Mortality Review Committee; NOM - National Outcome Measures; NPM - National Performance Measures; NQF - National Quality Forum; PC - Perinatal Care (Joint Commission Indicators); PRAMS - Pregnancy Risk Assessment Monitoring System; SPM - State Performance Measures; WIC - Women Infant Children

Appendix D
Compendium of Taskforce Workgroup Feedback
***Verbatim if provided in writing; based on notes if provided during calls.**

Data Workgroup Feedback

Feedback from the Data Workgroup is provided below by question, including answers to questions by individual Workgroup members and summarized discussion from follow-up calls.

Q1. We will select 6-7 birthing hospitals (levels I-IV, different practice models, wide range of annual delivery volumes, teaching and non-teaching) as pilot sites for severe maternal morbidity (SMM) surveillance and review. How should additional hospitals be involved after the completion of the pilot phase?

- Recommend focusing on the hospitals that have recently had the greatest number of pregnancy-associated deaths.
- Put out a survey to ascertain interest. It would be beneficial to have hospitals that are interested in doing this, and it would increase response rates. Also, important to look at the geography of the hospitals to make sure there is a variety of locations - rural and non-rural.
- Based on the results of the pilot evaluation, a risk assessment for each level hospital should guide the decision as to which additional hospitals (and level) to involve. For example, if the risk assessment is based on the percentage of severe maternal morbidities per deliveries and a level 1 institution has 100 deliveries and 10% are classified as SMM compared to a 10,000-delivery institution at 10% the decision may be to add more level 1 institutions.
- Request for volunteer hospitals.
- Could use a combination of number of births by race and ethnicity and using the hospital assigned disproportionate share percentage associated with each hospital as an indicator of vulnerable populations. Using the percentage by hospital that CMS publishes each year may be useful in this regard.
- The Maryland HSCRC is interested in supporting hospital participation in this initiative. Hospitals have volunteered for other initiatives in exchange for advanced access to data regarding performance.

Q2. Following an approach developed in Illinois, we will establish a statewide SMM review committee similar to the statewide Maternal Mortality Review Committee. What process should be used to establish a statewide SMM review committee? Who should be members of the SMM review committee?

- The SMM should be a part of the Maternal Mortality Review Committee process.
- Engage jurisdictional health departments, community-based organizations and advisory boards, Insurers, FQHCs, Chronic Disease specialist.
- An application process to determine interest and to obtain qualifications.
- Partnership should be beneficial to the desired outcomes and should be balanced (urban, rural, suburban), racial and ethically balanced, and aware of biases. Obstetricians, L and D nurses, Midwives, Doulas, QA personnel, MFM, head of departments, MCO reps, patients who have experienced SMM. Community leaders (faith, neighborhood assoc. presidents, CHWs, Peer support persons-recovering) epidemiologist, racial/ethnic diversity.
- Recommend membership of persons with a broad understanding of how preconception health influence maternal morbidity and mortality. There should also be representatives with

mental health and substance abuse treatment expertise. Finally, there should be representatives with experience in preventing intimate partner violence.

- Balancing a multidisciplinary approach with hospital staff constraints will be key. In its first year, it may make sense to identify hospital champion leaders representing teaching and community hospitals, and various Maryland geographies. Lessons learned about remote collaboration may also be used to entice participation from some experts who could be invaluable to this process but may worry about the time commitment. Possibly a 3-year term would be reasonable for continuity and intensity of commitment.
- The SMM review committee should include people from a variety of backgrounds including providers, midwives, researchers, clinicians, epidemiologists, among others. A good starting point will be to start with the MMR Committee and reach out to contacts there.
- You could specify the expertise areas you are looking for and do a call for representatives from broad cross section of birthing hospitals and community stakeholders. This would include clinical, quality improvement, data, and policy experts from physician and hospital and community stakeholder groups and contributors.

Q3. We will develop a maternal health data dashboard to increase data availability and facilitate data use for knowledge generation, communication, and decision making. What maternal health indicators should be prioritized for inclusion on the data dashboard?

- Appendix 3 indicators look good.
- Pre-existing condition (CVD, previous complications in L and D/postpartum) ethnicity/race, obesity, C/S, prolonged second stage of labor, community of risk, and measure of socio-economic risk beyond individual-level income and education measures. To apply this measure, we would need to know the census tract of the individual (Geo-coding). Health is in the community so if we are looking at community-level intervention to address both SMM and MM we would be well served to have this information.
- For community-level measures, this article is a good reference: https://hqlo.biomedcentral.com/articles/10.1186/s12955-020-1275-x
- Data related to preconception health (obesity, hypertension, diabetes, heart disease).
- Data on perinatal mental health.
- Data on perinatal substance abuse treatment. Data on identification of women at risk for Intimate Partner Violence (IPV), and uptake into programs to assist with women experiencing IPV.
- Most of the indicators available on the birth certificate - number of prenatal care visits, initiation of prenatal care, time between pregnancies, pluralities, birth order, prior preterm birth, delivery method, any complications. Hospitalization data would be useful for diagnoses and cost information.
- Learning from Illinois as a way of knowing what indicators, for example, asking them if they could only report out on a limited number of variables which ones would they pick? Social determinants will be key.
- If the starting points are ICU/CCU admissions and receiving blood of a certain quantity, we could work backwards to assess the key causes that have associated interventions and make sure we have those data points that account for a high percentage of potentially avoidable cases.
- Pregnancy intention (4 categories), chronic disease (Y/N), adequacy of prenatal care
- For Severe Maternal Morbidity, reporting diagnosis-based and procedure-based indicators
- Please refer to email to see table format for the above suggested additions:

- See Table 2., p.29 of 2008-2012 New York SMM Report: https://www1.nyc.gov/assets/doh/downloads/pdf/data/maternal-morbidity-report-08-12.pdf
- Table 2., p.2 of 2013-2014 New York SMM update: https://www1.nyc.gov/assets/doh/downloads/pdf/data/severe-maternal-morbidity-data.pdf

Q4. What data sources should we consider for data linkages at the state level, keeping in mind feasibility, timing of release and need for data use agreements, mainly with MDH, for data access?

- The data sources in Appendix 3.
- If this is related to reporting out results similar to the annual mortality report, that report has an appropriate amount of data to assess state performance. Annual works well too.
- Pregnancy Risk Assessment Monitoring System (PRAMS)
- Behavioral Health Administration, overdose treatment program data
- Centers for Medicare and Medicaid (CMS) data
- Vital Statistics Administration (VSA) - Birth records, Fetal death records
- Health Services Cost Review Commission (HSCRC) data
- Maryland case mix data routinely collected and used by the HSCRC with CRISP unique patient IDs. The ID assignment already uses probabilistic matching.

Q5. How should hospitals be recognized for participation in state-wide maternal health program activities and improvements in maternal health indicators over time?

- Kudos and recognition through the public forums.
- Give rewards and recognition.
- HSCRC is interested in considering methodologies that include hospital and physician incentives for improved performance.
- The addition of an Epidemiologist to quality insurance staff.
- If this initiative could be leveraged with the states' population health goals under the Maryland Model, it could be very helpful to keep hospitals focused on fewer but most important measures. To build trust in the process, maybe for just participation, then reporting, then overtime move to improvement in outcomes. Of course, all hospitals would be trying to improve as they are now, but I think creating an environment where there is collaboration and trust building among all parties will be key.

Policy Workgroup Feedback

Feedback from the Policy Workgroup is provided below by question, including written responses answers to questions by individual workgroup members and responses summarized from handwritten notes made from telephone or zoom calls with workgroup members. Written comments and direct quotes from workgroup members are noted with quotation marks.

Q1. What are the main workforce-related, provider compensation, or policy/legislative issues impacting maternal health in Maryland?

- There are a number of issues related to paid leave during pregnancy and in the first 6-12 months post-partum as well as affordable, quality daycare that impact maternal and early childhood development, but that is beyond my expertise to suggest policy changes
- Doulas could prove beneficial for low-income women who lack the time or financial resources to attend prenatal and labor classes or may need additional support to deal with stresses and concerns that are not sufficiently managed by typical obstetric care. Doulas could act as informal case managers helping link women to dieticians, behavioral health providers, domestic violence resources, and transportation needs. Doulas should be available to women during pregnancy, through labor, and into the first 1-2 months postpartum. However, doulas should have baseline education/training and certification if the expectation is that they will improve prenatal, intrapartum, and postpartum outcomes for women and their babies. Training/certification should also be required if tax dollars are going to be used to pay for these services.
- The CDC (Preventing IPV Across the Lifespan: Technical Package, 2017) has identified two evidence based policies that show promise in impacting both maternal health and reduction of IPV. One policy is microfinance, which has mostly been studied in low/middle income countries. However, in some of Maryland's impoverished communities the opportunity to obtain no-interest or low interest start up loans, training on relevant skills (with safe childcare), and maternal health education may be an effective policy initiative. The second is legislation strengthening paid leave supports, particularly paid parental leave for up to 13 weeks. Policies that support time at home following birth result in fewer depressive symptoms, reduction in IPV, and help women remain employed.
- 1) Perinatal Mood & Anxiety Disorders a) Lack of provider knowledge to treat (medication) b) Lack of resource information (where to refer) c) medication but NO follow up. 2) Lack of screening for pmads. 3) Maternal mortality. 4) Infant mortality. 5) Access to prenatal care. 6) Racial inadequacies. 7) Substance use training during pregnancy (with compassion - not an immediate call to DSS. 8) Correct and consistency among PRAs - every jurisdiction is doing this differently and few women are actually connected to services.
- Socio-economic disparities
- Many of the barriers manifest in the realities of systematic and institutionalized racism and how it plays out in the lives in the community.
- Programming: often the program is developed by entities outside of the community with limited involvement of the community in its design, implementation or assessment of outcomes. As stated before this is a repeated pattern of ‘saviorism’ in which outside entities come into the community to create programming to solve a problem, without first examining the origins of the problem or offering solutions that address all social determinants of health-specifically employment/workforce development. Many problems associated with poor maternal health outcomes stems for the need to have sustainable employment, especially for those serving and supporting the community. Programming limits how funding is utilized on how gets paid and why they are paid; especially in creating employment opportunities in the community.
- Funding: of programs and policy-making entities does not include a continuation of employment opportunities- especially to those who provide front-line support such as doulas and other specialized community health workers. Often the largest portion of funding centers on salary and benefits, with the greatest portion going toward upper management. This disparity in salary is especially problematic when weighted against who has direct contact with clients and community members. Those on the lower end of the employment hierarchy in many programs often do much of the heavy-lifting on client engagement, service provision, and data collection. This ‘heavy lift’ in programming creates a high turnover rate; so often there are disruptions in service and time spent looking for replacements. Overtime,

recruitment becomes a problem because it becomes a known fact the cost-benefit of the position is often not worth the potential workload. This is one of the reasons many doulas, lactation professionals, and varied professions under the community health worker program often go into 'private' practice, where they can manage their workloads and income.

- Professional Designation: there are current professionals designated under the newly rolled out 'Community Healthworker Program' allowing for the state to 'certify' and credential those under the program; opening the door for a clear and concise job title, position description and salary scale. This also allows for more direct funding streams and expanding the opportunity for employment potential.
- (In response to direct question about challenges related to PRAs by MCOs): MCOs cannot reach out if the pregnancies are not identified. Challenges with early identification of pregnancies is limiting the completion of PRAs. MCOs do act on PRAs. Completion of PRAs can be low at some practices; midwives and NPs tend to complete them more often. Transportation is part of the challenge in getting women to care early.
- Doulas need recognized certification and training. The current Doula legislation did not have enough detail and would benefit from more detailed fiscal notes. Without this it is a "non-starter" in terms of accreditation. In Maryland's community health worker (CHW) experience, it was important to justify their skills, training, and supervision. These details are what made it acceptable to the Centers for Medicaid and Medicare Services (CMS). The doula effort would benefit from similar detail.
- There is an acute need to do provider training. This should be pre-licensure as well as throughout their careers. Providers' biases are getting in the way of care. Stigma against Medicaid is already significant. Providers need to understand the barriers women face in accessing existing resources.
- In 2018 IHSMarkit did a workforce model for the Maryland Health Care Commission to estimate future workforce supply and demand for key provider types. This study found that, while the demand for Obstetrics/Gynecology providers has historically outpaced supply, the supply of these providers is expected to increase to exceed demand in the near future. However, the supply of these providers is unequal on a geographic bases, so that some parts of the State have better access to providers than other parts of the State. [See *"Maryland Primary Care and Selected Specialty Health Workforce Study" completed by IHS Markit under contract to the Maryland Health Care Commission*"] for this data as well as data on related provider types. This suggests a need for solutions that take into account geographic specific solutions, not solely statewide solutions.
- Note that geography also is relevant to placement of birthing hospitals in the State. Central Maryland has the higher level birthing hospitals, while rural areas of the State have level I and II birthing hospitals. Geographic issues lead to questions about provider recruitment and retention, but also issues related to patient access to transportation, hospital transfer procedures (an issue the Maryland Patient Safety Center has worked on), and even temporary housing near higher level facilities.
- The Maryland Health Care Commission did recently complete a 2 -year study on Infant Mortality in African American Infants and Rural Infants (Report and Appendices). The recommendations in that report may be helpful considerations for this work. This work was done with support from the University of Maryland School of Public Health, Department of Family Science. You may find it useful to talk to Prof. Sandra Quinn about her insights working with the State on that report.
- A workforce issue that came up in that group was the relationship between doulas and community health workers. The Maryland Department of Health has established a certification program for community health workers.

Q2. What are the main Medicaid policy issues impacting maternal health in Maryland?

- The latest available Maryland Maternal Mortality Review Committee report shows that 80% of the preventable pregnancy-associated deaths were due to drug overdose (62%), suicide, and homicide. Although MCOs are charged with connecting women with behavioral health providers, we have not seen that happen in practice. We are now in our 6th year of our maternal substance use treatment program in Calvert County, and our nurse case manager is only aware of one instance when an MCO contacted a patient whose Maryland Perinatal Risk Assessment indicated substance misuse, and that occurred two months after we had her enrolled in our program. Our local health department also runs our county's only domestic violence shelter and a linking community clinic. We are unaware of a single referral from an MCO to domestic violence services.
- MCOs need to be held accountable for legal mandates related to high-risk pregnancies. I realize that staffing at MDH is extremely limited, making effective auditing of MCOs all but impossible. Perhaps a new subdivision that blends staffing from the Medicaid and Maternal Child programs should have auditing and enforcement powers (i.e. ability to issue financial penalties linked to MCO senior management compensation) to ensure legislatively required programs are actively operational.
- 1. Being able to expanding the Medicaid coverage period beyond the 60 days postpartum.
  2. Adding to the screenings covered: maternal depression, as well as screenings for IPV.
  3. Covering Doula care.
- "I'm not sure I'm qualified to answer this question but appreciate seeing what other states are doing in this area."
- Health disparities
- While the expanded Medicaid programs offer accessibility, it does not offer a holistic approach that foster continuity of care, especially in the postpartum period While several programs and organizations within the state structure of parenthood classes, visiting nurse programs, and other supported services they are fractured in their access, delivery, and connection to medical providers and other available social services.
- Please see the recommendations in the Report on Infant Mortality in African American Infants and Infants in Rural Communities. MHCC defers to the Maryland Department of Health on Medicaid topics.
- It is important to consider other state policy tools, aside from Medicaid. With respect to racial disparities, those disparities occur at all income levels, not just at levels served by Medicaid. Maryland has a unique all-payer rate setting system for hospitals that could be an additional policy lever. HSCRC staff are the state experts on that payment model. Maryland also has a state-based exchange, which insures some families who do not qualify for Medicaid. It doesn't appear that anyone from the Maryland Health Benefit Exchange is on the taskforce. Perhaps an invitation should be extended?
- The Maryland Health Care Commission designates the State Health Information Exchange, CRISP, which could potentially play a role in data exchange which is important to patient care coordination. MHCC also supports the adoption of telehealth. MHCC urges the task force to consider IT as an important component in successful implementation of health program improvements.

Q3. Are there state-level Medicaid policies, programs, or initiatives not currently in place in Maryland (state Medicaid information is detailed in here under the third tab, "Inventory Summary") that should be discussed by the Task Force and considered by the Maryland legislature? If so, which policies and how might they be used to improve maternal health?

- Continued care should be facilitated for those diagnosed with gestational diabetes through at least the first year postpartum. This program should be coordinated with the new MDH/CDC initiative to reduce diabetes burden in Maryland. MCOs should be aware of women diagnosed with gestational diabetes via ICD-10 billing codes. These women can then be scheduled with their PCP during their second postpartum month to screen for ongoing diabetes and determine a management plan.
- In the short- to mid-term period, this will lower risks during subsequent pregnancies. As a result both maternal and neonatal complications during future pregnancies will be reduced. In the long-term, diabetes programs tailored to women with gestational diabetes will lower chronic disease risk in high-risk minority populations since better weight management will also lower hypertension rates, kidney disease, heart disease, strokes, and cancer incidence.
- Breastfeeding should continue to be emphasized since it not only optimizes infant nutrition, but supplements the infant's immune system. This reduces the incidence of childhood asthma and diabetes. Breastfeeding also accelerates pregnancy weight loss. Whether it's due to strictly to weight loss or involves other factors, breastfeeding lowers maternal diabetes and heart disease risks, as well as long-term breast cancer risks.
- Focusing nutrition management tailored to cultural factors of various minority populations and income limitations of Medicaid recipients will also lower the risk of child obesity in African-American and Hispanic communities. Better grocery shopping choices and healthier food preparation habits will benefit both generations.
- 1. Expanding the Medicaid coverage period beyond the 60 days postpartum. In particular in conjunction with mandatory parental leave coverage, this could reduce financial stress, increase access to health and improve safety. 2. Screening for maternal depression (AND IPV, which is not specifically listed, but is a major risk factor and increases post birth). 3. Covering Doula care. Doulas can be excellent sources of support and excellent advocates for moms who are laboring. Can be a way to push back against biased interpretation of symptoms by healthcare providers.
- Mandatory pmad screening.
- Post natal coverage resources for the mother
- Before we can further discuss programming, we first need to establish the needs across the state and develop a policy to address specific regions in the state and the communities living in those areas. The needs of the Eastern Shore, are vastly different from Western Maryland. Programs that have shown some success in Baltimore City and suburban areas surrounding DC make not be viable options in other areas. It would be premature to even discuss what works in other states before we fully understand the scope of the problem and the needs not just on a state level but also by region. In terms of legislation, you will find those involved in the development of legislation and state leaders are seeking to foster this attitude in current bills introduced, offering broad base interpretation for each city/county to develop specific programming, for example, the establishment of MMRC's on the local level.
- Doula reimbursement is not necessarily a fix. In other states where it has been reimbursed, the reimbursement rate is so low that covering the service may not have desired impact. Challenging public relations related to "death doulas" protest when bill was discussed may have soured legislators.
- With respect to extending postpartum Medicaid coverage to one year, they point out that about 80% of women are eligible for Medicaid after delivery. Those who are not may be eligible on the state exchanges. It's important to use the state exchanges to ensure the continue to exist. Perhaps it would be useful to educate women about their eligibility for Medicaid after birth and/or how to transfer from Medicaid to state exchanges.
- "Churn" is an important issue; MCOs have a mandate to provide case management. The PRAs must be returned.

- Medicaid has not seen CMS agree to a match (50/50). Such a proposal would cost estimated 20 million a year. Not clear who is willing to pay for that
- MD does not have a workforce breastfeeding law. This would be helpful to promote the importance of breastfeeding.
- Coverage – including by Medicaid- for doulas is critical. It presents a way to both improve care for women and to involve the community in that care. Engaging the community in doula services would also alleviate some other workforce challenges. Doulas must be seen as part of the maternal care team.
- There must be an emphasis on antenatal screening for depression and anxiety, not just "postpartum'. We need more creative outreach to address mental health in perinatal clients.

Q4. Are there legislative initiatives, other than Medicaid, at the federal level or in other states that should/could be considered in Maryland? Participants were provided with an overview of legislative initiatives for review.

- Paid parental leave policies.
- Increased funding to address lead paint in low income housing.
- Priority access to housing for mothers made homeless by IPV.
- 2018 National Crime Victimization Survey data point to 89% of violent victimization experienced by women was at the hand of an intimate partner.
    - 2019 point in time counts by HUD reported 44,752 individuals made homeless by IPV. That same year, the National Network Against Domestic Violence reported sheltering 42,964 survivors and children made homeless by IPV with Maryland's portion totaling 281.
    - The 2015 National Intimate Partner and Sexual Violence Survey reported 64% of respondents first experience with IPV was between the ages of 18-34, prime childbearing years. Of women reporting IPV in their lifetime, 68% also reported experiencing an IPV related impact defined by the NISVS as, "experiencing any of the following: being fearful, concerned for safety, injury, need for medical care, needed help from law enforcement, missed at least one day of work, missed at least one day of school. . . any post traumatic stress disorder symptoms, need for housing services, need for victim advocate services, need for legal services, and contacting a crisis hotline."
- BHIPP expansion similar to MCPAP for Moms in Massachusetts. Training for ob/gyns around pmads. Bias training for all medical professionals. Birth control for free and family planning consultation. Postpartum visits for all new moms
- I would need to research
- There must be an emphasis on antenatal screening for depression and anxiety, not just "postpartum'. We need more creative outreach to address mental health in perinatal clients.
- We need policy that support programs that create holistic services for certain populations like adolescents. She used example of a teen clinic in Washington DC that created an entire network of services geared toward adolescents.
- There needs to be a recognition that it is not easy to get resources – it is very hard work to get connected to resources. Policies are needed that remove barriers.
- Transportation is a concern in rural areas.
- Review of data on maternal morbidity, as well as mortality, seems important, particular if data is race stratified and contextualized with qualitative feedback from the women and families.
- It is also important to consider if technology provides solutions (e.g. telehealth, remote patient monitoring). During the current pandemic, telehealth is probably being used in cases

that it has not been used in the past, providing an opportunity for evaluation of whether expanded use of telehealth may be appropriate over the long term.

Q5. What are the practical implications of the current maternal-health related legislation in Maryland for maternal health in the state? Participants were provided with an overview (see Appendix 4.2) of Maryland-specific legislative initiatives for review that were current as of 25 March 2020, a few days before their comments were invited. Please note, HB 1067 Doulas-Doula Technical Assistance Advisor Group and Certification was not included in on this list in error.

- Implicit bias training (HB837) likely holds the most promise of changing the quality of care for historically disadvantaged populations. However, this will be a very gradual process and may take the form of a generational transformation rather than a major shift among mid-career professionals. The greatest emphasis of this training should be in academic institutions, especially hospitals and clinics with residency programs.
- Maternal Mortality Review (HB 286) - excellent idea and needed to delve into the data and look for systems gap issues to be addressed. Important to make sure the right stakeholders are at the table. In particular, the members should reflect areas of most concern and populations most at risk.
  Health Insurance - Telehealth (HB 488/ SB 402) Could be helpful in rural areas. Need to ensure access to the technology that would allow moms to take full advantage of service. phones with minutes or lack of a smartphone will hinder access. Could this be paired with public library private access rooms for example? The other issue is whether this can be provided to individuals living in Shelter settings and still be billed to Medicaid
- Implicit bias training (HB 837) and cultural competency coursework for PH professionals (HB 639) - will help if the training is robust and not just a check on a to do list. Most trainings like this only work if they are intensive and practitioners have a chance to practice the skills they learn.
- Some legislation has not actually been enacted that passed. Anything that improves access to care and treatment of moms!
- I am not sure at this time
- *HB 837 Pubic Health- Maternal Mortality and Morbidity – Implicit Bias Training and Study.* The report on Infant Mortality in African American Infants and Infants in Rural Communities recommended implicit bias training for health care providers. This bill relates to that training.
- I think it is also important to look at bills that are not specific to perinatal health. For example, HB 998 / SB 501 continues the Maryland Loan Repayment Program which can help support providers who work in rural and underserved areas, improving recruitment for those areas.

Below are comments provided by workgroup members that did not otherwise fit into a question above. The quotes indicate that this was part of a workgroup member's written submission or a direct quote.

- For the master's tools will never dismantle the master's house. They may allow us to temporarily beat him at his own game, but they will never enable us to bring about genuine change. Racism and homophobia are real conditions of all our lives in this place and time. I urge each one of us here to reach down into that deep place of knowledge inside herself and touch that terror and loathing of any difference that lives here. See whose face it wears. Then the personal as the political can begin to illuminate all our choices.' Audre Lorde

- The analysis and development of a policy framework to address challenges in maternal health and birth outcomes in the state of Maryland; either under a group of stakeholders gathered under this program; research conducted in the strictest guidelines within academia; or the examination of raw data by an epidemiologist is mute and has been proven to be ineffective if it not being led by or in equal partnership with the community in which it is centered and who are directly impacted in any way by existing policy. This is the key element in why existing policy and programming are often ineffective or limited in its ability to approach the underlying variables contributing to the overall challenge; or in poor community participation.
- While well-intentioned, most attempts to correct a social injustice in all its forms looks to the community as the victim and the victimization continues when the voice and autonomy of the community are coopted or muted. Impacted communities must be allowed to set their agenda and course of action; while those in perceived places of power and privilege focus on how to begin to how their policies, history, and institutions have created and contributed to the disparity in question. Once both sides take ownership of the history and development of the problem; their role in continuation; and how they can work together in collaboration- with the community as the dominant voice and prevailing guide on future programming and policy.

Quality Improvement Workgroup Feedback

Feedback from the Quality Improvement (QI) workgroup is provided below by question, including answers to questions by individual workgroup members and summarized discussion from the QI workgroup call. Direct comments submitted by workgroup members are provided as quotes.

Q1. What quality improvement skills training will most benefit labor & delivery implementation teams, and how can this best be delivered?

- There is no standard or formalized QI skills training for L&D staff, particularly on the analytic side. Generally, these skills are acquired through on the job training, conference, or on-off external trainings.
- Many hospitals have versions of CUSP teams or QI teams, those are voluntary activities, not everyone gets it. Depends on the leadership in the L&D departments, a lot of variability from hospital to hospital
- QI skills training for L&D implementation teams should include training on data collection and analysis and use of data to design and evaluate interventions. This should include the collection of disparities data. The training should also include basic education on the state of maternal health in Maryland, disparities, and the role that health care providers and institutions play in perpetuating and addressing disparities.
- Skills training in team building and how to do 'debriefing' and 'root-cause analysis' in a non-judgmental manner may help provide 'buy-in' for further collaboration with MDMOM. The staff need to understand the value of collaboration.
- There are several QI tools that would be helpful for teams when implementing quality improvement initiatives. These include stakeholder analysis, project charter and plan, process mapping, 5 whys analysis, run charts and implementation plans. Many of the tools are simple and can be templated out for organizations with examples.

- Substance Exposed Newborn Training, Harm Reduction in Pregnancy, Resource awareness – particularly about home visiting.
- This probably varies by hospital. Training has to be both relevant and feasible for the institution -- what is going to be useful/doable for the academic institutions may not be so for community hospitals and vice-versa Solutions have to be able to take into account the varying mix of patient acuity, the various EMRs and especially the varying L&D staffing models including the provider mix (i.e. MFM, generalist, midwives). It might be helpful to assist the hospitals in conducting some sort of standardized QI capacity/needs assessment. ACOG, for example, has a program - Voluntary Review of Quality of Care (VRQC) – which is a confidential, voluntary, consultative peer review service offered where a team of providers (OBs and midwives) with specific training in patient safety and quality improvement visit the institution in order to evaluate the degree to which practice patterns are consistent with published guidelines, and to suggest possible avenues for improvement. Often hospitals go through this process following a sentinel event. It might be useful for hospitals to go through a process like this proactively (rather that in reaction to an adverse event). Maybe MDMOM can financially assist hospitals to go through VRQC or a similar process. Or maybe it would be desirable for us to work to create a similar program in which we develop local capacity/team experts that guides a hospital through their own QI self-assessment and development. (I am involved with a group that does this internationally as part of its simulation-based emergency obstetric training – we assist local teams in diagnosing system barriers and identifying achievable strategies to improve patient safety and birth outcomes – this part of our training is often cited as one of the most beneficial processes teams have gone through).
- Question about who ends up being involved in the design and implementation of the QI project in the dept, important to have clinicians involved, to try to recruit people who aren't always seen as leaders, make sure you have a diverse team, elicit a lot of input from staff
- The coordination of activities and keeping them in line with what is new and available is different work, ACOG has training for safety leaders. The skills providers need to do QI work often gets missed
- Recommend that any QI skills training developed for L&D implementation teams should incorporate input from the MDH-Medicaid Physician Consultant [redacted] as well as the MCOs. Key MCO staff for input would likely include MCO Medical Directors, clinical quality program leaders, and OB case management program/leaders, or others who would influence policy and/or clinical practice protocol development for their pregnant Medicaid members. Part of the effort would be to ask the MCOs how they currently work with/partner with hospital L&D teams to develop new or modify existing training protocols for pregnant and postpartum Medicaid members.

Q2. What other statewide resources for quality improvement in maternal healthcare would you recommend that the MDMOM program consider promoting or developing?

- Taking regional best practices and expanding them. For example, what can other parts of the state learn from B'more for Healthy Babies?
- Look at different parts of the state as their own unit, see what their specific needs are—different regions have different priorities and different resources
- Importance of needing to go well beyond the walls of acute care hospitals, if we are truly going to impact SUD, it will be at community and system level
- In MMR, there are big gaps in the availability of treatment for SUD during and after pregnancy. Women go back to family and social networks, contributors to their quality of life/failure to thrive—hospitals can't address this

- Harm Reduction, coordination/resources for peer-based support, developing a resource inventory/conducting research about neighborhood effects on health.
- The tools being generated from IHI as part of their Better Maternal Outcomes Initiative have been helpful and being tested in other institutions across the country. The modules looking at postpartum hemorrhage, hypertension management and post-birth warning signs could be useful for QI projects we might undertake.
- The MOM Model, led by Medicaid, is going to be looking at developing enhanced care management module for MCOs. Develop practitioner resources, including working with CRISP for SDH screening tool.
- Align with and/or leverage the Maternal Opioid Misuse (MOM) Model work, led by Medicaid-IRD. Connect with currently in-progress efforts around developing a SDOH screening tool and resource directory resources through CRISP (led by MOM Model team). Recommend engaging the two Medicaid Home Visiting Services (HVS) Pilot Lead Entities (Harford County Health Department and Garrett County Health Department) for qualitative input from their experience implementing the Healthy Families America (HFA) evidence-based home visiting model in a Medicaid population. See also 2019 HealthChoice evaluation; preliminary results from the HVS Pilot may be available at the end of this fiscal year. Consult with the Behavioral Health Administration on best practices for pregnant individuals with mental health and/or substance use disorder; their Gender-Specific Services team has a wealth of knowledge.
- PG County has transforming neighborhoods initiative, successful in gathering community leaders, groups still meeting, regional initiatives to strengthen relationships on SDH—model to look at
- Specifying what best practices would be included—HV specifically? Some work on training and HV, leverage that work. HV pilot sites in rural areas have some mature programs for women with SUD. Local health depts and health improvement coalitions could be good partners. Utilize regional approach, some local jurisdictions have maternal health as a priority area.
- Community Health Resource Commission, collective impact model to address SDH (Germantown)
- Most OB offices and clinics are not set up to do all the screening and follow-through that are recommended for their patients. This is, basically, due to lack of funding and training for auxiliary staff. Prenatal care is a unique opportunity to improve the overall health of a woman and her family which is often not utilized. Regardless of tools and resources developed, they often are not utilized due to lack of prioritization of perceived non-obstetrical/medically related problems. Training and providing funding (billing codes, etc.) for non-provider staff to screen for depression and other psychiatric disorders, substance use disorder, intimate partner violence, and unstable living conditions (a few examples) and then providing follow-up and resources as needed would have a long-lasting impact. Non-compliance (a derogatory word) with both appointments and patient self-management (taking meds as prescribed, etc.) is often perceived as a patient failure. Providers then discharge someone from their practice or just anticipate a sub-optimal outcome that is considered the patient's fault. These patients are most likely to have obstetrical emergencies, poorer perinatal outcomes, and worse long-term health. Addressing the reasons for "non-compliance" would improve all these parameters. Each community (however one wants to define that) should have a multi-level collaborative group to address pregnant women with specific disorders, such as substance use disorders, diabetes, etc. MDMOM could identify community members and give specific training (including in how to facilitate collaboration). A community-based model is most likely to have sustainability if well-thought out and not reliant on just one 'champion.

- An online clearinghouse of maternal health related resources/guidelines. It would be helpful for hospitals to have support for sustainable staff and provider training on core set of skills of new staff and providers as well maintenance programs for those who have already completed initial training (e.g. standardized interpretation of FHR tracing, standardized criteria for diagnosis of protracted or arrest of labor, etc.). Our hospital currently uses a program called GNOSIS, which is a high quality on-line, evidence-based program (https://www.relias.com/product/relias-ob). I do not have any financial relationship to this entity. Having completed A LOT of trainings in my time as a provider, this is in my opinion one of the better ones (it is adaptive so it conducts an assessment of existing knowledge and then creates your training base on that, so that you don't have to go through information you already know. It provides benchmarks so that you can tell a provider's strengths and weaknesses relative to other providers in the same institution and to providers in other institutions (which allows hospitals to identify areas for individual and team improvement). It is expensive, so it would be nice for OB units to have support to make that available to their providers, or to have support in approaching their hospital leadership or insurers to help underwrite a program such as this. It would be great for all Maryland hospitals to be able to implement all the AIM Obstetric bundles. Providing support for hospitals to work on the bundles that they feel would be most helpful and relevant (these may be different for different hospitals). I think simulation-based training is a key part of QI in the management of obstetric emergencies. Therefore, the building of hospital capacity in this arena is something I would recommend. Finally, tort reform is critical. Providers, particularly those in Baltimore, need protection from a medical malpractice environment in which following best practices can still result in multi-million award. Quality initiatives are seriously undermined by the current medio-legal climate in Maryland. For example, many years' worth of efforts to reduce c-section rates can be quickly undone by a single lawsuit in which prosecutors successfully claim that a c-section would have prevented an adverse neonatal outcome (even if such an allegation is widely agreed by medical experts to not be true).
- I am glad that MDMOM is including home visiting programs in the quality improvement strategies. A standardized curriculum for programs to deliver across the state is a great idea. Fatherhood programs could be a good resource.

Q3. What quality measures are hospitals already collecting/reporting, that could help monitor and evaluate quality improvement efforts supported by the perinatal collaborative and MDMOM?

- Units collect so much data for a variety of things, any time we can engage a partner in the data sharing, get DUAs with HSCRC or MDH, can tap into existing.
- Beyond basic perinatal outcome data that is collected, services that are already rendered can be measured qualitatively: patient education, social work evaluation, lactation consulting, nutritional evaluations, etc. Data around patients that are admitted to the antenatal unit have been limited to reason for hospitalization, obstetrical/medical outcomes and LOS. There is so much more that can be done.
- Most hospitals have a peer review committee that evaluates care when there are poor outcomes. The data these committees collect can be used to assess quality of care identify disparities in outcomes and the quality of care.
- Hospitals already collect and report a series of measures for Joint Commission, MIEMSS and other entities. The state also assesses readmission and length of stay. Additionally, hospitals may collect other hospital or system-specific measures. For example, UMMS has a system-wide OB Patient Safety Committee that among other activities, creates and updates guidelines and has also created measures to assess progress towards guideline

implementation and guideline effectiveness. C-section rates, VBAC rates, blood transfusions, GBS prophylaxis, HIV testing, breastfeeding initiation, VTE prophylaxis, maternal admission to ICU, maternal postpartum readmissions, etc. are some of the measures we keep. Building simulation training capacity.

- In addition to what is reported as part of a collaborative, hospitals report NHSN measures, some of which may relate to OB. The HSCRC uses administrative data to calculate 3M Potentially Preventable Conditions. Some of which relate to OB and are simply reported. OB docs are not necessarily in agreement that these measures are worthwhile. Any other measures that can be calculated with claims type data could also be produced.
  Data on social determinants can be collected outside the hospital, and community organizations can be data collection partners
- Social work involvement in data—they collect a lot of information that does not seem to be included in other reports
- C-section rates in joint commission. There is also vital statistics data.
- Discharge planning—so much of information patients receive at discharge is useless, where are patients referred, what needs are they assessed to have?
- A group meeting on 1-2-3 equity campaign, identified that quality of hospital/local data not fully accurate. Even at local level, race/ethnicity data needs to be collected more accurately
- HSCRC data has race, ethnicity, and language data. They are currently looking at race/ethnicity data to report on known disparities around readmission rates and went through best practices with hospitals to empower patients to self-identify. Most hospitals were within a range of reasonableness compared to census. Hopefully hospitals are following best practices from training this training.
- HSCRC may provide this information – [redacted] and [redacted] are good contacts.
- HSCRC—agrees, case mix data set, all admissions, L&D expertise needed to understand how to make data useful to practitioners.
- As we look at measures, we need to be explicit about having any measures stratified by race, ethnicity and language if available. Measures beyond existing perinatal measures can be helpful. Maternal morbidity outcomes such as postpartum hemorrhage, postpartum attendance rate. Looking at Press-Ganey or other patient satisfaction to look at measures of respectful, high-quality care would be interesting to assess the perception and trust between providers and women.
  It is difficult to link race/ethnicity to outcome data
- What measures have been validated? No valid risk adjustment for SMM, and if they can't take into account risk factors, is it meaningful for hospitals?

Q4. How can the MDMOM program best coordinate its planned activities for hospitals (e.g., provider trainings and quality improvement initiatives) to ensure feasible and timely implementation within each hospital and across the state?

- All hospitals' process improvement or change activities not related to the COVID-19 response are on hold until we are through the crisis. With non-urgent procedures on hold and as the state looks to reactivate clinicians who are not currently practicing, and to enlist help from medical and nursing students, it would be unrealistic to expect hospital clinicians to participate in any new activity until we're well on the other side of the surge.
- Assess what is currently underway within hospitals as part of their OB quality Improvement efforts and is there any ability to partner on those efforts. With AIM and insurers (public and private), there is a lot of incentive to improve outcomes for mothers---getting a sense of what is currently underway could inform our work.

- Implementation needs to take hospital-specific goals and capacity into account. Often these state-wide initiatives 'impose' the what and when of this QI work. It would be preferable to let the hospitals have some say in what they take on. For example, maybe MDMOM can set as a goal the implementation by each hospital of one the AIM bundles within a year's time, but to give hospitals ability to determine which bundle and the timeline within that year and offer then support/assistance in achieving this goal. Or maybe MDMOM can help accelerate existing work at a hospital. Again, some sort of standardized and targeted assessment of each hospital's QI resources and activities could help guide this work.
- Remote sessions; pairing institutions to share updates, progress and hold each other accountable; regional meetings; engage stakeholders at multiple levels; set clear timeframes
- Using time already scheduled for physician, nursing, and SW education to speak on a specific topic. Doing a several hour clinical conference on a specific topic with CMEs and CEs provided. A plenary session, followed by workshops on specific topics has worked in past, if advertised well in advance and supported by departmental leadership.
- Work with hospital-based coordinator/champion and implementing agencies to facilitate training and initiatives on site. Upon trainings have screening tools/resource packets/evaluation tools available for distribution so that there is no lag in implementation
- Potentially having trainings that are several hours that are interdisciplinary, as well as those during prescheduled training times—with a goal of encouraging collaboration on a local level. Oftentimes physicians don't know who else is interested in these problems.
- Use a phased approach for initiatives, with incorporated training especially given there are varying resources and sponsorship at the hospital level.
- Medicaid-IRD can help coordinate across MCOs for input/alignment. Recommend also consulting HSCRC and Maryland Hospital Association (MHA) for the possibility of using existing infrastructure to communicate and coordinate across hospitals statewide. Bring in maternal (and child) health experts from leading birthing and academic hospitals such as Johns Hopkins, UMMS and Sinai - they have an existing collaboration that could be tapped.
- HSCRC is running with CRISP reporting services portal—instead of creating a new forum, tap into this, regulatory reports published there. May be able to establish new data in an existing form

Q5. What resources are available for maternal education on warning signs of postpartum complications and how would you rate their quality?

- Literature needs to be situationally and culturally relevant
- Ways that we can build deeper relationships with individuals doing this work in the community and provide that information in hospitals. Research showed that mothers did not feel like the information they were given was for mother's own well-being or included their own voice. Black moms felt that it assumed they were using substances or would not be breastfeeding. Engage community members to create the literature, to reflect different perspectives and voices. Target information to moms and their well-being. The current information often makes assumptions especially about women of color (assuming they have substance abuse issues, assuming they will not breastfeed). Have the people doing the work create the literature.
- The only quality literature I've seen is on postpartum depression. Postpartum, women are focused on their new infants and often neglect their own wellbeing. Introducing the importance of postpartum maternal evaluation during pregnancy and while hospitalized postpartum would be vital in refocusing these women on their own health. I often tell my high-risk pregnant women that having a healthy mom is important in having the best

possible perinatal outcome. That message needs to be extended to the postpartum period. I have not seen any focused patient literature on the importance of substance use disorder treatment, psychiatric care, diabetic care, cardio-vascular follow-up, etc. for the postpartum period.

- Postpartum education can be poor, and seems to be limited to postpartum depression, breastfeeding, and contraception—patients get little education during hospitalization for delivery on other postpartum topics. There is a wide open for providing additional services and information
- Most EMRs have handouts on warning signs. Babyscripts is an app that many institutions use, and it is a platform for patient education. Doulas are also a great resource for maternal education and patients tend to have a trusting relationship with their doulas and feel comfortable following their recommendations.
- One of the best resources I have seen is from the DC Primary Care Association, Human Centered Design to Improve Reproductive Outcomes and Maternal Health. The checklists places mothers at the center and elevates the importance of patient voice that is missing from so many efforts.
- We use Partners for a Healthy Baby and the curriculum focuses on the relationship between parent and child. Health information is very general but included. We need accurate information that is easy to read for cognitively delayed parents, visual aids that can be used with multiple languages, and locally targeted information instead of the general stats combined.
- Medicaid-IRD can help gather this information from MCOs, and the HVS Pilot Lead Entities using the HFA evidence-based model of home visiting.
- Prenatal support group curriculum (touches on postpartum complications): Baby Basics – have gotten mixed feedback; Becoming a Mom – generally positive but there is a lot of wordy info that can be over-bearing.
- Look at Text for Baby if it is still active

Q6. How might home visiting programs coordinate with healthcare providers when their clients experience or have questions about signs of postpartum complications?

- What we are learning about providing remote services to women during COVID-19 – we have started doing zoom centering groups, and this has presented great opportunities to connect in a different way and in the home. It has been helpful, to reach out to women past the stage of six weeks, where there is a loss of connection, and remote contact presents an opportunity to maintain connection. There is actually better attendance at video postpartum meetings than the in-person meetings, and we plan to incorporate video meetings routinely. Tying in the HV to that could be a fantastic opportunity
- Group support using technology, speaking through interpreters – new technology can become a new opportunity
- First, home visiting programs should be available and funded for all postpartum women and should be introduced during prenatal care. There is a stigma around home visitation when it is only presented postpartum by social services, as if the woman or her home is deficient in some way. When home visitation is perceived as a support service for any new mother, it has been shown to be better accepted. Each provider group should be briefed on the role of home visitation and that they are expected to collaborate with them. Then, each group should provide a mechanism for the home visiting personnel to contact the provider or office personnel (with an internal algorithm of how to handle communication). Women who deliver with no identified OB provider need special attention since they are most likely not to access

needed care postpartum. In person home visitation may be only for a designated timeframe, but phone contact should be continued for a year postpartum, when warranted.

- The home visiting programs that my practice works with either have the visiting nurse or the patient call the office to address concerns. Home visiting programs could be given a direct line to a point person in the office to share concerns and circumvent delays that often occur when calling the mainline. Visiting programs should always notify the practice or hospital when they recommend that a patient go the hospital. Our hospital recently addressed the issue of postpartum patients that were being seen by the Emergency Department for complaints such as elevated blood pressure. In the ED patients were not fully evaluated for postpartum preeclampsia and were often sent home without treatment or adequate follow up. Our department coordinated with the ED to ensure that all patients presenting to the ED are asked if they recently gave birth, and then seen in the L&D accordingly. Home visitation is a great opportunity to enhance postpartum care. If simple assessments can be done at home such as blood pressure measurement, the home visit could be linked with a telehealth visit with the health care provider. We routinely do a 4-5 day postpartum blood pressure check visit for patients with a history of hypertension. This visit could be done from home if the home visit included a blood pressure reading that was immediately shared with the health care provider.
- Excitement about possibility of telemedicine during home visits, having HVs equipped with tablets so they can make calls with lots of other professionals during visits has been helpful to connect with medical care immediately
- A practice incorporated previously was direct relationship with therapeutic services, which reduces intake wait for mental health services and helps retain staff
- Consent would need to be obtained and negotiated among everyone involved. Other than having explicit consent and open/direct lines of communication it would be tricky. Other than that it would likely look like how case managers do it – if there is a concern that the client does not feel confident bringing up, the home visitor calls the provider on their behalf or other organizations to gain the information they are looking for. MD MIECHV is beginning to work with CRISP to do something like this with granting home visitors limited access to EMR's for clients, which may hold some promise.
- Who are other points of contact for patients within the health system that can assist with coordinating care. Are there patient navigators, community health workers that are liaisons to patients and assist in their care? Non-traditional providers - such as birth advocates and doulas – are important sources of postpartum care and can provide the social support that can be as important as the clinical risks women may be facing. It is important to think outside of home visiting programs. What about those patients who are not part of those programs, since we know we are nowhere near meeting the needs of families? We also need to consider reaching women and families who choose to not receive those services or may not be "high-risk" or deemed eligible for these services. How are we thinking about coordinating care for women who are privately insured and may not be identified or offered home visiting services, where are the points of connections for their care?
- Many report being uneasy or fearful of requesting mental health support in the hospital due to fear of CPS, ICE etc. Increased comfort with in-home postpartum visit by CHW, doula or nurses to receive supportive resources
- Polls show that women do not attend postpartum visits for many reasons including childcare, transportation, need to work etc.
- Our hospital has implemented a successful program in which all postpartum patients received follow-up contact from hospital, and nurses follow-up with patients flagged for additional support and they help coordinate getting these patients into care with providers. Assisting hospitals with this type of follow-up and care coordination is something that may

be possible for home visiting programs to assist with. Also simplified ways for providers or programs such as ours to refer to and coordinate with home visiting programs would be ideal. 'Rebranding' some of the services as postpartum support services rather than home visitation might help. Improved referral systems to mental health services and to substance use disorder treatment with expertise in specific needs of postpartum population is needed.

- If there are medical concerns home visitors request authorization to share information with family's medical home (for target child and primary caregiver; sometimes other family members).
- Medicaid-IRD can help gather this information from HVS Pilot Lead Entities based on their experience with and best practices learned through the Medicaid HVS Pilot. In addition, recommend working with the MCH Bureau and the MIECHV team for information on how they've already developed home visitor training programs. Recommend collaborating with the national offices of the evidence-based home visiting programs currently operating in Maryland, especially those that focus on the health of pregnant and postpartum women (as compared to those models that focus more on early learning/kindergarten readiness for example). The two models approved for use in the Medicaid HVS Pilot program are HFA and Nurse Family Partnership (NFP), although no jurisdictions are currently operating an NFP model pilot.
- CMS webinar—NY hospital OB program sharing lessons learned with COVID-19, goal to continue some benefits of telemedicine for postpartum care. Opportunity to identify postpartum issues through telemedicine model.
- Defer to SME- I would need to understand the current barriers home visiting programs have with coordinating with providers.

Telemedicine Workgroup Feedback

Feedback from the Telemedicine Workgroup is provided below by question, including answers to questions by individual workgroup members.

Q1. **What birthing hospitals in Maryland would benefit most from telemedicine for expert MFM consultation, genetic counseling and/or other services for pregnant and postpartum women?**

- Remote and rural hospitals also those that are in low socioeconomic areas
- U of M Upper Chesapeake, Medstar Harbor, Adventist White Oak, Carroll Hospital (based on current lack of perinatal outreach and live birth volume)
- Not familiar with the demographic makeup, Medicaid recipients, locations (rural areas) of these hospitals but in general benefit would be for those who otherwise don't have access. Special attention to vulnerable populations- where in person visits may be challenging- this presents an opportunity
- Hospitals outside of the DC Baltimore metro region. Western Maryland, Southern Maryland and the Eastern Shore are at particular disadvantages for access to high risk obstetric and obstetric anesthesia care and consultation
- Level 1 and 2.
- For prenatal genetic telemedicine services: MedStar St. Mary's Hosp, Leonardtown, MD. Western Maryland Regional Medical Center, Cumberland, MD. MedStar Southern Maryland. Union Hospital of Cecil County.

- Rural hospitals (which are predominately level I and level II birthing hospitals) would likely benefit most. Also, hospitals in high poverty urban areas because many mothers in those areas may not have access to reliable transportation for in-person visits.

Q2. What concerns or barriers might hospitals have for adopting telemedicine for perinatal services, and how can a pilot program help address these concerns and barriers?

- Staff is not trained in telemedicine and patients are not well equipped but that can be overcome with training
- Lack of technical resources available if done in ambulatory vis-a-vis hospital setting. Funding source. Limited providers accepting relevant payment model. Patient engagement / adherence challenges. Staffing limitations in ambulatory and inpatient environment.
- Reimbursement? Pilot programs- have to ensure max/adequate billing, and demonstrate how providers were trained to achieve this?
    - Medicaid- patient location requirements for medicine visit reimbursement? Postpartum health coverage.
    - Cost of implementation? Return on investment--potentially reducing visits (especially for high touch disorders GDM etc. and bundled payments reducing visits means more time back to operate/procedures etc.?
    - Patient satisfaction: patient satisfaction surveys (comparison to usual car)
    - Missed diagnoses: comparison to a usual care group
- access to equipment and IT services to support telemedicine as well as the setup of infrastructure. The pilot should dedicate some focus to establishing a standard infrastructure and assistance with standards for documentation between hospitals outside of the U of MD and Hopkins systems.
- I would say Infrastructure and hardware for actually conducting the visits. Will these be patients consulting MFM services or general obstetricians consulting the MFMs? One of the biggest barriers will likely having compatible systems that would enable a patient from one system to interact with a physician in another.
- Lack of a knowledgeable financial counselor (or, a so-called "genetics counseling assistant") to assist specifically with insurance issues/ore-authorizations related to indicated genetic tests which may vary quite a bit from patient to patient. A pilot program would have an identified individual to serve in this key financial counselor role for the telemedicine outreach patients being served.
- The Hospital's concerns about the needed assistance of a clinic coordinator (a trained patient service coordinator) for appropriate scheduling -- including the timing of appointments as far as gestational weeks -- for pregnant women for specialized services involved in Prenatal Genetics. Note, all of the various appointments related to prenatal genetics can be done via remote scheduling by a designated, knowledgeable clinic coordinator for the telemedicine program at the lead center
- The outreach site's having the proper telemedicine equipment to provide such services.
- Reimbursement/ costs for the office space and equipment in which telemedicine services can then be provided.
- A pilot program would serve to iron out the technical details and costs which would then be generally applicable to other sites.
- Language barriers: demonstrated successful use of interpreter services in pilot program would circumvent this.

- The biggest barriers might be making sure mothers have the technology necessary to conduct telehealth visits and advertising the availability of telehealth as an option. Another concern might be trust. Mothers may be skeptical about allowing doctors to see into their homes (however little the doctor may see) and to allow new technology in their homes that would be connected to their healthcare. Individuals in rural and urban areas can be quite skeptical about motives from the healthcare industry. Privacy can be an issue for individuals in crowded housing situations and/or with no private space at work.

Q3. Are there telemedicine models that can be used to inform the design of a pilot perinatal telemedicine program in Maryland?

- Yes, there are a few in Cardiology but these are different patient populations.
- Remote monitoring for high risk cohorts, including gestational diabetes and hypertension. MFM telemedicine consultations at distal site of care / home / group classes. Patient activation for specific goals, including postpartum contraception and appointment adherence.
- Babyscripts (app based, integrates into EMR/Epic; remote monitoring, case management text reminders, special modules for GDM, preeclampsia, obesity etc.). It is integrated in many health systems (Georgetown University, used in DC--pilot that insurance cover cost as a mechanism to reduce disparities)
- Penn Heart Safe motherhood, postpartum blood pressure text-based program (cost is about 20-30K for them to give you access to dashboard and do training)
- Maven clinic- women's health medicine private pay platform (clinical visits + emphasis on education, includes nutritionist, psychiatry, lactation consultants, Intimate partner violence counselors, postpartum contraception)
- Johns Hopkins has an established telemedicine program that can be used for the pilot for perinatal including MFM and Anesthesia services
- Arkansas ANGELS is the only Statewide program that I know of. Wash U and many other institutions have remote consultations, but those are for patients within their system.
- We have undertaken telemedicine successfully during the SARS-CoV-2 pandemic. There are a number of platforms we have utilized successfully in Prenatal Genetics at Johns Hopkins wherein our patient volumes have not dropped significantly despite 2/3 to 3/4 of the patient "visits" having gone to virtual visits via telemedicine.

Q4. What will be key challenges for developing a larger perinatal telemedicine program and how can we overcome these challenges?

- Health system and resources need to be allocated appropriately. Most physicians don't understand the billing. I think the biggest utility of this program is in patient education and reduction of psychological stressors. Bedside patient care is still very important and in pregnancy that cannot be substituted by telemedicine
- Funding mechanism overcome through grants / value-based care model(s). Patient engagement managed through proactive outreach strategies. SDOH factors addressed in coordination with this initiative.
- Will patients always have reliable connections Wi-Fi or otherwise for health? Currently with COVID, Medicaid allows phone calls, zoom, basically any communication to be billed- will this continue?
- One of the largest obstacles is documentation amongst hospital with different EMR's. In addition, in regard to anesthesia it is making services available and providers in remote areas aware of available services.

- Payment and infrastructure. Who will be paying for these services? and which providers will be providing the consultations?
- The key challenge will be to hire enough genetic counselors to implement the program in what are several of the neediest geographical regions of Maryland. This challenge it cited as #1 because there is a shortage of genetic counselors in the United States. Once we start with (for the pilot) one telemedicine prenatal genetics outreach site and one genetic counselor whose recruitment we move ahead with expeditiously to advertise the position, interview, and then hire, in order to expand from there we would want to immediately advertise so as to hire an additional genetic counselor for what will become an expanded prenatal genetics telemedicine program, eventually seeing that the entire state of Maryland is adequately served.
- Second key challenge will be the recruitment and hiring of a genetic assistant or other financial counselor trained to sort out the complexities of insurance pre-authorizations for genetic tests and other services or procedures related to prenatal genetics; this will also be an important and necessary piece of the planning phase. The volume and caseload of patients in need of prenatal genetic services at each site will be proportionate, generally, to the number of deliveries at that hospital. The pilot program will help to predict the workload and thereby the personnel needed as the program expands, first to two hospitals, and ultimately several hospitals to assure there is provision for Prenatal Genetic services by telemedicine to patients -- and their obstetrical providers -- in all regions of the state.
- Trust in the healthcare industry will be a major challenge. Allowing new technology in people's homes that could be used for surveillance will make some people nervous. A trusting relationship with the doctor/nurses involved will be extremely important.

Other comments/suggestions

- This is a wonderful project and I think we have the potential to be a novel state in this area
- At the risk of over-analysis, better understanding of specific opportunities by hospital / region, i.e. differences in intrapartum events and / or antepartum conditions including diabetes, hypertension, etc.? This can inform where and how different telemedicine models can be strategically deployed.
- Any role for doulas, lactation consultants, nutritionist, therapists etc. to be integrated into these models? Any emergency system for women to text special code phrase for safety issues?
- I would first want to conduct a needs assessment of the Level 1 and 2 hospitals to determine what they lack currently and how that compares to national standards. There are mechanisms currently in place for the referral of the highest risk patients into tertiary care. Is this working? Not working? If it is not working, why not? Will telemedicine be able to fix these issues? Will it create additional issues?
- Parental Genetic counseling is categorically suited for telemedicine as a way to reach obstetrical patients in remote geographical areas, and thereby provide information about what is an increasingly individualized and increasingly complex array of choices of genetic screening and testing options from which pregnant women must choose. Provision of genetic counseling will likewise greatly assist -- and better inform and educate -- obstetrical providers in remote geographical areas. The impact of genetic counseling will be to allow patients to make informed choices about prenatal screening and testing, which in turn does lead to the identification of pregnancies at risk for fetal /neonatal anomalies, congenital disorders, and complications, and in some cases maternal complications, and does identify which patient needs to be "triaged' so as to deliver in a tertiary care facility. There is only one reason why telegenetics has not been implemented already in Maryland and many

other states: Its provision is stymied by the fact that genetic counselors are not recognized (in most states) as 'providers' under Medicare, and therefore they cannot use this capability in their work as they cannot generate revenue for the service to cover the cost of their salaries. The provision of telegenetics for genetic counseling -- which heretofore has simply not been able to be provided -- to a much broader community statewide under the auspices of a grant-funded approach will see immediate and valuable 'return on investment' in terms of improvement in perinatal outcomes.

Training Innovation Workgroup Feedback

Feedback from the Training Innovation Workgroup is provided below by question, including answers to questions by individual workgroup members.

Q1. Are the proposed trainings and modes of delivery meeting the needs of maternal health care providers in Maryland? Are there other critical training areas that the MDMOM should address or critical content to include in the proposed trainings?

- I don't have a comprehensive answer to this question. My expertise in perinatal health, to the extent I have expertise in this subject, comes from coordinating the recently completed "Study of Mortality Rates of African American Infants and Infants in Rural Communities" from 2019. The proposed implicit bias training would be an implementation of the third recommendation from this report: " Implement rigorous implicit racial bias training in relevant health care providers' education and clinical practices." The study report also recommended that providers obtain "continuing education in recognizing and addressing mental health issues and substance use disorders in pregnant and postpartum women", which relates to the planned substance use stigma course. Another topic that came up in this study that did not result in a training recommendation, but might be amenable to a training solution, was how to increase provider use of risk assessments (like medicaid's PRA) and related referral and care management activities, so that social determinates of health and other risks are identified early and women are connected with appropriate services.
- Yes, when focusing on bias and communication this sound sufficient. However, providers views and support or lack thereof of physiologic birth also contributes to morbidity. The overuse of EFM contributes to increase rise in c-sections which increases morbidity and mortality without reducing hypoxia in newborns as it was intended to do. I would recommend focusing on how we actual manage labors and educate our patients about normal birth to help to reduce negative outcomes. Also wider acceptance of the benefit of doulas can be helpful in reducing mortality and morbidity. Anecdotally, many providers tend to react negatively when they find a patient has a doula. This is not missed by the doula or the patient and creates a communication and trust barrier. Patients who have chosen doulas do so in an effort to offer protection and comfort for themselves, when providers feel negatively about use of a doula it disrupts the relationship between the patient and the provider.
- The proposed trainings and modes seem to be appropriate.
- The proposed trainings offer a good start. Would surveying the actual providers early on help to see what they feel is needed for their particular institutions?
- We need to work on teamwork, real teamwork!! a must! This will help communication which is the cause of many of the bad outcomes

- Interactive online modules for training will be most beneficial with opportunities for additional formats per provider requests...Specific demographic training for a providers working geographic area may be helpful in understanding the specific needs of their community.
- Yes, the trainings appear to be sufficient; there is a need to standardize policies or make recommendations that can be used across the board on how a pregnant women should be triaged when entering the healthcare system thru the emergency department
- The trainings and modes of delivery are good but there are other critical trainings in addition to implicit bias, substance use, and recognizing/managing severe maternal morbidity that would be appropriate for best practice training such as PPH, preeclampsia, and potentially infection would be appropriate especially for community hospitals. It could be approached as an improved continuing education system for active providers who are not in educational settings. There could also be a discussion of using simulation as part of the trainings.
- They are, but there are other critical areas beyond implicit bias, substance use, and recognizing/managing SMM. Specifically, best practice training on PPH, preeclampsia, potentially infection would be appropriate particularly for the community hospitals. Sort of a improved continuing education system for active providers out of educational settings. Simulation should probably be a part of this discussion.
- I recommend exploring the research of these authors:
    - Burgess, Bokhour BG, Cunningham BA, et al. Communicating with providers about racial healthcare disparities: The role of providers' prior beliefs on their receptivity to different narrative frames. Patient Educ Couns. 2019;102(1):139-147.24.
    - Burgess, Bokhour BG, Cunningham BA, et al. Healthcare Providers' Responses to Narrative Communication About Racial Healthcare Disparities. Health Commun. 2019;34(2):149-161.
    - Devine PG, Forscher PS, Austin AJ, Cox WT. Long-term reduction in implicit race bias: A prejudice habit-breaking intervention. J Exp Soc Psychol. 2012;48(6):1267-1278.28.
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Q2. How can implicit bias trainings be designed to effectively address disparities in maternal health and ensure high hospital and maternal health care provider (obstetricians, midwives, and nurses) participation?

- I don't have expertise on this topic, other than research-based knowledge that trainings must be reoccuring to be effective over the long term. In addition, executive leadership buy-in is crucial to creating an organizational culture that values this topic.
- A pre self assessment can help to clue thproviders into their own implicit bias. For instance the Implicit test by Harvard. Perhaps having a video package showing testimony from patients who feel they were impacted by implicit bias could be helpful. This way providers are hearing from a first hand source. It could also be useful to have testimony from health care providers who believe that they witnessed instances of bias and how it negatively impacted the care of their patient. This could be part of a package that is viewed prior to taking part of the training so that providers feel connected to the issue through the stories of others. This of course could be linked to data so we have both the qualitative and quantitative supporting each other. In order to make sure that we are targeting different types of learners there could also be written reflective activities. So after a video or literature activity providers can be asked to write a reflection on what they have learned from the

piece provided. There could also be interactive practice of interview techniques to help providers get to know their patients better. Implicit bias can be reduced when providers make a point of knowing their patient as an individual rather than clumping them into a group. What types of questions can be used to help create an individual connection with patients like: Tell me about yourself and your partner (if one is involved), what is most important to you about your pregnancy and the way you experience it, what's your biggest fear. Personalization is key to avoid stereotyping.

- It will be important to and understand understand the disparities that exist in Maryland across the available national perinatal measures, and to address issues of social determinants that impact the disparities. These may include Medicaid as a proxy for income, race and Area Deprivation Index (ADI), among other factors.
- I think that personalizing the information presented will help. Give the data for the particular institution on actual disparities for that institution. I think that many believe the problem is not theirs, but occurs at "other" institutions. It needs to be clear how this affects "me."
- Unfortunately, it probably will need to be mandated. The real question is can it be done where it is truly meaningful. one lecture will not help. it needs to be built into a yearly competency where physicians/providers can get CME credit..
- I don't think we have clear evidence on how to use trainings to effectively address maternal health disparities. Any training should include specific clinical interventions that can be applied. Mandating training will ensure participation but may weaken impact. I recommend using an appreciative inquiry framework to explore implicit bias among providers. It's a safe way to inquire about the issue. Health care providers will be more responsive if there's clear data indicating that bias is impacting care and contributing to disparities. In my experience nurses were most likely to participate in activities that occurred on the unit or at least the same floor where they worked. Integrating training into mandatory department meetings is also a great way to engage a captive audience.
- Implicit bias trainings should be mandated by the state board with yearly competencies. Modules that are somewhat personal/emotional in nature may be more effective.
- Provide examples and maybe case studies during the training; offer certification for healthcare providers who complete the training
- The trainings need to be as evidence based as possible and there will need to be a sustained effort to engage providers.
- They should be as evidence based as possible, and potentially need to be a sustained effort.

Q3. What potential barriers could there be for implementing the proposed trainings? What steps can we take to avoid them?

- I defer to individuals who routinely work directly with providers on this question.
- Timing and availability. Making some elements available online for self adminsitration by providers can help. Making sure that the segments that are online actual require attention to move through, for instance assessment queestions at the end. Perhaps offer live interactive online classes periodically to provide segments of the training. This allows for providers to interact without having the trouble of getting to a location.
- Hospitals will need to understand the benefits of participation in this initiative.
- Barriers include lack of staff engagement on the front line (L&D, MCU staff- nurses techs, etc). Staff seem to complete trainings for the sake of completion. Engaging staff is an ongoing challenge. Unfortunately, with the current COVID crisis, I think this will be even harder. We struggle with getting staff to even attend a CUSP meeting, let alone volunteer to participate in an initiative.

- Time commitment with all the other responsibilities people have. this is something which is going to take a great deal of time.
- Barriers: Health care providers who believe that they don't have biases that impact care. The sense that this is just another mandatory online trainingI recommend adding an element of fun or celebration of what's working well. Integrate the trainings into a long term initiative. Make the objectives of the training clear and tangible with a specific goal for patient care.
- Barriers could include the sense that it does not affect a given provider, true biases, and lack of state/medical board support. Steps to include in order to avoid barriers is true, transparent information highlighting the disparities and true impact on the community and individuals.
- Timing-it is difficult to get doctors and nurses to participate in a training that is held during the day; a lot do not want to attend on the weekend either; maybe the training should be on-line ie webinar with CEUs/CME
- The active "buy-in" of hospitals as well as provider availability and amenability for training could be barriers. The requirements triggered by the new law are helpful but there could be incentives and/or rewards developed for active participation.
- Hospital buy in/provider availability and amenability for training. carrots and sticks-- I think the requirements are a helpful to a limited degree, but then figuring out a way to reward institutions or individuals that participate?

Q4. How can the MDMOM program best coordinate across the various hospital-based initiatives, including the proposed trainings and QI initiatives? What support can the Task Force provide to hospitals?

- I defer to individuals who routinely work directly with hospitals on quality initiatives on this question.
- Institutions have their own online training programs. Making the digital assessments, videos, etc available for institutions to link to their already existing programs could help.
- As a state policy maker, I do not feel I can best answer this question.
- As a former staff nurse within the past year, I think that only staff involved in particular initiatives really understand what is involved. Yes, all staff are educated, but lacking engagement in the process, there is no drive to really absorb the information and act on it. There are so many trainings required of staff, they are often completed just to get it done. Honestly, the AIM bundles aren't really even clear in that staff may not know what an AIM bundle really is. We need to find ways to draw staff in to want the information and want to act on it.
- I think you will find some hospitals don't need much support and others will absolutely welcome it.
- Provide clear steps. Map out a plan with obvious targets. Integrate any training into an initiative to improve institutional data on disparities.
- Multi-hospital panel with input for a more standardized process that can be enforced by hospitals on the state level. ACOG leadership can also further support the necessity of the training on a national level. The task force can provide information, tools, and physical support to hospitals for implementation. Volunteer consultants could also be useful.
- See response above which addresses how to coordinate the proposed trainings for healthcare providers
- MDMOM should actively support AIM and similar state based efforts by disseminating information and encouraging active participation and adoption.
- Help support AIM and similar state based efforts in dissemination