2020 mom™

Closing Gaps in Maternal Mental Health Care

A Conversation for Change: What Medicaid Agencies and Managed Care Organizations Can Do To Close Gaps In Maternal Mental Health

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Close maternal mental health service gaps by incentivizing equity

Strategies for State Medicaid Programs, MCOs, and Providers

April 2021

What does the data tell us?

Prevalence of self-reported postpartum depressive symptoms, 2018 CDC PRAMS data

Race/ethnicity	Prevalence
American Indian/Alaskan Native, non-Hispanic	22.0 (17.7–26.3)
Asian/Pacific Islander, non-Hispanic	19.2 (16.6–21.7)
Black, non-Hispanic	18.2 (16.5–19.9)
Other, non-Hispanic	16.3 (13.1–19.5)
Hispanic	12.0 (10.8–13.2)
White, non-Hispanic	11.4 (10.7–12.1)

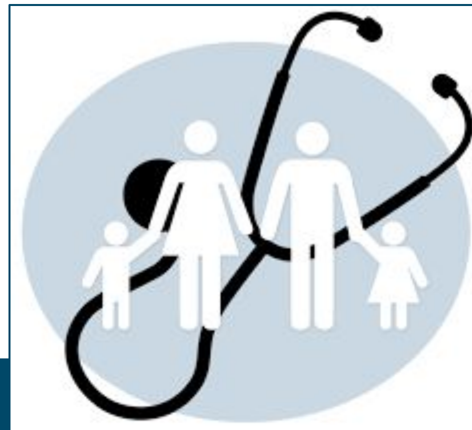
* 31 states: Alaska, Colorado, Connecticut, Delaware, Georgia, Illinois, Kansas, Kentucky, Louisiana, Maine, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Nebraska, New Jersey, New Mexico, New York City, North Dakota, Pennsylvania, Puerto Rico, Rhode Island, South Dakota, Utah, Vermont, Virginia, Washington, West Virginia, Wisconsin, and Wyoming. https://www.cdc.gov/mmwr/volumes/69/wr/mm6919a2.htm?s_cid=mm6919a2_w#T1_down

Socioeconomic status and maternal depression

- Studies show women at lower socioeconomic levels are at greater risk to develop postpartum and/or antenatal depression
- Women with lower incomes are less likely to report symptoms of depression to health care professionals, even *if* they have access

Goyal, D et al. How much does low socioeconomic status increase the risk of prenatal and postpartum depression in first time mothers? Womens Health Issues. 2011 Mar 1. (references the following studies for these two statements as well: Beeber & Miles, 2003; Beeghly, Olson, Weinberg, Pierre, Downey, et al., 2003; Rich-Edwards, Kleinman, Abrams, Harlow, McLaughlin, et al., 2006; Kimerling & Baumrind, 2005; Song, Sands & Wong, 2004).)

What can Medicaid, payers, and providers do about this?
How can they get better data?
What can they do to build trust with women of color receiving Medicaid benefits?



We need to step back.

Exercises

Tempo

Dynamics

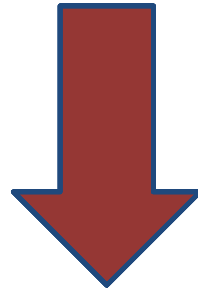
Limitations exist across

- **Data**
  - Race/ethnicity
  - Disability status
  - LGBTQIA+ identity
  - Primary language

- **The lack of analysis of the intersections between physical and mental health (e.g. CVD and depression)**

- **Understanding the role of discrimination in and outside of healthcare**

This leads to



Systems that are ill-equipped to adequately and effectively meet the needs of ALL communities.

Poor maternal mental health outcomes overall, and disproportionately so for people of color.

Framework

1. Work with partners from a range of sectors to improve **data collection across health and social metrics**, including processes, use, and stratification;
2. **Better understand those who are enrolled in Medicaid programs, and who is left out**, focusing on state infrastructure and serious staff self-reflections using a racial equity lens; and
3. Together, with sector partners, **develop and implement value-based initiatives** that are centered around maternal health needs across race/ethnicity and other intersections and incentivize equitable outcomes.

STEP 1: DATA COLLECTION

- **A** Collect data across hospital, provider (e.g. FQHCs, Perinatal Quality Collaboratives, Maternal Mortality Review Committees, clinics, social services), payers
- **B** Identify gaps in demographic groups
- **C** Add fields to data collection tables + make sure to enable stratification of data across demographics
  - ***Considerations: having patients self-identify***

STEP 2: WORKING ON INTERNAL IMPLICIT BIAS

- **A** assess infrastructure and **identify policies, payment, and program structures that promote or mitigate inequities**, and alter them as needed;
- **B** **meet with community stakeholders**, including people enrolled in Medicaid to identify which health and social services need to be included in a maternity care bundle; and
- **C** **examine racial bias in internal practices, procedures, and thought processes**.

Example: California Birth Equity Collaborative

CMQCC
California Maternal Quality Care Collaborative

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ABOUT CMQCC | MATERNAL DATA CENTER | QI INITIATIVES | RESEARCH | RESOURCES & TOOLKITS

QI INITIATIVES

BIRTH EQUITY

- Core Values
- Collaborative
- Resources

CARDIOVASCULAR DISEASE

EARLY ELECTIVE DELIVERIES

MOTHER & BABY SUBSTANCE EXPOSURE

OBSTETRIC HEMORRHAGE

Birth Equity

Racism and social injustice perpetuate a violent cycle that includes inequities in maternal

Implicit Bias and Birth Equity Trainings

The following key trainings are available to help hospital's meet California Senate Bill 464's Implicit Bias and Birth Equity Training Requirement:

Diversity Sciences

- "Dignity in Childbirth and Pregnancy" course available for free online for 1 Continuing Education Unit

March of Dimes

- "Breaking Through Bias in Maternity Care" course available to purchase online for 1 Continuing Nurse

https://www.cmqcc.org/content/birth-equity

What needs to be done to address internal racial bias?

- **Education + internal bias training including:**
  - Discussions about historical policies driving inequities
  - Myths upheld by the healthcare system (e.g. Black people have a higher pain tolerance than white people)
- **Develop community advisory boards, focus groups, town halls**
  - Must be developed by ensuring that those at the table are respected, heard, and that their time is valued and compensated for

After receiving bias training, look at data and ask questions such as:

- What is the risk prevalence for adverse outcomes?
- What chronic conditions exist prior to pregnancy?
- What SDOH impact a person living in X city vs. Y town?
- Have people been screened for behavioral health concerns and/or are they in care if they have concerns?
- What types of providers serve pregnant and postpartum women in our state?
- Are collaborative care models being used before, during and after pregnancy?

And questions, such as:

- Is there a strategy in our state to increase engagement among women of color? LGBTQIA+ individuals?
- What population health management strategies can be implemented?

STEP 3: DEVELOPING MODEL AND PROCESS

- Get stakeholder buy-in and determine what needs to be done to understand services populations need. With information, state Medicaid offices can develop:
  - Maternal care bundle payment model
  - Implementation timeline
  - Process of implementation

Models must

- Include an equity framework and incentivize maternal and child health outcomes
- Incentivize and pay providers more if they are reducing health inequities and penalize those who stall progress or who increase gaps
- Steer away from models that allow providers to cherry pick patients

What needs to be in an equitable value-based package?

Payment contracts built around community, provider, and payer input---acknowledging racism’s role in systems and institutions and reflecting on what needs to be done to rebuild

Creating data dashboards with key measures on perinatal, maternal, and infant health processes and outcomes

– Including demographics, data sharing processes

Promoting equity in value-based care involves

- **Payers:** must be held accountable for equitable outcomes
- **Providers:** must be incentivized and compensated to provide a range of services, including team-based care, receiving implicit bias trainings, working with social service providers, reformulating clinic processes to better address patient needs
- **Community members:** allow them a say in processes, allow access to disaggregated data to help them make informed choices about what facilities provide effective and equitable care

Prevalence of self-reported postpartum depressive symptoms, 2018 CDC PRAMS data

Health Insurance at Delivery	Prevalence
Private	10.1 (9.5–10.8)
Medicaid	17.2 (16.3–18.2)
None	13.2 (10.0–16.3)

Self-reported Depression Before Pregnancy	Prevalence
Yes	28.7 (26.7–30.7)
No	10.6 (10.1–11.2)

Self-reported Depression During Pregnancy	Prevalence
Yes	34.3 (32.2–36.5)
No	9.9 (9.4–10.5)

* 31 states: Alaska, Colorado, Connecticut, Delaware, Georgia, Illinois, Kansas, Kentucky, Louisiana, Maine, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Nebraska, New Jersey, New Mexico, New York City, North Dakota, Pennsylvania, Puerto Rico, Rhode Island, South Dakota, Utah, Vermont, Virginia, Washington, West Virginia, Wisconsin, and Wyoming. https://www.cdc.gov/mmwr/volumes/69/wr/mm6919a2.htm?s_cid=mm6919a2_w#T1_down

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A Conversation for Change:

Fireside Chat with Joy, Isha & Dr. Moore

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