Quality and Access to Care Workgroup

Introductions

Ed Ehlinger:

Steve, good. I was hoping you'd make it.

Steve Calvin:

Yes, so was I. Emma got me directed correctly here. So it looks like there are nine of us, so welcome everyone who has an interest in quality and access. Do we have the list, Emma, the list of the recommendations? Is that something that can come up on the screen?

Ainura Johnson:

Hi, so do you want the presentation that you sent us up on the screen?

Steve Calvin:

Yeah, I think actually that we can do that as our second item. I did invite Kendra Wyatt. Part of quality and access has a lot to do with health information and so I thought that that would be a good thing to discuss, but I think our first charge is to take a look at the recommendations and then see those through the lens of quality and access. So I'm not sure if, Ainura, do you have that?

Ainura Johnson:

Did you send it as... Is it the-

Steve Calvin:

There it is.

Ainura Johnson:

... Access to Maternal Healthcare in Rural Communities? It should be.

Steve Calvin:

I think actually, Ed, you just shared your screen, right? Yes. Okay.

Ainura Johnson:

Ed, you're currently muted right now.

Ed Ehlinger:

Right now, it's your email. When I share my screen, it gets everything screwed up and I now know how to turn off the mute. So, I will do this. I won't do a lot of input because I've had a lot of input on these recommendations. I will leave the talking, but I will monitor it and scroll it as we need to.

Steve Calvin:

Yes. And I think too, maybe for starters, so we can go through here, I think I introduced myself before. I'm a maternal fetal medicine specialist working with midwives here in Minneapolis. I know, Ainura, you are our host. And Ed, we all know our chair. But maybe the others who are joining us, Ally, Andria, Heidi, and Kendra could introduce themselves. So maybe unmute yourselves and why don't you go ahead, Kendra.

Kendra Wyatt:

Hi everyone. My name's Kendra Wyatt. I'm coming to you from Overland Park, Kansas and New Birth Company, which is a freestanding birth center, midwifery model of care. We are an example of one of those maternity providers who do work with American Indian moms who may or may not get referred from a city located center, as well as having traditional lands and reservations in the state of Kansas, and also very close connections to folks who are as far away as Oklahoma. And happy to be here and kind of have a bias towards wanting to know more about what we can work on in terms of maternity interoperability. Thanks, Steve.

Steve Calvin:

Yep. Okay. And how about Ally?

Ally Atkenson:

Good afternoon. My name is Ally Atkenson. I'm a policy associate with the National Academy for State Health Policy and I staff our perinatal health policy work. Specifically we work on a policy academy with seven states and this is one of the issues we're really interested in. So I'm just here to listen in today.

Steve Calvin:

Great. Thanks for joining us and Andria Cornell?

Andria Cornell:

Yes. Hi, all pleasure to be with you. I am the Associate Director for Women's and Infant Health at AMCHP, the Association of Maternal and Child Health Programs. We are on the executive team of the Alliance for Innovation on Maternal Health and we're very interested in supporting the true comprehensive perinatal workforce, indigenous birth workers. We've got a number of efforts underway focused on advancing anti-racism in reproductive perinatal and women's health, including supporting the 20 Safer Childbirth Cities grantees that are funded by Merck for Mothers in a large co-funding circle, as well as a learning cohort of six states focused on what Title V can do from an anti-racism space in reducing preterm birth. So it's really exciting to be with you all and looking at this through this lens and I have to hop off in 20 minutes, but looking forward to the conversation.

Steve Calvin:

Great. Thank you for joining us. Heidi Sylvester?

Heidi Sylvester:

I'm Heidi Sylvester. I'm a certified professional midwife. I'm washed out, I will say, of practice on my own and working at the health department now. I abstract both maternal infant and sudden infant death, so I kind of have my hand in the reviews on both the child fatality side and on the maternal and infant perinatal side. I don't have a lot of expertise in the American Indian community, but I'm like the hands on the ground seeing all the cases on the really detailed level, so I have unfortunately seen them.

Steve Calvin:

Sure. And Heidi, where are you located?

Heidi Sylvester:

Oh, sorry. I'm in Utah.

Steve Calvin:

Okay, great. And let's see, Kristen Zychermann. Did I pronounce that correctly?

Kristen Zychermann:

You did. I'm sorry, I have a dog barking in the background. I'm the ex-officio from CMS.

Steve Calvin:

Yeah.

Kristen Zychermann:

I am located in Eldersburg, Maryland, which is about 45 minutes outside Baltimore.

Steve Calvin:

Great. Thanks for joining. And ShaRhonda Thompson, ShaRhonda is one of our committee members and I'm really glad, ShaRhonda, that you've chosen to join us in this work group. But why don't you introduce yourself as well?

ShaRhonda Thompson:

Hello, I'm ShaRhonda Thompson. I'm from St. Louis, Missouri. And as Steve mentioned, I am a community advocate. My job I feel is to advocate for the voices that are heard to provide that lived experience.

Steve Calvin:

Great. Thanks. Thanks for joining us. And I think finally, Sherri Alderman, you're also new to the committee, correct?

Sherri Alderman:

Yes, I am. Sherri Alderman, I'm in Portland, Oregon, and I am by training a developmental behavioral pediatrician with a special interest in infant mental health.

Recommendations

Steve Calvin:

Great. Well, so I think as Ed has shared his screen too, I should have had that myself, but from the perspective of the work groups, we have kind of the list of prioritization or our thoughts. The draft recommendations that we have, Ed, do you have those that we can just list them? There we go. Great. So here's kind of where we're... It's going through there.

Ed Ehlinger:

Yeah, we've got 24 of them here.

Steve Calvin:

Oh my goodness. Well, let's start up near number one and go through things. So we can take these first six. Does anyone have any comments on this first six?

Recommendations 1-6

Ed Ehlinger:

Some of this is going to be data driven, but I think the real point is, it's the referral for homicide and suicide. If they go to the emergency room, how do you identify that? And how do you get to the care? So this is both a data issue, but it's also a service issue.

Heidi Sylvester:

Is there some discussion of adding questions or triggers into the electronic health record for that? Is that kind of the type of recommendations we're looking for here?

Steve Calvin:

I think that is accurate. And I think even at the end of this we'll have a discussion. Just from Kendra's perspective, we met with some Centers for Medicare and Medicaid Innovation folks a week and a half or about a week ago about health information interoperability. Because as I even look at this with different eyes even after that discussion last week, I see that so much of it is if we don't have the information, then the patient does not get access to the best care

because we're operating without accurate... They can't access appropriate care if we don't know what care they need and what they are at risk for. But yes, I think what you just mentioned, Heidi, is that the more we can know, if someone flagged it and saying, if the time that a pregnant woman is seen, if she doesn't have any obvious evidence of intimate partner violence, she may have had it in the past.

Steve Calvin:

And it's really helpful to know by looking at her health record and saying, oh my goodness, six months ago, she came in all bruised up and we didn't know exactly what that was and she wasn't able or willing to tell us, I think it's that kind of thing. So I mean, any other... I think the comments from everyone about how would this work, I mean, ShaRhonda, can you think of things that people should know about based on just looking at the health record of an individual person who's been through the system in various ways? Can you think of any aspects of that that we could do better?

ShaRhonda Thompson:

Oh, are you addressing that to me, Steve?

Steve Calvin:

I mean, sorry, ShaRhonda.

ShaRhonda Thompson:

Oh, okay.

Steve Calvin:

Yeah. Sorry. I messed your name up. Yeah, I just... I mean, do you have thoughts too? I mean, we've all interacted with medical providers through our health record. I mean, the electronic health record is sort of ubiquitous now, but can you think of ways that access is improved?

ShaRhonda Thompson:

Yes. So one of the things that as I was reading this that kept popping out to me is education materials. As a person that goes through that system and you are providing me with paperwork that I really, truly, even if you say you're trying to put it in a language that I understand, I really don't understand the impact to me personally. That education material is not about me personally. So how do I take that information and use it? How do I use it? How do I know to apply it to myself? This is where I think more education on the doctor, or the midwife, or even if there's a social worker in the facility to speak with that person on a one to one basis and explain how what they're going through really truly affects them personally versus let me give you this material and say, "Hey, this could possibly happen to you or this could possibly..."

ShaRhonda Thompson:

Let me sit down with you and break down what I see in your medical records, your medical history, and compare that to this and kind of explain to you how it's going to affect you personally. I think that's... Yeah, I understand you want to educate the patient, but you're going to have to do it in a manner that they'll actually benefit from it.

Steve Calvin:

Yeah. That's such a good point. The direct one on one, rather than saying I handed the literature to her or I gave her the video and she was able to watch it. And any other comments from anyone else?

Heidi Sylvester:

It seems like the payment model really defies what ShaRhonda was just suggesting, which I think is brilliant, but we pay people based on procedures and that's not considered a procedure, and so there's no model that supports it right now.

Steve Calvin:

Yeah. That is important. It's like just checking boxes or putting things together. I think Kendra mentioned whenever we see the word materials we have to be suspicious.

Sherri Alderman:

This is Sherri and I really appreciate the conversation. And it gets me thinking about there's... I don't see a mention of a multidisciplinary team approach. And in this particular conversation that we're having now, if that team included, say a social worker, who could be the source of the educational material and then be ready right there to facilitate the recipient's process of applying it to their own lives.

Steve Calvin:

Yep. That's a good point.

ShaRhonda Thompson:

I can second that, Sherri, because I actually lived that experience. Right? When I was pregnant with my first child, I was 19. I had no clue what was going on. It was unexpected. So I went to the doctor's office and the doctor told me this and I'm like, okay, I have no clue what to do from here. Well, I was at a clinic because I didn't have medical insurance and the social worker came in and said, "Hey, do you have everything that you need? Do you have questions?" And I was like, "Yeah, I have no clue what I'm doing here." And she pulled me into her office, and she walked through things with me, and even provided me with resources. And honestly, one of those resources has led me to where I am now as far as advocating for others. So that experience, I

will always recommend that if that is possible in anybody's facility to offer it.

Recommendations 7-12

Steve Calvin:

That's very important. Okay. Well, Ed, do you want to scroll up a little bit more past number six here and we'll... Let's see. Mental health services for sure and I think the monitoring of maternal and postpartum mental health things is important. And a lot of it though has become just kind of a rote what's the number. I think there's a lot more attention to it now. Any other things on this seven through 12 recommendations, any comments?

Sherri Alderman:

This is Sherri again, probably one of the reasons that I came to this breakout group was because of number eight and I really appreciate specifically pointing out infant and early childhood mental health issues. Even the national mental health crisis that we are all living amongst right now, it doesn't include, it's not inclusive in people's minds, infant and early childhood as being a time in a person's life that is hugely impactful and can be experiencing a diagnosable mental health issue. So I really appreciate number eight spelling that out.

Steve Calvin:

Yep. Could you give, because of your area of expertise, could you give a couple of examples of how that would work well? I mean, just kind of specific here's how this is assessed. Is it a maternal child dyad, the child, how the child's doing?

Sherri Alderman:

It's often an area of expertise that's not readily available in medical clinics specifically. And there are efforts for integrated mental health services. And even in that instance that the psychologist, or social worker, licensed clinical social worker that's hired to fill that position within the clinic may not even have infant and early childhood mental health expertise. And so the way it would work would be that there would be a trained professional specifically in infant and early childhood mental health, who would be able to participate on the team and be available when there are concerns that come up or questions during even a routine primary care visit. So it's complicated, but it's well addressed when again, I go back to that team approach, when there is a team approach and professionals specifically with expertise in infant and early childhood mental health can provide service. And at the same time be educating the rest of the team on infant and early childhood mental health issues and how it presents in a medical clinic.

Steve Calvin:

Great. Thanks. Anyone else have any other comments?

Kendra Wyatt:

I'll just do a plus one that we should value the time that we can spend teaching moms on what early milestones are versus waiting for a quote professional to find it months later, so that would be my... Let's spend more time valuing mom, parent, she is the expert of her own child.

Steve Calvin:

Yep. Number 10, we could just hit that for a second too. Having worked doing prenatal care with the women's prison here in Minnesota and I know that there's been some attention on the way that pregnant patients are treated in our prison system, so I think that's just... It's something that should definitely be continued on our list of important things to pay attention to. It's on the order of a few thousand women who give birth while they're incarcerated and it's an important area. Okay. How about we go down a little further? Oh, go ahead.

ShaRhonda Thompson:

Yes. So I know we're focusing on the birthing parent and the infant, but when it comes to mental health, we can't forget about the partner that's there supporting the birthing parent and the child, because we've seen, as COVID has shown, that if their mental health isn't assessed as well it can prove detrimental for the birthing parent and the child.

Steve Calvin:

That's a good point. And the more that other partner is involved, the better too. Right? I suppose that it's not leaving people kind of in a lurch.

Ed Ehlinger:

Steve, and number 12, this is a theoretical thing. I've heard about this, the Mothers and Infants Together Program and the Residential Parenting program, I couldn't find any information. I tried to get somebody from those programs to testify for our committee, so it's a theoretical thing. It seems like a good idea, but I don't know that practically. So I'll try to get some more information about number 12. I mean, I hate to recommend something that has been shown to be detrimental. I don't think it would be, but I just haven't seen any data on it yet.

Recommendations 13-20

Steve Calvin:

Right. Good point. Okay. Yeah. So how about this 13 through 20?

ShaRhonda Thompson:
Okay. So I have questions about the telemedicine.

Steve Calvin:
Sure. Go ahead.

ShaRhonda Thompson:
Will that access or will this portion also provide the parent with access, right? That's my question. Will we have some way to ensure that they will have access to attend the telemedicine appointments?

Steve Calvin:
Yeah. And I think what you're speaking to then is just either the laptop, the phone, the tablet, or something.

ShaRhonda Thompson:
Right.

Steve Calvin:
Yep, the access.

ShaRhonda Thompson:
Yeah.

Steve Calvin:
Well, I think that it does seem that the current administration and prior administrations I think have focused on that. I don't think we've done... I mean, it's certainly not a problem that is solved, but that's a good point and I'll make... So, we talk about the wonders of telemedicine, but if there is no way to actually do it, sometimes I think even just telephone is okay, but there's, especially during COVID, we've made a leap forward probably by more than a decade of at least the use of telemedicine, but it might only be accessible to those that have the resources to have multiple ways of accessing the internet. And I think we have to be really careful about that. So telemedicine and equity or telemedicine and access, right?

ShaRhonda Thompson:
Right.

Steve Calvin:
Yeah. Thanks for pointing that out too. Number 20, trying to get more healthcare providers and doulas are not healthcare providers, but they're incredibly important to the system of care as it evolves that we really do need to make sure that there's both recruitment then support for education of midwives of color, Latina midwives, First Nations folks as well.

Ed Ehlinger:

Yeah, and number 20 really came from the race concordant care work that was done by Patricia Thompson last fall with the committee.

Heidi Sylvester:

It seems like there needs to be a financial support to that number 20 effort as well. I mean, the barrier for a lot of those people is access to that education and the time it takes to spend in training.

Steve Calvin:

Yeah. Yep, that is definitely true too. I mean, I'm a product of the National Health Service Corp back in the late 70s and it paid for medical school and I know we do have those programs. I think that Dr. Pitaro Lao, she was an example of someone who came in it through that kind of support, but that's a good point, Heidi. Does anyone else have any other comments?

Andria Cornell:

I have to hop off shortly, but I just wanted to share or add. Related to data, this was earlier among the recommendations, I was thinking, and this was inspired a little bit by Kendra's comments in the chat, but Kendra, if I'm taking them in a different direction, please don't allow me to bungle your words. But I've been thinking a lot about how community rooted organizations and the close touch that they have with their clients and the support that they provide. They have a lot of data, a lot of information about the risk of their clients and the social stressors that they're facing and can... They know their clients very well and from different funding sources, so I don't even want to just emphasize the federal ones, but Healthy Start grantees, McVie grantees, a vast array of different local implementing organizations.

Andria Cornell:

Some of them have very comprehensive data systems, others could with appropriate investment and support, and really have great information if only health systems and healthcare facilities sort of valued bidirectional data sharing with these entities. And so as we were... I just wanted to raise that there are sources of information and support that if we created equitable bidirectional data sharing with community rooted organizations and the health facilities and in their areas that really could elucidate some of these needs or interests. So I wanted to raise that, but I also just wanted to share, I think it was in response to, I think maybe it was recommendation 18, 17, it's a little bit higher up. Just wanted to highlight, I know that we're all very conscious of this, but there was language related to intervention related to an intervention that targets.

Andria Cornell:

I just wanted to acknowledge that was kind of outsider in language that we were using that a certain community or population required intervention, a targeted intervention, as opposed to sort of perhaps we should be using language that is more sort of like community rooted investment in community solutions that... I apologize that I can't find the... It was maybe a little bit earlier in the recommendations.

Steve Calvin:

Sure.

Andria Cornell:

Support, there it is, 13, support interventions that target. So just an acknowledgement that it's support community solutions that address or support the community to protect themselves against the threats, the structural violence against their community. So just wanted to uplift that. Apologies for dropping all that so quickly.

Centers for Medicare and Medicaid Innovation

Steve Calvin:

Oh, no, I think that's just fine. Thank you very much, Andria. And I think too, if you wanted to put your contact info in the chat, that would be helpful. I think some of us would be happy to connect with you. I can envision that, because it sounds like you need to go. Okay. So we do have about 25 more minutes. I think it would be helpful, Ainura, if you could bring up the PDF about the Centers for Medicare and Medicaid Innovation slides that I think Kendra presented last week. Some of it relates to so much of this, it all weaves together. That's why Kendra's so active in this area. So if you could bring that up, that would be great. I've taken notes. So I'll have something to say in the breakout group summary.

Ed Ehlinger:

Where would I get that?

Ainura Johnson:

Sounds good. I can pull it up.

Steve Calvin:

Yeah. Yeah, Ainura can pop it up.

Ed Ehlinger:

Okay. So I'll stop sharing my screen then.

Steve Calvin:

Yeah. Thanks, Ed. You saved my bacon.

Ed Ehlinger:

You owe me a beer then.

Steve Calvin:

Okay. Sounds good. All right. So Kendra, why don't you know give us 10 minutes, or 15, or something and people can stop her as well. This is just really interesting stuff from my perspective and from a full disclosure standpoint, I mean, I own a birth center and work collaboratively with midwives. Kendra owns the New Birth Company. We have both faced challenges in trying to better serve the patients that want our care, but particularly mothers that come to us through Medicaid, or through Tricare, and others. So why don't you go ahead, Kendra, and we'll see what kind of discussion we get.

Kendra Wyatt:

Yeah. How about this? I'll do like six minutes really quickly and you guys-

Steve Calvin:

Yeah, sounds good.

Kendra Wyatt:

... can tear it apart. Why don't I start by saying the things that I'd like to share with you from a provider perspective who intentionality is to have optimal birth experiences, because I think we talk a lot about poor ones, I think we need to talk more about what a fabulous birth experience looks like and have more reasons for living and more reasons for supporting fabulous birth. So the things I want to talk about that I find to be missing from the conversation is multi-payer alignment. Women do not give birth differently based on who pays the bill. I'd like to talk a little bit about maternity interoperability. We have to be the only service line that does not have HIT at the forefront of the conversation versus the last thing. We talked a lot about HIT in terms of research, we need to talk a lot more about enabling mom in the first place, and then mom enabling the provider.

Kendra Wyatt:

So I'm going to mention the VA and other national payers that could perform a backbone, including the IHS, for that kind of model. And then I am coming at it from a provider perspective and a small business owner, because we're really at a point where I think we're kind of asking the question to our federal agencies, do you envision small business in healthcare? Because if you do, we need to change, radically change, the way we value how we pay for things and how we support this infrastructure. And if we don't, I'd just rather know upfront, and then everybody can go work for a very large IDN in their community, and we'd know what to do. Next slide. And you can tell I'm really upfront. So this just happens to be a couple comments and this is kind of the context is I'm coming at this from we view pregnancy

like it's only a short term thing when we know it affects the entire lifespan of women.

Kendra Wyatt:

And so I would really like that to be acknowledged up front. Obviously, we need to do better and we need to acknowledge we pay for what we get right now, which is why you'll hear my drum beat of we need to pay for things differently and then we will get a different answer. And then in terms of our frontier, and our native, and our rural populations, this really struck me. Just the other day I was up in Leavenworth, Kansas who lost their level one maternity hospital two years ago and they're finding in their data that their mother mortality is growing because of car accidents. And why is that? It's because they're driving further. So I'm really kind of on fire on we're doing this to ourselves because we're designing ourselves into these poor outcomes. Next slide, please.

Kendra Wyatt:

Again, this is my reference as a small business owner that I interact with all of these cabinet members every single day, because I'm in network with Medicaid, I'm in network with Tricare, with the VA CCN program, with helping moms with SDOH across the board, and then I understand the context today with IHS. We do have native moms who are seeking our services. And again, without context and cultural congruence, we really do ourselves a disfavor. So I'm very big on the national, whether it's HHS or how high we need to go to realize this is the fragmented picture that we as providers, and I would say as mothers, are faced with when we interact with the government. Everything's a program instead of infrastructure and consistency. Next slide.

Kendra Wyatt:

This is another way to look at the payer perspective and it also gets into the infrastructure we need to support. It doesn't matter who pays for you, we should be enabling you to have a fabulous birth. And then ultimately, again, what happens during pregnancy ripples through our entire lifetime. Pregnancy is a stress test for our cardiac, certainly indicates if we're going to have diabetic complex and certainly pulmonary. And then COVID, I just cannot say enough from a provider perspective has taken us into a completely different league in terms of moms who would not have been quote sick, their babies wouldn't have been sick, and now because of COVID, they get sick much quicker. And so, again, that puts the emphasis and the need for us to have more appropriate level of care systems, systems that keep healthy people out of the hospital systems. And then an ability to move more quickly in terms of to get people to the right level of care quickly. So I've got a lot of attitude here about we need to move from claims to clinical information.

Kendra Wyatt:

And most importantly, out of all of these conversations, we need to start every conversation with grounding that the mom, the woman, is the expert in her own body, and that we should start every encounter quote with her in enabling her to look out for herself. Next slide.

Kendra Wyatt:

So this is just a little reference of this is how I see the world in America right now. There's kind of two worlds. One world is highly integrated, you're part of a very large integrated delivery system. You tend to be on Epic because Epic is more likely to be implemented in those very large delivery systems. So you're either over there and kind of encompassed, you're employed, you're not worried about how we're going to get paid or perhaps exchanging data is much more easy. Or I come at it from being a small business provider, which is where small obstetric offices, small pediatricians, those of us who work in maternal child health, and this includes federally qualified health centers as well and rural clinics, we are all small. And I think it's actually important for us to advocate for small, because again, this is an attitude and an opinion that I think we do maternity care better when we do it small. And then we replicate that small model. Next slide please.

Kendra Wyatt:

So this is infomercial, the White House has obviously come out and said, hey, we need to do better, but I am going to call out the point about the maternity interoperability from the VA. Again, there's a couple strategies that I would look for us to partner with national organizations to give us some infrastructure we can all hang our hats on, and those are Tricare, so Tricare, military moms, and veteran moms, so that is a couple payers where it doesn't matter where we are in America we're going to be interacting with relatively the same systems and we expect those systems to work better for us. And then bluntly, we're talking about the same vendors. These are not like mythical creatures. We know who they are. They have names and they make money off of us as taxpayers because they do the same thing multiple times versus once we do it with one payer, we should be replicating that across multiple payers, i.e. maternity interoperability. Next slide.

Kendra Wyatt:

This is an example from the private sector. So this happened to be coming out of Blue Cross Blue Shield North Carolinas, it's pretty hot to trot. I wanted to make a reference here because CMS is very focused on birthing friendly hospitals. And I just think to myself, you can focus on hospitals all you want. If we don't focus on prenatal care and prevention of predictable and preventable events in the hospital, we will not move the needle. And so that's again, a place where we need to look at the entire episode of care and have infrastructure that supports that entire episode. Next slide.

Kendra Wyatt:

And I'm almost done, guys. I have a very audacious thought that again, this is one of my themes, is why don't we give the money to the mom and let her spend it because then she'd go spend it on what makes sense. And I think if this wasn't about women, that's why I always say we're talking about women, if it wasn't women, I think we'd hand money to people all the time. It's called money follow the person models, and then the money stays into a bank account, it's monitored, it's all data driven. What if we gave the first $10,000.00 to the mom and said, go spend on the most fabulous pregnancy you can envision. Here's all the rack rates. Here's all the ratings of everybody. And go do the pregnancy and birth that works for you. What an audacious thought. I think that is completely appropriate and that's one of the threads we're bringing up with the Centers for Medicare and Medicaid Innovation Center. Next slide.

Kendra Wyatt:

Again, this is just another way to look at that perinatal episode of care. I think we need to recognize that continuity of carers, as well as continuity of care is what gets the job done. One of the ways we have continuity of carers is to keep things small and then to replicate the small. I think as we focus more and lift up cultural competency of those carers, as well as continuity of carers, especially in the native populations, well, then we would have more practices that reflect native traditions. We would do things more naturally. We would spend more time on nutrition and food as being a harmonized part of the lifespan.

Kendra Wyatt:

So I think all of that is absolutely key here. I also believe that we need to be looking at mother baby diad, our medical Western philosophy of tearing moms and babies apart is killing us. It's killing moms, it's killing babies. We need to put moms and babies back together and we need to recognize that we as providers, again, that idea of continuity of care, continuity of carer matters. And we should be highly incentive to want to work together and to work with our community partners. Next slide.

Kendra Wyatt:

This is another representation of what the NIH is doing in terms of their mother baby longitudinal record research. And all I'm indicating is that there's a pattern here where they get it. They're saying, yes, we should look at things from an antepartum birth, postpartum, and then pediatric perspective together. So I think this just supports what we're saying. Next slide.

Kendra Wyatt:

And guys, just another way of looking at the same data picture and the idea of could this be a reproducible model where teams of carers are

focused on 350 to 400 moms at a time annually. There's a certain number of... There's kind of a philosophy, whether well proven or not, is there's a certain number of people that we as humans can care about. And I believe in that, and I believe that teams, and we can benchmark with the UK and other countries where they do practice primarily midwifery model of care, and then they bring in other levels of care on purpose. And again, the mom, the family, the community is the number one center of the care and everything else is about how do we support her and her family. Next slide.

Kendra Wyatt:

This is another blown up view of that. Again, I'll refer to this as a pod model and very heavy on all of the supports that lift up social determinants of health and movement into the medical model and lifting up the medical model of care as indicated, but not assumed. So, a little bit of an opposite of what we traditionally do in saying somebody goes to an OB office. And then I would just challenge, so whether it's native health or a mom who's on Medicaid, you're highly likely to not have continuity of care. You're highly likely to have access to a more fragmented system. And I'm sorry, I'm not trying to speak on behalf of the IHS, it's only our own practical experience from the Medicaid system, a system of care here in a large metropolitan area, when we know that continuity of carer and a very culturally competent, personalized antepartum care plan that is really goal oriented and mom driven is what makes a difference. And again, is lifted up as a reason for success and a reason for a fabulous birth. Next slide. And I think I'm almost done, Steve, here.

Steve Calvin:

That's fine.

Kendra Wyatt:

Yeah. I lift this up because this is something to focus on. Like Kendra, that's so big, how do we get our head around it? Well, even the first prenatal risk assessment, which is a mandatory thing for us to do as Medicaid providers, we could take a lot more action off of that. And this is something that could be... This is something for us to focus from a standards and maternity interoperability, just even getting mom to the right level of care after that first prenatal visit where we've had a set of labs. And we know from the very get go, she's going to need access to an OB. She's going to need to have a higher level of care. We want to get mom on the right level of care as soon as possible, not mess around with that. And then treat her like the queen she is.

Kendra Wyatt:

So I think I'm going to pause out here, Steve. I covered a lot of ground. So just in summary, again, the things I'm really focused on is put mom in the center, give mom access to her own information 100% of the time, and we need to pay providers differently in order to support

us to support her in that model. And then we've got a long ways to go and need to make up a lot of ground when it comes to maternity interoperability. We've got data in a lot of silos today that we could be doing a much better job on. And again, thanks for allowing me to be a guest today.

Questions

Steve Calvin:

Sure. Thanks, Kendra. So we have eight minutes or so, any comments, questions for Kendra? And you can see why I was excited after just participating in the call with CMMI and the folks at CMMI, including Caitlin Cross Bennett, I think is her name, she was the person that did the Strong Start study as an analyst. There's a lot of optimism. There is a pathway to better care, but anyway, anyone have any comments, questions?

ShaRhonda Thompson:

I do. I'm all for giving the mother access to all of her health records and making decisions, but who's going to help her, right? Who's going to help her make those decisions? Who's going to help her look at that information and actually understand what she's looking at?

Kendra Wyatt:

Yeah. Great, thought, ShaRhonda. Steve, could you go back to maybe one of the model slides like the birth center care delivery slide?

Steve Calvin:

Yeah.

Kendra Wyatt:

Yeah. Stay there. So ShaRhonda, I don't imagine doing any of this without providers who actually spend the time to walk through things and being surrounded by culturally competent and congruent healthcare workers, whether that is doulas, whether that is community health workers. None of it matters if we send somebody their CBC and say, "Oh, see? You need to do better." That didn't do anything. But presenting that, and then in context, and being able to... I just think access to information is power. It gets held over women every single day. You need to do such and such because you're such and such is bad. So part of my strategy is free the data always, it needs to always start with mom having access to it. But 100% it needs to come in context and informed decision making, informed consent shared decision making always needs to be inherent.

Steve Calvin:

Yeah. ShaRhonda, thanks for making that point too. And so I don't know if I mentioned when we first met here with our last meeting, but I did my medical school training in St. Louis in the late 70s. And right now actually, Ebony Carter is one of the high risk OB doctors down there at Wash U, and she's very interested in better serving north St. Louis and the community. And I've just encouraged them, this kind of model that we're discussing is the way to go. There has to be community health workers and others that will sit down with a mother so that she doesn't feel intimidated when someone just hands her, either a tablet to fill it out or a clipboard and said, "Here, you fill this out, and then we'll kind of try to get you the sort of the right pathway." So thanks for pointing that out. Any other comments?

ShaRhonda Thompson:

I know for me another, and probably something similar for you too Kendra, but more of a whole health in one space.

Kendra Wyatt:

Yes. Yes. Yes.

ShaRhonda Thompson:

I think that would help a lot because that's one of the hardest things for a parent. Okay, I got to go here for this test, then I got to go here to do this, then I have to go here to do that. I have to pick because at this point how am I going to get there? Do I have the time? Do I have the time to take off work to get all of this done? Who's going to watch, if I have other children, who's going to watch my other children while I'm going to these 30,000 different appointments to different places?

Kendra Wyatt:

I totally agree and I was thinking about, as everybody was saying, if you could do one thing, I would bring primary birth back, whether it's to an IHS facility that does not have birth, but does everything else, or FQHCs, for example, I would shove primary birth, i.e. low risk pregnancy and birth, as close proximity to everywhere. And we have a number, from a rural perspective, we had a number of critical access hospitals who used to have birth 20 years ago and I'd bring it back. I'd bring low risk birth back and just get it closer to people. We've taken it away and it's killed their souls as well as their bodies.

ShaRhonda Thompson:

Yeah. And I think it's increased risk because if you are someone who may have had hypertension before you were pregnant or developed hypertension during pregnancy, then I'm getting treated by one doctor for this thing and then I have to go to this doctor for another thing. It can be daunting.

Steve Calvin:

It's really helpful. Ally, Heidi, Kristen, and Sherri, do any of you have any comments?

Kristen Zychermann:

I have a question on how you envision continuity of care? Because I love the idea of that and I think it's great, and just thinking back on my experiences working as an OB nurse, but also as someone that had babies, there are a lot of larger OB practices because of the way that lifestyles OBS choose. They don't want to have to cover the hospital three or four days a week. So are you envisioning continuity of providers as far as like prenatal care-

Kendra Wyatt:

I am.

Kristen Zychermann:

... and then they might go a hospitalist model, but then they will never have met the person that delivers the baby before they day.

Kendra Wyatt:

They don't meet them today and the reason our induction rate is so high is so people get booked on the provider's call day. So I just think we should be transparent. I think there is an optimal number of care providers. It's called five to six tops and that the midwifery model of care is in the center, and that more moms should never even see an OB. Now in our model, all of the moms because of scanning are getting to at least have one visit with a maternal fetal medicine specialist, but that's to okay that she's completely normal.

Kendra Wyatt:

So I think we've got this two part system and here's the thing, that's if you have insurance. Multiple OB practices in my community do not take Medicaid and that means that moms get fragmented care in prenatal and then they are sent over to the university system for which they do not have any continuity of care and they're expected to be okay with medical students. And that is re-visioning and taking on a whole can of worms, but I think we're so bad can't we start taking that on and at least increasing the number of moms who are seen within this pod model.

Steve Calvin:

Yep. And I agree with Kendra. I mean, we've known each other for a long time. What we have here at the Minnesota Birth Center is we do about 400 to 450 births per year. And we do use, Kristen, you mentioned the word OB hospitalists or laborists, and that's what we do have. We have a relationship. But the moms are followed through their care either at the birth center or if they need hospital admission sometimes mostly the midwives will go with them for intrapartum transfer. We try to maximize continuity of care, but rather than

dumping them into an industrial system just kind of from the outset, there is continuity of care if they need.

Steve Calvin:

And our NTSV C-section rate for first time moms is around 14%, so it's much lower, but some of those moms will meet a hospitalist. But I've worked really hard because I spent a lot of political capital to get the hospital system on board. Those moms are treated very well. They're not looked at funny as like, why were you trying to give birth across the street here? So continuity of care and an independent system of a pod like thing that Kendra describes with integration to the larger system is the key. And I think we're getting there. It's exciting.

Sherri Alderman:

This is Sherri.

Steve Calvin:

Yeah, go ahead, Sherri.

Sherri Alderman:

And as we talk about continuity of care from the baby's perspective, we could do a far better job at connecting OB with pediatrics. And that's an area that many, many families, expecting families, know where... They're already admitting applications for childcare and have not even given any thought to selecting a pediatrician. And if the system connected OB with pediatrics, that would not be the case, then there would be a much smoother handoff and building that relationship with the new parents can begin earlier. So I think the diagram was really illustrated, pediatrics went off to the left and OB went off to the right. And I realize that's just a graphic, but that's really indicative of the system as well, that really needs to change.

Steve Calvin:

Yeah. And Ainura, I think Ed said that he'd like to see us at 3:40, so maybe if we had just a couple more minutes, I think someone else will-

Ainura Johnson:

Okay. I can check with Emma, but just to give you guys' space.

Steve Calvin:

... Oh, sure. Did someone else have a quick comment? But thanks so much for all of your participation.

ShaRhonda Thompson:

I do. I want to second what Sherri mentioned. When I was going through my pregnancy as a teen, no one sat down with me and was like, oh, you need to pick a doctor for this baby that you're about to have. I was

fortunate enough that I'm an avid reader, so that big book that they gave me about Medicaid, and the dos and the don'ts, and what you can and what you can't do, I'm an avid reader, so I sat and I read the whole book. And in the book it mentioned, we'll pay for you to go to see a pediatrician, to see if that's the one that you want to pick for your child. So I was fortunate enough to look through that book, read through that book, and learn that process, and go through that process, and have my child's pediatrician picked before I gave birth. But not everyone does that and not everyone even knows that Medicaid will pay for you to visit a pediatrician while you're still pregnant too.

Steve Calvin:

Yeah.

ShaRhonda Thompson:

See if that's the pediatrician you want to pick for your child.

Closing

Steve Calvin:

Yeah. This points out, ShaRhonda, why you're such a valuable member of this committee. I wish everybody would just listen to what you have to say because a lot of this could get fixed. So thank you all for your participation, I guess, Ainura, you can send us back if you need to, we can go ahead and do that.

Ainura Johnson:

Yes.

Steve Calvin:

Okay. Am I pronouncing your name correctly?

Ainura Johnson:

Yeah, it's Ainura.

Steve Calvin:

I am.

Ainura Johnson:

Yeah. So you guys should just be able to use the links that you got this morning to go back into the meeting. And I will get a copy of that link and put it in the chat.

Steve Calvin:

Okay.

Ainura Johnson:
Give a second for Emma to get that for me. I will send it.

Ainura Johnson:
Okay. So you need find, if you go the invite that was emailed to you this morning, you should find the link back to the main group through that.

ShaRhonda Thompson:
Okay. Thank you.

Ainura Johnson:
No problem.

Ainura Johnson:
Do you need help or anything or are you okay in getting back?

Ainura Johnson:
So Heidi, can you hear me? Click the link in the chat and that will open it back to the main room.