



# SB 332 Semi-Annual Report 1

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## Executive Summary

In accordance with Senate Bill 332 (the Infant Mortality Bill) of the 131<sup>st</sup> General Assembly, the Ohio Department of Medicaid (ODM) began conducting community assessments to identify and mitigate barriers women of reproductive age (15 – 44) insured by Medicaid experience, while navigating the healthcare system for optimal birth outcomes. The state fiscal year (SFY) 2018 Community Assessment I was conducted with key informants (n=7), representatives from prominent maternal child health community-based organizations (CBOs) and focus groups (n=8) with women insured by Medicaid (n=45) in Athens, Cuyahoga, Franklin, Hamilton, and Ross counties to identify access barriers specific to prematurity prevention, tobacco cessation and optimal birth spacing interventions. This report summarizes the qualitative data collected. Data was then analyzed from Assessment I (SFY 2018) to identify key barrier themes, and recommendations from ODM to mitigate these barriers in the future. The qualitative data findings also are represented as a comparison to quantitative data collected from the 2016 Ohio Pregnancy Assessment Survey (OPAS) for the three intervention areas. This report summarizes key barriers identified through comprehensive data collection analysis and offers ODM’s recommendations to eliminate future impediments to quality care.

### Key Findings of Community Assessment I (SFY 2018):

Key Barrier Themes	Related Themes	Examples of Barriers
Lack of effective communication	Lack of responsiveness to needs	Lack of available services, issues contacting physicians, excessive wait times in providers’ offices vs. time with clinicians, lack of symptom-related care, and unresponsiveness to concerns presented at time of care.
	Lack of respectful communication	Harsh and demeaning communication from health care providers, disrespect for patient decisions related to health conditions, and perceived disrespect for privacy and basic customer service.
	Lack of easily accessible resources	Difficulties navigating the healthcare system and locating needed services.
Lack of empathy	Perceived lack of compassion	Participants perceived healthcare provider(s) had negative attitudes towards them and appeared insensitive to their individual needs and life choices.
	Perceived lack of fair/equal treatment/provider judgment	Participants perceived that providers’ judgment affected the quality of care they received. They perceived judgment was related to visual observation, income level, race, social status or lifestyle choices.
Lack of trust	General mistrust of the health care system	Participants expressed general mistrust of the health care system due to past or current experiences.

## Introduction

Infant mortality is considered a mark of the overall health of a city, state, or nation. In 2016, Ohio's infant mortality rate of 7.4 per 1,000 live births placed the state among the worst in the United States. The infant mortality rate among Ohio's African Americans was even higher with African American babies dying at almost three times the rate of white infants. Prematurity, also higher among African Americans, contributed to 35% of these deaths.<sup>i</sup>

Many factors contribute to prematurity including: the overall health of a woman at the time of conception, serious health conditions a woman may develop during pregnancy like diabetes or high blood pressure, smoking, and birth intervals that are shorter than 18 months that impede a woman's body to recover between pregnancies.<sup>i</sup>

Ohio's Medicaid program covers more than fifty percent of all Ohio births. The agency is in a unique position to identify and remove barriers contributing to higher than optimal rates of prematurity and infant mortality. Pursuant to the Ohio Infant Mortality Bill – Senate Bill 332, in SFY 2018, ODM initiated an effort to identify obstacles women insured by Medicaid experience as they navigate interventions intended to reduce infant mortality. This is particularly so as it relates to preventing preterm birth, reducing tobacco use, and promoting safe birth spacing.

ODM reviewed current methods for assessing barriers to women of reproductive age in accessing services related to the three interventions mentioned above. The agency focused directly on the "voice of the customer" by capturing the perspective of this population and community leaders through interviews and focus groups within targeted geographies.

The March 2018 Access Barrier Assessment Report (Appendix A), submitted to the Ohio General Assembly, the Ohio Commission on Infant Mortality, and the Joint Medicaid Oversight Committee described ODM's approach. Input was gathered from approximately 45 women residing in five counties with high preterm births in Ohio: Athens, Ross, Cuyahoga, Franklin, and Hamilton. Observations of community leaders representing organizations providing services and supports to pregnant women are also included. These community interviews, while valuable, were limited, and do not meet statistical analysis standards. However, to ensure ODM gained a comprehensive understanding of the barriers women experienced, the agency adopted a broader approach to barrier identification and coupled the community interview learnings with the most recent Ohio Pregnancy Assessment Survey (OPAS) results, which represent more than 3,300 women.

In this report, ODM describes and discusses the findings from the community interviews and the Ohio Pregnancy Assessment Survey (OPAS) survey and identifies strategies for addressing the challenges experienced by pregnant and postpartum women to prevent preterm birth, reduce tobacco use, and promote safe birth spacing across the state.

## Methodology

Historically, ODM has learned about barriers to care through several different sources, including feedback from Medicaid providers and provider associations, state patient surveys, sister state agencies, external stakeholder input and administrative data. These methods have provided ODM with information regarding access to general Medicaid services, but have not focused on women at highest risk for poor birth outcomes. In addition, the amount of information specific to the barriers encountered by women of reproductive age, particularly in relation to their access to interventions aimed at preventing preterm birth, reducing tobacco use, and promoting safe birth spacing, has been limited with few opportunities to drill down to root causes.

The March 2018 SB 332: Access Barrier Assessment Report detailed the many sources that ODM reviewed. Of these, the Ohio Pregnancy Assessment Survey (OPAS) was the most relevant, as it was the only data source that addressed barriers to medical care and tobacco cessation.

The 2016 OPAS, a stratified mixed-mode, random survey, collected information on the experiences and attitudes of all Ohio women approximately two to four months after delivery. Specific populations of interest, such as the nine Ohio Equity Institute (OEI) counties (as displayed in the map) were oversampled to facilitate analysis of the state’s initiatives and ongoing program development.



9 Ohio Equity Institute Counties

The survey asked questions about experiences before, during, and after pregnancy and provided a representative view of women in Ohio. However, the survey did not provide rich detail around the experiences of women insured by Medicaid when attempting to access services aimed at preventing preterm birth, tobacco cessation, and safe birth spacing. This report details quantitative OPAS findings followed by qualitative focus group data relating to the three areas of intervention.

To obtain the perspective of communities with high rates of infant mortality, ODM contracted with an external quality review organization, Health Services Advisory Group (HSAG), to conduct a series of community interviews within five counties: Athens, Cuyahoga, Franklin, Hamilton, and Ross. County selection was based on higher preterm birth rates in Cuyahoga, Franklin and Hamilton counties, and the accelerated declines in preterm birth and distressed outcomes influenced the selection of Appalachian counties Athens and Ross.

Community interviews consisted of two parallel phases. The first phase involved in-depth telephone interviews conducted with seven key informants, employed by community-based organizations (CBO), asking open-ended questions to identify any system, organizational, social, or personal barrier preventing the receipt of the three infant mortality targeted interventions. For the second phase, five focus groups were conducted with a total of 45 women of reproductive age insured by Medicaid who resided in these high-risk communities. Focus group participants were asked questions about their experiences with prenatal care, tobacco cessation, obtaining birth control and birth spacing, as well as their general health before, during and after pregnancy. The interviews and focus groups were completed during the first half of calendar year 2018.

Table 2: Focus Group Participation					
Rural/Appalachian		Metropolitan/OEI			Total
Athens County	Ross County*	Cuyahoga County	Franklin County	Hamilton County	
11	9	9	10	6	<b>45</b>

\*Includes women from surrounding counties

## Findings

### Overall Barriers

Quantitative results from 2016 OPAS indicated that compared with their privately insured counterparts, women insured by Medicaid were:

- More likely to experience depression both prior to becoming pregnant (24.9% vs. 10.5%) and after delivery (14% vs. 5%).
- More likely to experience a greater number of stressful events (e.g., loss of a job, death of someone close to them) (22.04 vs 4.80%).
- More likely to feel upset due to perceived prejudices because of their race in the 12 months before their baby was born (9.91% vs. 3.35%).
- More likely to experience unintended pregnancy (41.35% vs. 20.60%).
- Less likely to begin prenatal care as early as they wished (83.79% vs. 94.40%).
- Less likely to attend postpartum medical visits (89.45% vs. 84.85).
- Less likely to quit tobacco use during pregnancy (24.73% vs. 41.23%).

The community interviews conducted by HSAG provided insight into some of the reasons for these findings.

HSAG’s research allowed ODM to identify three prominent barriers that women insured by Medicaid experienced when accessing interventions intended to prevent infant mortality. These themes, which centered around prenatal care settings were:

- Lack of empathy from providers of care.
- Lack of trust of the health system.
- Lack of effective communication within the health system.

These themes were prevalent across all three intervention types: prematurity prevention, tobacco cessation and birth spacing. The relationships of these findings with OPAS’ results are discussed in more detail below.

### Prematurity Prevention

Preterm births, defined as infants born prior to 37 weeks, are the leading cause of newborn death. They account for nearly a third of all infant deaths in Ohio.<sup>1</sup> There are significant disparities in preterm birth rates among racial and ethnic groups in Ohio, with the preterm birth rate for non-Hispanic African American women 32% higher than the rate for non-Hispanic Caucasian women. In 2017, 85.5% of all live Black births occurred at less than 37

weeks gestation, representing 22.2% of Black infant death; while 0.7% of extremely premature Black births (infants born at <23 weeks) represent 41.5% of Black infant death.<sup>ii</sup>

Early prenatal care mitigates risk factors for preterm birth. However, 2016 OPAS results show that women insured by Medicaid are almost twice as likely as those with another source of insurance to experience delays in prenatal care (19.9% vs. 11.1%).

The community interviews added perspective explaining why delays exist. According to community focus group participants, lack of respectful communication and lack of consistent, safe and trusted transportation delayed care. These contributed to appointment scheduling difficulties and an overall distrust of the health system.

Women participating in community focus groups commented on poor provider/patient communications, disrespectful treatment to their requests, and lack of provider responsiveness for routine pregnancy care. Examples include not receiving testing for gestational diabetes mellitus, nor receiving ultrasounds and obtaining details on how far along the pregnancy was in terms of gestational weeks. These omissions often prevented respondents from receiving care and services during their respective prenatal periods.

Challenges related to transportation was a consistent topic of concern. The women expressed scheduling difficulties and complicated approval processes.

*“I’m on a managed care plan, but it took a while for me to get access to transportation. All I needed was ride to the doctor. Any type of vehicle is alright, just as long as I get to my appointment. I don’t understand why I have to keep going through different people for approvals.”*

Community interviews also revealed that once in the office for an appointment, the long wait times contributed to women feeling as if their own schedules and priorities were not respected.

*“Sometimes I wait forever in the waiting room, and that’s before they even call me back to see the doctor. I know there’s other people there, but I schedule an appointment for a reason. When my appointments run late it’s aggravating. I have children and we have things to do, so sometimes it’s very inconvenient for me.”*

*“I went to a walk-in clinic and was told I was pregnant, but they didn’t tell me how far along I was. Later, I called the clinic and tried to schedule an appointment, and they told me I had to wait about two months. I didn’t want to wait. So, I lied and told them I was bleeding just to get in earlier to find out how far along I was.”*

*“I feel like the staff wasn’t listening to what I was saying. I got the impression that they didn’t believe that I was pregnant. I know ‘my body’ and had missed two or three periods before that appointment. But each time I went in for an appointment they kept telling me I wasn’t pregnant. When they finally tested me, I was seven weeks along.”*

Interest in attending health appointments is necessary for both mom and baby. Women with Medicaid expressed that feelings of stress, judgment from the provider, providers not addressing medical needs and/or concerns, and a lack of easily accessible and understandable information results in barriers by creating a less than desirable care environment that reduces interest in attending prenatal appointments.

## Tobacco Cessation

Tobacco use is a known contributor to infant mortality. Tobacco use during pregnancy can lead to increased rates of miscarriage, preterm birth, low birth weight, and birth defects. In addition, after delivery, smoking in the home increases the risk of Sudden Infant Death Syndrome (SIDS), which accounts for seven percent of infant deaths during the first year of life.<sup>ii</sup>

Based on 2016 OPAS results, women insured by Medicaid were more than twice as likely as women with other insurance types to smoke during the two years prior to pregnancy (41.6% to 14.9%), and during the last trimester of pregnancy (58.23% to 23.1%). Statewide barriers to quitting smoking prior to pregnancy are summarized below.<sup>iii</sup>

<b>Barriers to Tobacco Cessation Prior to Pregnancy</b>		
	Women insured by Medicaid	Women not insured by Medicaid
Cost of medications	33.9%	23.7%
Cost of classes	23.1%	26.1%
Concerns of weight gain	33.5%	31.1%
Coping mechanism for stress	77.5%	68.7%
Social Cues	69.9%	58.6%
Physical/psychological cravings	83.6%	72.4%
Worsening depression	38.3%	24.6%
Worsening anxiety	46.4%	33.7%

Results of the community interviews mirrored OPAS' statewide findings. Focus group respondents reported everyday life stressors, social connections (or lack thereof), trauma and depression as reasons for continued tobacco use before, during and/or after pregnancy.

*"I personally experienced childhood abuse and never took time to do counseling or therapy. Now, I've been diagnosed with anxiety and depression. When I get depressed, I want to smoke."*

The 2016 OPAS results provide insight into the many stressors that women insured by Medicaid experience prior to becoming pregnant.

<b>Stressors Experienced 12 Months Prior to Pregnancy (2016 OPAS Results)</b>		
	Women insured by Medicaid	Women not insured by Medicaid
Job loss	16.5%	2.9%
Reduction in pay	24.0%	10.0%
Difficulty paying bills	31.1%	9.4%
Separation or divorce	11.0%	3.9%
Change in residence	39.7%	31.2%
Incarceration of self or partner	6.8%	1.2%



Alcohol or drug use by someone very close	25.3%	9.1%
Death of someone very close	23.8%	13.5%

In addition to economic stressors, social stressors were also common. During the twelve months before delivery, a greater percentage of women insured by Medicaid experienced a separation or divorce (11% compared to 3.9%), and a move to a new address (39.7% to 31.2%) than women not insured by Medicaid.

The use of tobacco as a stress reliever, a coping mechanism, and a means of interacting socially for support was also emphasized by the community interview respondents. The focus group participants noted that they felt support to quit smoking was lacking. They also believed they were being judged by providers who lacked an understanding of all the factors that go into being ready and able to quit. The women asked for judgment to be set aside and to approach their behavior with empathy. They asked that providers assist them in quitting by helping them understand the risks of smoking during pregnancy to analyze their reasons for smoking, to withhold judgment in order to help address the root causes of their smoking habits (depression, social isolation, stress).

According to 2016 OPAS results, approximately 97% of women insured by Medicaid were asked about cigarette use by their providers during their prenatal visit. When Ohio women of reproductive age are seen by a clinician, the vast majority are screened for the risk of tobacco use. In combination with the qualitative information from focus group respondents, the prevalence of opportunities for discussion highlights the importance of forming relationships and building trust through empathetic conversations with women. These relationships help Ohio Medicaid understand how best to promote readiness to quit, prioritizing underlying contributing factors: stress, anxiety, depression, and a desire for social connection. In addition, available referral resources that supply response reports back to the provider about the patient’s quit progress would support care coordination, follow up, and relationship building between the patient, provider, and community resources.

### Optimal Birth Spacing

The third intervention of interest discussed during the community assessments was optimal birth spacing. Birth intervals that are shorter than 18 months allow less time for a woman’s body to recover between pregnancies, increasing the risk of preterm birth, and impacting infant mortality.<sup>iv</sup> OPAS results from 2016 revealed that women insured by Medicaid were more likely than women with other insurance types to be asked about their plans to use birth control after delivery during their prenatal visit (86.9% compared to 73.7%).<sup>v</sup>

The interviewed women identified three main barriers to optimal birth spacing: perceived or experienced negative side effects of birth control; feelings of judgment of and lack of respect for personal choices; and general mistrust of the healthcare system.

Close to 30% of responses from the community focus group participants indicated negative experiences or perceived negative side effects related to birth control use, including weight gain, menstrual abnormalities, and fertility issues after discontinuing use. For example:

*“I chose Depo Provera and I didn’t like it because I experienced hair loss, and I gained weight. I originally weighed 120 lbs., but after getting on Depo I hit 200 lbs. in three months. So, I stopped using it.”*

Community focus group respondents also addressed individual choice as driving the timing and spacing of pregnancies. Some participants indicated that their age played an active role in determining when to begin having children. These individuals wanted to ensure that they could adequately engage with their children over their life course. Others saw having children as an expression of their femininity and noted the historical acceptance of having large families. For example:

*“The only birth control I ever took was the pill. I’m really connected to my femininity. The main part of being a woman is the ability to give birth. That’s the one thing that makes you a woman.”*

General mistrust of the healthcare system and perceptions of being judged also created barriers to women planning their pregnancies and their use of birth control. Women reported feeling that birth control was being pushed on them to control their reproductive systems, and they said they felt judged when deciding not to use birth control. Additionally, African American focus group participants indicated a perception that birth control was not tested on women of their race, consequently rendering it less effective for their population. For example:

*“There’s actually a greater chance for African Americans to get pregnant on birth control. Contraceptives aren’t tested on us for effectiveness.”*

Participants also were wary of the influence the pharmaceutical industry has on physician prescribing practices, leading to concerns that the health of individuals was a secondary concern for providers. For example:

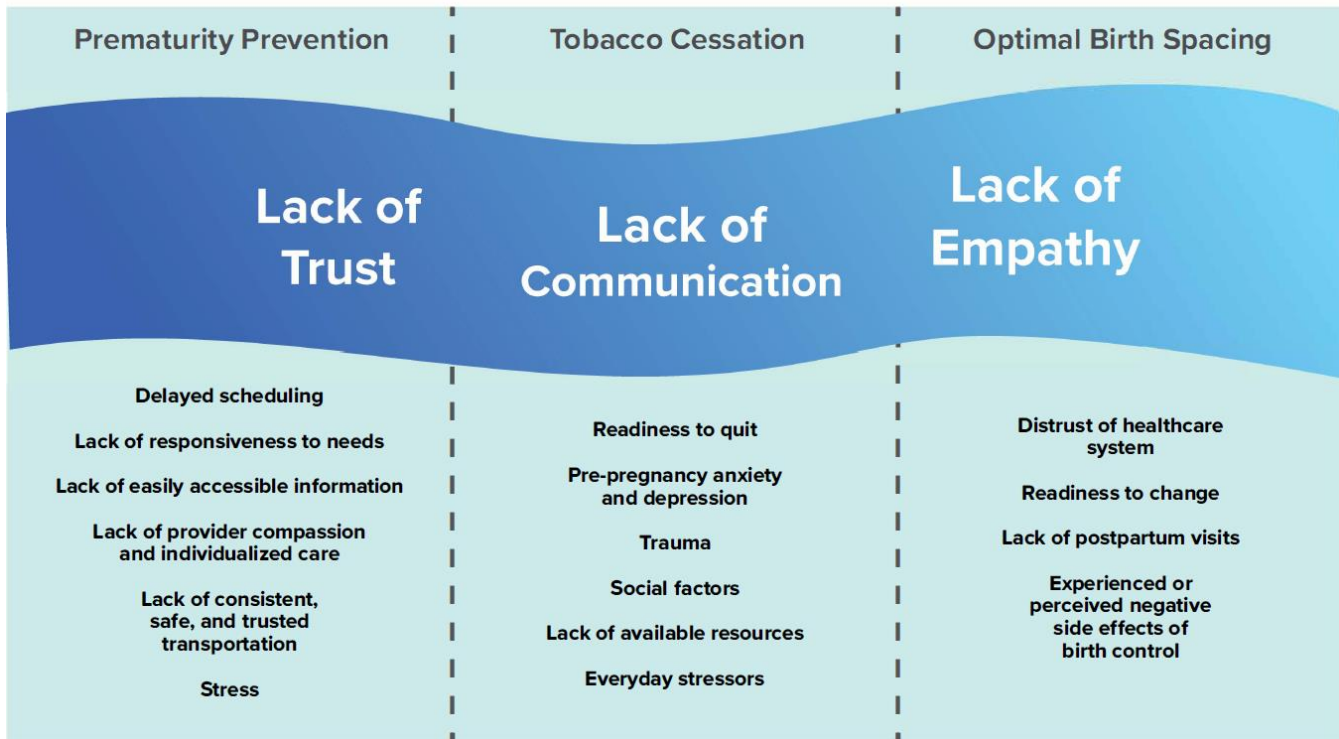
*“Pharmaceutical companies are trying to sell their products. I used to work for Kroger’s Pharmacy Call Center, and know the manufacturers change medication prices at any given time. One day a prescription would cost \$12 and another day it would increase to \$20 or drop to \$1. It’s a multi-billion-dollar industry that pushes doctors to promote their products to their patients. Ultimately, they’re trying to make money.”*

The community interviews added dimension to the 2016 OPAS results by revealing that the decision to use contraception was shaped by pharmacological side effects, historical factors, and the way women felt they were treated by the healthcare system. It is critically important for healthcare practitioners to understand women’s perceptions and preferences, and to communicate without judgment, as they assist them in planning for the health of themselves and their families.

## Discussion and Path Forward

As one of the largest health insurers in the state, ODM has a unique opportunity to encourage access to equitable care and other services needed to promote optimal birth outcomes. The graphic below indicates the most prevalent barriers to the three intervention areas, in addition to the key themes identified.

### Community Assessment I: Barriers to Prematurity Prevention



Upon reviewing the results of this barrier assessment, in conjunction with the 2016 OPAS results, ODM identified the most prevalent barriers to preventing prematurity, tobacco cessation, and optimal birth spacing faced by women insured by Medicaid of reproductive age. The three main themes identified are:

- Lack of empathy from providers of care;
- Lack of trust of the health system; and
- Lack of effective communication within the health system.

OPAS results indicated women insured by Medicaid have different experiences and outcomes in comparison to women with other insurance types. The community assessment findings indicated women insured by Medicaid have different experiences due to insurance type and underlying issues related to poverty. Paired with feelings of judgment and not being heard, as well as poor experiences with the health system historically, it is believed that these factors formed a powerful barrier to accessing the care needed to prevent preterm birth and infant mortality. Providing individualized care to all women is imperative to ensuring quality care. For optimal care to occur, women must feel free to discuss their life circumstances and stressors, and also must receive an empathetic response from the healthcare system to what they have shared.

The development of a trusting relationship begins with open and timely access to the clinicians dedicated to obstetrical care. A healthcare workforce that reflects the cultures and backgrounds of those being served also may facilitate shared understanding, while promoting trust.

ODM is actively working to respond to the barriers identified in this assessment. Routine open communication with the Ohio Collaborative to Prevent Infant Mortality (OCPIM) and the Ohio Perinatal Quality Collaborative (OPQC) provides a way to stay connected with women in the Medicaid program and better understand issues as they surface. Some of the initiatives currently underway are highlighted below, and additional efforts will be developed in conjunction with community partners as progress is made.

## Formal Partnerships with Sister Agencies and Community-based Organizations

### Home Visiting

ODM is working with the Ohio Department of Health (ODH) to increase appropriate referrals of high-risk pregnant women to home visiting through ODM's online pregnancy notification system, the Pregnancy Risk Assessment Form (PRAF) 2.0. The goal is to have all clinicians caring for pregnant women in the Medicaid program submit this web-based form that serves multiple purposes, including: notifying the individuals' managed care plan (MCP) of pregnancy and pregnancy-related needs, and serving as a flag for high-risk conditions that may require special coordination of services such as transportation, progesterone provision, or home visiting; and updating ODM's eligibility system so that coverage is maintained during pregnancy. An infrastructure also is being developed to share the results of assessments conducted during these home visits with Medicaid MCPs to reduce duplication and increase efficiency of service provision.

In addition, ODM will work in partnership with ODH and the National Initiative for Child Health Care Quality (NICHQ) to develop content for home visits specifically designed to improve infant mortality outcomes. ODM also supported the Ohio Federally Qualified Health Center (FQHC) Infant Vitality Initiative to increase access to same day, long-acting reversible contraceptives (LARCs) by partnering with ODH and a family medicine program to streamline clinic processes and remove barriers for prescribing and administering LARCs.

### Quality Improvement Initiatives

ODM also has several quality improvement initiatives underway to improve outcomes for pregnant women in the Medicaid program in partnership with Ohio's Perinatal Quality Collaborative (OPQC), sister state agencies, clinical practices, and communities. The intent of quality improvement projects is to establish or standardize best practices, then sustain and spread improvements. The information gathered as part of the community interview efforts will help inform intervention strategies going forward. Some of the current improvement projects addressing contributors to infant mortality are summarized below.

### Progesterone Quality Improvement Project

Progesterone is an evidence-based therapy that can significantly decrease the risk of preterm birth among women who are at risk due to a previous preterm birth or short cervix. In collaboration with ODH and OPQC, ODM aims to spread the use of progesterone in order to decrease the rate of premature births before 32 weeks gestation. The partners are actively working to increase the use of progesterone by promoting the use of best practices, including early identification of women at risk of preterm birth through the administrative data, and use of a standardized notification of pregnancy form (ODM's PRAF 2.0) to remove communication barriers, ensure the maintenance of Medicaid eligibility, and promote a coordinated approach to serving the needs of women insured by Medicaid.

Since its inception, the Progesterone Quality Improvement Project has engaged 23 high-volume Medicaid practice sites across Ohio in reducing the rate of preterm births for women in two high-risk categories, before 32 weeks and before 37 weeks gestation, through improved screening, identification, and treatment of pregnant

women likely to benefit from progesterone therapy. Published data shows that the project resulted in a 17.1% decrease in preterm births prior to 32 weeks for women insured by Medicaid.<sup>vi</sup>

Although late entry into prenatal care and refusal to accept progesterone treatment were identified as common barriers to progesterone use, the lack of efficient communication across health care providers, insurers, county eligibility staff, pharmacies, hospitals, and pregnant women was the most significant cause of delay or interruption of progestogen treatment. The project addressed this coordination issue by instituting a standardized communication form, the paper-based PRAF (and later the PRAF 2.0) that allowed women to be more easily connected to services while maintaining their eligibility and reducing administrative burden. The next phase of the project focuses on disseminating the successful interventions to maternity care providers in the nine Ohio Equity Institute (OEI) communities and engaging practices in a QI learning collaborative.

### Smoke Free Families Initiatives

The Ohio Smoke Free Families-Perinatal (SFF-Perinatal) learning collaborative is a partnership between the OPQC, ODM, and ODH that aims to reduce tobacco use among women insured by Medicaid during pregnancy and improve birth outcomes for their babies. The SFF-Perinatal project is a quality improvement effort building on the accomplishments of previous tobacco cessation initiatives and expanding resources and interventions for pregnant women. The project involves OPQC training high volume OB-GYN sites on the Ohio SFF provider toolkit, assisting providers in determining patient willingness to quit using the "5 A's" (Ask, Advise, Assess, Assist, and Arrange), assessing the patient's readiness to quit using the "5 R's" (Relevance, Risks, Rewards, Roadblocks, and Repetition), and using motivational interviewing to assist women in making progress toward quitting.

The Smoke Free Families-Pediatric (SFF-Pediatric) project with the Ohio Chapter of the American Academy of Pediatrics involves pediatricians in addressing household members' contribution to mother and infant tobacco exposure.

### Ohio Equity Institute (OEI) Evaluation

In partnership with contracted MCPs, ODM funded community-based organizations in the nine OEI counties to target the racial disparity in infant mortality rates in 2018. Focused on closing the disparities in infant mortality and addressing key barriers identified during community assessments, CenteringPregnancy®, community health workers (CHWs) and home visiting were the three evidence-based interventions selected and funded for the evaluation period. All three intervention models addressed lack of communication, trust and empathy with the health care system by offering group care and non-traditional workers who were culturally competent and either worked or lived in communities in which the Medicaid recipient lived.

The OEI evaluation project began February 2018 and assessed the three intervention models on birth outcomes in preterm birth and infant mortality, along with tobacco cessation, progesterone and initiation of prenatal care. ODM plans to share viable data once available about the success of this project.

### Social Determinants of Health

The data from OPAS and the community interviews highlights that both social and economic factors contributed to stressors associated with preterm birth and higher infant mortality rates. Women insured by Medicaid were more likely than those with other insurance coverage to experience these stressors. To this end, ODM implemented a focused community infant mortality initiative through the MCPs responding to needs identified by communities with the highest disparities in infant mortality. Initial efforts focused on educational

opportunities that resonate with the communities. Subsequent efforts emphasized non-traditional community health workers and programs aiming to communicate and connect with women of color throughout this important phase of a family's life. CenteringPregnancy® programs, home visiting, and community health workers were the main strategies, although support was provided for efforts that routinely gathered women and families in neighborhoods to discuss pregnancy-related issues.

### Community Health Workers

ODM has encouraged the MCPs to assist in the development of a community health worker workforce in order to enhance connection and communication within the areas Medicaid serves. Due to their close connections with their communities and their ability to address social determinants of health, these community health workers or community navigators, are trusted individuals that others listen to. Capitalizing on the use of community health workers/navigators, or other professionally trained individuals, is key to identifying and addressing the many social conditions experienced by women, as well as to establish long-term and trusting relationships.

### Accessible Communication

One of the top barriers identified by community focus group participants was a lack of effective communication between themselves and providers. In the area of prematurity prevention and optimal birth spacing, the primary sub-barriers of concern were the overwhelming amount of information received and the format of the information received from the MCPs and clinicians. These findings highlighted the gaps that exist between the information available and how it is understood and used to make good health care decisions. Focus group participants indicated receiving too much material with conflicting messages in outdated formats contributed to their lack of understanding health-related services and diseases. Formats of preference included web-based portals, applications, text messages, videos, or one location where they could access all useful information.

ODM recently enhanced its internal infrastructure to ensure that MCPs are using the most effective ways to present and deliver health information to members, including the use of mobile messaging and on-line videos and applications. All member materials are assessed by a central team, dedicated to ensuring materials are comprehensible. In addition, ODM's MCPs are required to convene quarterly consumer advisory councils with a diverse and representative membership. These groups are intended to elicit meaningful input about how best to serve their members, including providing effective communication. The councils also provide a unique opportunity for the MCPs to periodically test materials to ensure they are meeting consumers' preferences.

Despite these improvements, there still is much work to be done. CHWs are needed to assist with communication barriers by speaking with women about available services and resources and providing access to materials while easily explaining the contents and action required by the individual. The use of non-traditional workforces for the dissemination of information is another key strategy ODM believes will help move this population toward positive birth outcomes.

### Transportation

Lack of adequate, safe, reliable transportation was identified as a factor interfering with the ability to keep prenatal and post-partum appointments. ODM's MCPs are testing different ways of improving transportation for pregnant women for health purposes. One plan is providing unlimited transportation to pregnant women. Others are testing on-demand transportation services such as Lyft and Uber, without the requirement for 48-hour notice. Concerns expressed during community interviews regarding inappropriate behavior by male

drivers, as well as the safety and cleanliness of vehicles, could be addressed through the use of ratings functions such as those that exist for Lyft and Uber. Customer satisfaction should also be a consideration and be included in the MCPs' contracts with transportation companies.

### Value-based Care

Value-based care rewards MCPs and providers for achieving quality outcomes. ODM's current performance measures are anchored in core clinical functions, such as getting appropriate testing done or attending a post-partum visit. They are based on claims and medical records. Refining quality criteria to include the patient experience would incentivize establishing and maintaining trust. Although insufficient, is a necessary factor in improving maternal and infant outcomes. As our health care system continues to respond to the need to address upstream factors such as SDOH, finding a way to incorporate the cultural and socio-emotional aspects of quality of care into how we pay for value in health care will be increasingly important.

### Summary and Sustainability

This report highlights the need to advance discussions with clinical educators, health systems, policymakers, communities and others dedicated to improving outcomes for Ohio's mothers and our newest citizens. The community interviews conducted have provided ODM with unique insight into the barriers that women of reproductive age insured by Medicaid experience when attempting to access the three main intervention areas intended to prevent infant mortality.

Clear deficits exist in our health care system in the areas of trust, empathy, and communication; and these deficits interfere with women receiving the services needed to prevent preterm birth and infant mortality. It is imperative for ODM and our sister agencies to take these facts into consideration as we respond to the needs of Ohio's women.

The second wave of the community interviews related to SB 332 is in progress, and ODM plans to revise the methodology allowing for focused interviews from the OPAS sample. This assessment underscores the importance of hearing the testimonies of women served in the program.

Continued structured assessments with women in the Medicaid program, as well as receiving stakeholder feedback, will allow ODM to make program refinements that close the disparity gap in preterm birth and infant mortality with its MCP partners.

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<sup>i</sup> Ohio Department of Health, Bureau of Vital Statistics

<sup>ii</sup> Ohio Department of Health, Extremely Premature Births in Ohio, 2017 Report

<sup>iii</sup> In the OPAS Survey, women could select multiple barriers to smoking cessation. Therefore, the sum of the percentages listed is expected to be greater than 100 percent.

<sup>iv</sup> Ohio Department of Health, Bureau of Vital Statistics

<sup>v</sup> Data Source: 2016 OPAS. Subpopulation: women who received prenatal care; Non-Medicaid includes women with private insurance, other insurance, or no insurance for their prenatal care.

<sup>vi</sup> Iams, J. D., Applegate, M. S., Marcotte, M. P., Rome, M., Krew, M. A., Bailit, J. L., Kaplan, H. C., Poteet, J., Nance, M., McKenna, D.S., Walker, H.C., Nobbe, J., Prasad, L. Macaluso, M., Lannon, C. (2017). A Statewide Progesterone Promotion Program in Ohio. *Obstetrics & Gynecology*, 129(2), 337-346.

Appendix

Table: 1

Ohio Department of Medicaid’s Current Barrier Identification Methods (September 2018)		
Provider Perspective		
Method	Description	Limitations
<b>Pregnancy Risk Assessment Form (PRAF)</b>	ODM receives information on barriers to pregnant women through the PRAF. This form allows providers of prenatal services to alert the MCPs and ODM of unmet needs, both medical and social (such as the need for progesterone, tobacco cessation counseling, and transportation). It also prevents loss of Medicaid coverage during pregnancy by alerting the counties of the condition, so eligibility redetermination does not occur during this critical time period.	<ul style="list-style-type: none"> <li>• Provides a clinical assessment of barriers to care, not the patient journey.</li> <li>• Is not representative of post-partum or preconception health barriers to care.</li> </ul>
<b>Provider Association Feedback</b>	ODM takes provider feedback into consideration when assessing its policies and processes. Involvement with entities and provider associations such as OPQC, OCPIM, the Ohio chapter of the American Congress of Obstetricians and Gynecologists (ACOG), and other local organizations such as Ohio Better Birth Outcomes (OBBO) can provide ODM with insight into access barriers women of reproductive age experience. ODM can then work with internal and external entities to address these barriers.	<ul style="list-style-type: none"> <li>• Does not capture the individual beneficiaries access barrier to care.</li> <li>• Missing components specific to SB 332: Tobacco cessation, birth spacing and prenatal care barriers to care.</li> <li>• No systematic record of findings.</li> </ul>
<b>Direct Communication with ODM</b>	ODM allows individuals to directly communicate with Medicaid through the Ohio Medicaid website. Questions are then routed to the appropriate mailbox. Examples of internal mailboxes to which questions are routed include those dealing with	<ul style="list-style-type: none"> <li>• Not inclusive of three intended interventions: tobacco cessation, birth spacing and prenatal care barriers to care.</li> <li>• Limited Medicaid beneficiary input.</li> </ul>



	<p>hospital, non-institutional, and eligibility policy. The Progesterone Performance Improvement Project (PIP) email box provides a direct route for providers of pregnancy services to alert ODM of any barriers to assessing progesterone for their patients. Most common barriers identified include loss of coverage and miscommunication between entities such as MCPs, home health, and pharmacies. This email box is monitored daily and identified barriers are prioritized for resolution. ODM has many open forums. Groups convened by ODM policy and discussions with clinical entities are a few examples.</p>	
<b>Consumer Surveys</b>		
<b>Method</b>	<b>Description</b>	<b>Limitations</b>
<p>Ohio Pregnancy Assessment Survey (OPAS) Administered by the Ohio Colleges of Medicine Government Resource Center (GRC)</p>	<p>Captures questions pertaining to pregnancy and pregnancy-related services (PRS) of the individual member before, during, and after pregnancy. Data collected from OPAS provide useful information to improve the health of both the mother and infant. OPAS asks questions about lifestyle and behavioral choices associated with birth spacing, prenatal care, and use of tobacco or other drugs at preconception, conception and postpartum health. In 2016, the overall response rate of the OPAS survey was at 31.4%.</p>	<ul style="list-style-type: none"> <li>Information does not provide individual perceptions of barriers to care in accessing Medicaid services.</li> </ul>
<p>Ohio Medicaid Assessment Survey (OMAS)</p>	<p>Ohio-specific assessment that provides population health data with regard to health care access, utilization, and health status information about residential Ohioans at the state, regional, and local levels, with a concentration on Ohio’s Medicaid, Medicaid-eligible, and non-Medicaid populations. OMAS informs internal and external entities of</p>	<ul style="list-style-type: none"> <li>Data is not specific to barriers to care women of reproductive age experience when attempting to access Medicaid interventions aimed at tobacco cessation, birth spacing, or prematurity prevention.</li> </ul>

	Medicaid beneficiary health and healthcare status. Beneficiaries are randomly selected and called to answer a series of questions pertaining to their health. OMAS' dashboard offers useful data about both Medicaid- and non-Medicaid insured members based on age, gender, location, and demographics. In 2015, 42,000 adults and 10,000 children were interviewed.	
Consumer Assessment of Healthcare Providers and Systems (CAHPS)	Ohio Medicaid MCPs are required to conduct annual surveys to assess member experience and satisfaction with care. All five MCPs randomly select and survey both adults and children regarding general access to services. The CAHPS survey is useful in providing beneficiary insight about receiving tobacco cessation services. Several CAHPS survey questions asked the consumer if their provider(s) talked to them about quitting smoking, receiving tobacco cessation counseling, medication assistance, and/or tobacco cessation strategies.	<ul style="list-style-type: none"> <li>• Representative of the whole Medicaid population.</li> <li>• Not specific to women of reproductive age.</li> <li>• Does not include questions pertaining barriers to care for birth spacing or prematurity prevention.</li> </ul>
<b>Data Review and Reporting</b>		
<b>Methods</b>	<b>Description</b>	<b>Limitations</b>
Pregnant Women Infants and Children (PWIC) Report	Ohio Medicaid reports annually on its effectiveness in meeting the healthcare needs of low-income pregnant women, infants, and children. The report includes demographic information, birth outcomes and risk factors, utilization information, behavioral health, and information about the average cost of deliveries, prenatal care, and the first year of infant life.	<ul style="list-style-type: none"> <li>• Does not capture individual member perception of barriers to care.</li> </ul>
Maternal and Infant Health Measures: Medicaid Quarterly Dashboards	ODM creates quarterly infant mortality dashboards that include longitudinal statewide and community-specific data related to infant	<ul style="list-style-type: none"> <li>• Does not capture individual member perception of barriers to care.</li> </ul>

	<p>mortality by race and ethnic group. This data includes rates of preterm and very preterm birth, low birth weight, very low birth weight, infant mortality, prenatal care, postpartum visits, progesterone use, tobacco cessation, moderate to most effective forms of contraception, and adolescent well-care visits. This data shows trends over time and is stratified by rural vs. urban, MCPs, county, and race, and can provide insight into whether outcomes are claims-based nature.</p>	
<p>Fee-for-Service (FFS) Ohio Access Monitoring Review Plan (AMRP)</p>	<p>Ohio developed an access monitoring review plan (AMRP) to assess FFS access to care within the following service categories: primary care services, including dental care; physician specialist services; behavioral health services; and pre- and post-natal obstetric services, including labor and delivery, and home health services. The AMRP assessed FFS recipients' access to obstetrics and gynecology services by examining provider availability, Medicaid service utilization and whether patients' needs were met.</p>	<ul style="list-style-type: none"> <li>• Limited to FFS Medicaid population.</li> <li>• Does not assess Medicaid interventions of tobacco cessation, birth spacing or prenatal care.</li> <li>• Does not capture the individual members perspective of barriers to care.</li> </ul>
<p>Enhanced Maternal Care File</p>	<p>Analyses conducted by ODM and its MCPs have shown that pregnant women are often unable to access the prenatal care needed to reduce the probability of a poor birth outcome due to late identification of pregnancy. To aid its MCPs in more efficiently identifying women at risk of poor outcomes -- so that outreach and care can occur before the member becomes pregnant again -- ODM provides MCPs with monthly files that link Medicaid claims and vital statistics data. This data, along with enrollment files, allow the MCPs to identify members who had a previous poor</p>	<ul style="list-style-type: none"> <li>• Strictly a data source and does not capture the individual members' perspective of barriers to care.</li> </ul>

	outcome and engage with them to build trust, reduce barriers to care, ensure their needs are met, assist with planning toward reproductive goals, and connect them with needed services and supports.	
<b>Administrative Processes</b>		
<b>Method</b>	<b>Description</b>	<b>Limitations</b>
Ohio Consumer Hotline	ODM’s Consumer Hotline provides individuals eligible for or insured by Medicaid with direct access to a live person to assist with covered services, explaining Medicaid benefits, completing Medicaid applications, and locating a Medicaid health care provider. This service is available to Ohio residents during normal business hours, six days a week. The majority of calls in which the beneficiary requests assistance with locating a provider are resolved immediately by call center staff. All calls are tracked and repeat callers seeking assistance in locating the same type of provider are flagged as this might indicate a potential access issue.	<ul style="list-style-type: none"> <li>• Non-categorical tracking.</li> <li>• Not specific to tobacco cessation, birth spacing, or prenatal care.</li> <li>• Does not provide an overall annual standardized report of findings.</li> <li>• Accessing the hotline can be cumbersome.</li> <li>• Does not capture the individual Medicaid beneficiary perspective of barriers to care.</li> </ul>
Public Comment on Medicaid Policy Changes	The Ohio Administrative Code (OAC) rule filing process was designed to obtain information from providers and beneficiaries. Both have an opportunity to inform the content of Medicaid policies influencing the availability of these interventions through the OAC rule filing process. ODM releases a public hearing notice whenever a rule is considered for adoption, revision or rescission. The notice includes the date and time of public hearing. Copies of proposed rules are available online at <a href="http://www.registerofohio.state.ohio.us">http://www.registerofohio.state.ohio.us</a> . They	<ul style="list-style-type: none"> <li>• Does not capture individual member’s perspective on preventive interventions targeting tobacco cessation, prematurity prevention and safe spacing.</li> </ul>

	also can be obtained by faxing the Ohio Department of Medicaid’s Office of Legal Counsel (614-995-1301) or by emailing <a href="mailto:rules@medicaid.ohio.gov">rules@medicaid.ohio.gov</a> .	
Managed Care Plan Grievance Systems	All ODM contracted MCPs are required to ensure that members have, and are informed of, their right to file grievances, appeals or request a state hearing. This includes the process by which members may file grievances with the plan to express their dissatisfaction with any aspect of the plan’s or provider’s operation or provision of health services, activities, or behaviors. The process by which members may file appeals with the plan to request its review of an action, and the process by which members may access the state's hearing system is available through the Ohio Department of Job and Family Services (ODJFS).	<ul style="list-style-type: none"> <li>• Grievances are not captured in a categorical systematic method.</li> <li>• Data is not specific to barriers women of reproductive age experience when attempting to access Medicaid interventions aimed at tobacco cessation, birth spacing, or prematurity prevention.</li> </ul>
Ohio’s Medical Care Advisory Committee (MCAC)	The Medical Care Advisory Committee (MCAC) advises ODM in the development and refinement of its program by serving as an advisory group, providing feedback on current and evolving issues in Medicaid. Advocates, service providers, and public agencies strive to work together and share their experience and knowledge to maximize the care available to low-income Ohioans.	<ul style="list-style-type: none"> <li>• Does not assess individual members.</li> <li>• Data is not specific to barriers of care women of reproductive age experience when attempting to access Medicaid interventions aimed at tobacco cessation, birth spacing, or prematurity prevention.</li> <li>• Non-categorical tracking.</li> </ul>
Healthcek and Pregnancy Related Services (PRS) – County Department of Job and Family Services (CDJFS)	Ohio’s CDJFS agencies are required to have a PRS and Healthcek Coordinator. The coordinator is responsible for the administration of Healthcek and PRS in their county. Eligible individuals are informed of available services upon their Medicaid eligibility determination.	<ul style="list-style-type: none"> <li>• Does not assess access to care barriers.</li> </ul>