SB 332 Combined Semi–Annual Reports II & III

July 19, 2021

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medicaid.ohio.gov

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Executive Summary

In addition to providing insight into the status of maternal and infant health, infant mortality rates (IMRs) are often used to measure the overall population health of a community.[i] In 2017, Ohio's IMR declined from 7.4 infant deaths per 1,000 live births in 2016, to 7.2 infant deaths per 1000 live births. Yet, the racial disparity between white infant death and black infant death rates widened.[ii] The black IMR was 15.2 per 1000 live births in 2016 compared to the white IMR of 5.8 per 1,000 live births; and 15.6 per 1000 live births in 2017 compared to the white IMR of 5.3 per 1,000 live births.[iii] To address the disparity in Infant mortality and in accordance with state Senate Bill (SB) 332 (the Infant Mortality Bill), the Ohio Department of Medicaid (ODM) conducted assessments to better understand and address the barriers African American women experienced when attempting to access interventions aimed at prematurity prevention, optimal birth spacing, and tobacco cessation, all of which are proven to reduce infant mortality. To date, ODM has gathered information about barriers through the administration of three sets of community assessments, consisting of focus groups with women of reproductive age enrolled in Medicaid (15-44) (N=156), and key informant interviews with community-based organization (CBO) leaders (N=12). The findings referenced in this report are based on focus group participants from community assessments II and III, which occurred during state fiscal years (SFY) 2019 and 2020. The findings from the first community assessment can be found in a separate report.[iv]

Assessment II and III Key Themes

Key Barrier Themes	Other Associated Barriers Related to Themes	Expressed Examples of Barriers
Recurring Themes from Assessment I, II & III		
Lack of trust	General mistrust of the healthcare system	Participants expressed general mistrust of the health care system due to past or current experiences.
Lack of empathy	Perceived lack of compassion	Health care provider(s) had a negative attitude toward, and appeared insensitive to, the patient's individual needs and life choices, despite the patient's feelings.
	Perceived lack of fair/equal treatment/provider Judgement	Perceived judgment by the provider affected the quality of care received based on visual observation. Judgment appeared to be related to income level, race, social status, or lifestyle choices.
Lack of effective communication	Lack of responsiveness to needs	Issues contacting physicians, excessive wait times in providers office vs. time with clinician, not receiving care based on symptoms and concerns presented at time of care. Providers not offering alternative hours of services suitable for patients.
	Lack of respectful communication	Perception of harsh and demeaning communication from health care providers lacking respect for patient decisions related to health conditions, and a perceived lack of respect for privacy and basic customer service.
	Lack of easily accessible resources	Difficulties navigating the health care system and locating needed clinical and community services

Newly Identified Themes from Assessment III		
Lack of social support	Lack of postpartum support	Feelings of abandonment and social isolation after giving birth. Lack of community postpartum programs and support for mothers experiencing postpartum depression. Lack of community, social, family support, mental health services; and coping mechanisms for mothers (including single mothers and mothers with multiple children).
	Lack of community support for lifestyle changes	Lack of community programming and services offering emotional support, hope, coping mechanisms to support changes in health and lifestyle behaviors. Difficulties locating peer support groups, centering programs or general supports that promote hope and inclusion.
	Lack of family and partner support	Lack of family/partner support to change health behaviors, and overwhelming responsibilities to family and partner take priority to personal health care needs. Feeling overwhelmed by responsibilities for multiple children, work and daily life challenges.
Lack of Medicaid coverage of less-traditional providers and services	Lack of covered services and providers	Perceived lack of coverage for a variety of Medicaid providers and services types such as doulas, midwives, and home births.
	Variation in insurance coverage	Variation in coverage policies, contracted providers and pharmacies by managed care plan. Not all managed care plans contract with all Medicaid providers and pharmacies. Such variations result in access barriers to providers, services, and pharmacies based on location. Variations in prescription coverage for prenatal vitamins and other name-brand medications also was shared as a barrier to a healthy pregnancy.
Lack of community resources	Lack of affordable and safe childcare	Perception of publicly assisted child care services prohibiting access to employment opportunities due to qualification policies. Delays in approvals and available care providers with alternative schedules. Affordable child care programs being perceived as unreliable, unsafe, and low quality for childhood development.
	Lack of adequate resources to address social determinants of health	Community, clinical and public assistance programs are perceived as being understaffed, overburdened and unable to assist with SDOH including: housing, child care, employment, education, food, and transportation when patients are in need. Community referral resources often end in long waiting lists for public assistance with no resolution.

Source: Butler*, Cuyahoga, Franklin, Hamilton, Lucas*, Mahoning*, Montgomery, Stark, and Summit Counties focus group responses (Asterisk (*) indicates two focus groups were conducted in these counties)

Recommendations

- Develop a model of care that focuses on care coordination and continuity of care throughout the prenatal period and up to one year postpartum.
- Invest in less traditional providers and services to support women and their infants.
- Continue to provide and encourage cultural competency and implicit bias training to Ohio clinicians.
- Leverage opportunities at local CDJFS agencies to provide real-time information about available resources.
- Develop a population health approach to maternal and infant health support services for pregnant women on Medicaid in partnership with contracted MCPs.
- Invest in obstetric programs and support services similar to comprehensive primary care (CPC).
- Improve communication for contracted MCPs to provide consistent and culturally relevant messaging to women of reproductive age about what to expect when pregnant. This may include leveraging mobile applications, and social media communication campaigns.

Introduction

In April 2017, ODM began conducting semi-annual assessments in accordance with SB 332. ODM is interested in better understanding and addressing the barriers African American women experience when attempting to access interventions aimed at prematurity prevention, tobacco cessation, and optimal birth spacing, all of which are proven to reduce infant mortality. As part of SB 332, ODM also is required to report on progress in mitigating the identified barriers.

The contents of this report are based on the findings of Assessments II and III conducted during SFY 2019 (July 1, 2018 – June 30, 2019), and SFY 2020 (July 1, 2019 – June 20, 2020). Assessment II was conducted in SFY 2019, between November 2018 and March 2019, with both African American women enrolled in Medicaid and CBO representatives from Butler, Lucas and Mahoning counties. Assessment III was conducted in SFY 2020, between April 2019 – September 2019, with only individuals enrolled in Medicaid in Butler, Cuyahoga, Franklin, Hamilton, Lucas, Mahoning, Montgomery, Stark, and Summit counties. Counties were chosen based on epidemiologic evidence of the greatest disparities between African American and Caucasian IMRs.

The barriers identified during the SFYs 2019 and 2020 community assessments confirmed that the key themes identified in the SFY 2018 assessment: lack of communication, empathy and general mistrust of the health care system. SFYs 2019 and 2020 assessments also identified three emerging new barriers: lack of social supports, lack of community resources and benefits, and lack of non-traditional provider types. Additionally, the assessments identified other cross-cutting issues affecting the areas of preterm birth prevention, tobacco cessation, and optimal birth spacing. Specifically, women said they struggled with mental health issues and daily stress with an acknowledged lack of adequate coping skills. They felt racial and poverty-related discrimination by providers and lacked ongoing person-centered relationships with providers of care. Additionally, they felt that community services were neither holistic nor integrated in a way that recognized a mother in the context of her family. In this report, the term provider is used to describe the clinician and/or staff acting on behalf of the clinician (I.e., clinical and non-clinical staff including physicians, advanced practice nurses, nurses, medical assistants, and front-office staff in health care settings).

Methodology

The methodology for conducting the SB 332 barrier assessments evolved over time, based on what was learned at each community assessment. The first and second periodic assessments (Assessments I and II, respectively) took a two-pronged approach of conducing key informant interviews with CBOs and conducted focus groups with women of reproductive age enrolled in Medicaid. These two assessments consisted of brief telephonic interviews with CBO representatives from each county and one focus group comprised of 3 – 15 women of reproductive age enrolled in the Medicaid program. The third assessment included continued focus group studies with women enrolled in Medicaid but did not include CBO key informant interviews. The below table includes a summary of approaches used for each of the three assessments conducted to date.

Senate Bill 332 Sec.5162.136 Assessments Barriers to Prematurity Prevention, Tobacco Cessation, and Optimal Birth Spacing			
	Assessment 1	**Assessment 2**	**Assessment 3**
Time Period	July 2017 – June 2018	July 2018 – December 2018	January 2019 – June 2019
Age Range (in years)	15-44	15-44	19-44
Race	Caucasian, Black or African American and Multi-Racial	Black or African American	Black or African American
Key Informant Interviews	7	5	-
Focus Groups*	5	3	9
Total number of women enrolled in Medicaid in each focus group	45	13	50
Focus Group Counties			
Athens	X		
Butler		X	X
Cuyahoga	X		X
Franklin	X		X
Hamilton	X		X
Lucas		X	X
Mahoning		X	X
Montgomery			X
Ross	X		
Stark			X
Summit			X
Method/Qualitative Analytic Approach			
Semi-structured Interviews and Focus Groups	X		
Conversational Interviews and Focus Groups		X	
Demographic Questionnaire and Semi-Structured Focus Groups			X

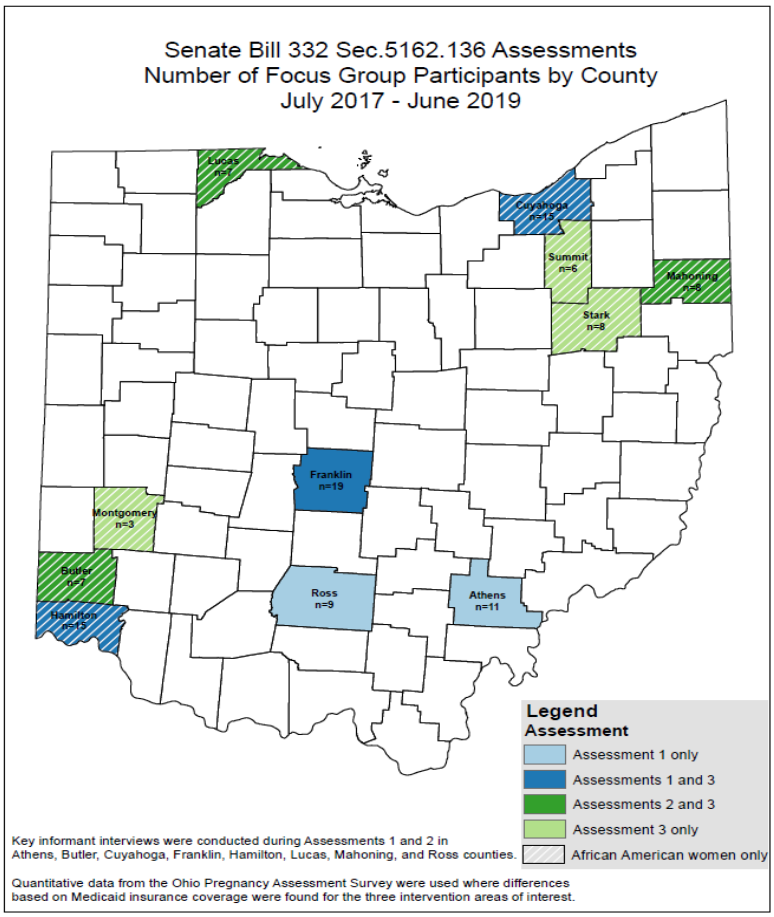
*Note: Quantitative data from the Ohio Pregnancy Assessment Survey (OPAS) were used where differences based on Medicaid insurance coverage were found for the three intervention areas of interest.

In SFYs 2019 and 2020, five 60-minute, telephonic key informant interviews were conducted with CBO representatives and 12 90-minute focus groups were conducted with 62 African American women of reproductive age (15-45 years) with Medicaid insurance residing in each of the OEI counties: Butler*, Cuyahoga, Franklin, Hamilton, Lucas*, Mahoning*, Montgomery, Stark, and Summit. An asterisk (*) indicates two focus groups were conducted in the identified county. In total, ODM reached 156 individuals with Medicaid insurance and 13 CBO representatives over the course of the three periodic community assessments. Each assessment specifically discussed interventions and health care access related to premature birth prevention, tobacco cessation, and optimal birth spacing. The map provides a summary of each assessment location, participant criteria, and sample size findings.

The first and second assessments were conducted by the Health Services Advisory Group (HSAG), ODM's External Quality Review Organization (EQRO), which conducted all qualitative interviews, provided ODM with transcripts, and drafted a final report of the findings. The third assessment was conducted by The Ohio State University Government Resource Center (GRC) with continued guidance from ODM. The project began being referred to as the Interview of Mothers on Medicaid (IMOM) beginning with the third assessment.

Setting

The state of Ohio has recognized its significant racial disparities in preterm birth and infant mortality, and in recent years has organized community efforts to improve these outcomes. In 2012, a group of organizations including CityMatCH teamed with epidemiologists from the Ohio Department of Health (ODH) to identify the state's counties with the greatest racial disparities in birth outcomes. They created a targeted effort that was referred to as the Ohio Equity Institute (OEI).[v] This effort identified nine metropolitan counties -- Butler, Cuyahoga, Franklin, Hamilton, Lucas, Montgomery, Stark, and Summit -- and one Appalachian county: Mahoning as having the greatest disparities in birth outcomes. These counties, often referred to as the OEI counties, are geographically dispersed and contain the state's six largest cities, accounting for 52.5% of Ohio births in 2018.[vi] ODM's SB 332 series of assessments were designed to build on prior work by recruiting focus group and key informant interviewees residing or working in one of the OEI counties (See SB 332 Sec. 5162.136 Assessments table).



Participant Recruitment

Community Assessment II

During SFY 2019, ODM conducted community interviews with 18 respondents, including five community leaders and 13 women insured by Medicaid residing and/or working in Butler, Lucas, and Mahoning counties. Key informants from CBOs with experience working with the target population in Lucas, Butler, and Mahoning counties were selected by ODM. Two key informants were from Butler County, two key informants were from Lucas County, and one key informant was from Mahoning County. Five semi-structured, one-hour phone interviews were completed with each of the key informants.

Participants were selected for three focus group sessions in Butler, Lucas and Mahoning counties using randomly sampled Medicaid claims data meeting the criteria of African American women of reproductive age (ages 15 to 44). Multiple communication strategies were used to provide outreach to selected women including phone calls, text messaging, and reminder follow-up calls. All participants were screened during the initial contact, at which time they signed consent forms and received a gift card for participation. Child care and transportation were offered to all participants.

Community Assessment III

Focus group participants for Assessment III again were selected using ODM administrative data. For this assessment, the target population included women currently enrolled in Medicaid within each of the identified counties who were 19-44 years of age and had a delivery of a live-born infant in 2018. Once this population was identified, a random sample of 200 potential focus group participants in each county was selected for outreach. In addition, administrative data was used to ensure that 50% of women selected for recruitment had a history of tobacco use. Each focus group was oversampled for participation, based on a 50% drop-off rate for participation, with a goal of securing of six women per focus group.

Based on what was learned from prior assessments, outreach to focus group participants was initially by direct contact via a cell phone text message, which informed the potential respondent that they had been selected to participate in a focus group about women's health; would receive a gift card for focus group participation; and should call for more information. This method enhanced the contact rate and made the recruitment more efficient than in prior assessment periods. One day after sending the text message, follow-up calls were made to women who had not responded, and follow-up phone calls continued until either recruiting targets were met or all women in the sample had been reached.

Potential focus group participants were screened over the phone using an eligibility survey. Eligibility criteria included current Ohio Medicaid health insurance (at time of recruitment), and current residence in an OEI county. Women who met the criteria were contacted one day prior to the focus group with a reminder message. During recruitment, women were notified that free child care would be provided by licensed caregivers during the focus group.

Upon checking in to the focus group, a brief survey was conducted with each participant to obtain additional demographic details of the target population. Prior to this survey, the collection of demographic details was not uniform and concise enough to report quantitative data.

Ohio Pregnancy Assessment Survey

The standardized Ohio Pregnancy Assessment Survey (OPAS) is Ohio's version of the prior CDC Pregnancy Risk Assessment Management System (PRAMS). It covers the entirety of the pregnancy experience, including many aspects of preterm birth prevention, tobacco cessation, and optimal spacing. The 2017 OPAS provided data and information for approximately 5,000 women. Subsequent community assessments and focus groups supplemented the understanding of the qualitative data regarding women enrolled in Medicaid that was collected using OPAS. Themes expressed in the focus groups were used to inform a more robust plan to address the barriers identified.

Community Assessment II and III Results

The results of qualitative data obtained from Community Assessments II and III focus groups are outlined in this section, divided by the three targeted intervention areas: barriers to prematurity prevention, barriers to tobacco cessation and barriers to optimal birth spacing. The 2017 OPAS results were used as a data source. It is noted in each section where differences exist for women with Medicaid insurance based on quantitative data related to the three intervention areas, followed by quantitative data and any potential alignment between the two data sources.

Demographics and Health Status

Community Assessment III

Based on self-reported demographic data, Assessment III included 49 African American women who participated in nine focus groups, with five to six women per group. Most participants (69%) were ages 25 - 34 years; had two or more children; and had resided in the target county for at least one year, with 42% of participants residing in the county for 10 or more years. Approximately 41% of participants were employed at the time of the focus group and 18.7% had a college degree. While 82% of participants reported having a steady place to live, 10% did not and another 8% reported anxiety about losing their home in the near future. Additional details are in Table 1.

Table 1: Demographic Characteristics of 2019 IOMM Focus Group Participants (N = 49)

	Frequency	Percentage
Age (in years)		
19-24	7	14%
25-34	34	69%
35+	8	16%
Number of Children*		
1	7	15%
2	13	27%
3	16	33%
4+	12	25%
Educational Attainment		
Less than high school	4	8%
High school diploma or equivalent	20	42%
Some college	15	31%
College degree	9	19%
Current Employment		
Working full or part-time	20	41%
Unemployed	29	59%
Current Living Situation		
Have a steady place to live	40	82%
Have a place to live today, but worried about losing it	4	8%
Do not have a steady place to live	5	10%
Duration of Residence in County		
Less than 1 year	7	15%
1-5 years	15	31%
6-10 years	6	13%
10+ years	20	42%

Note: All data are self-reported and obtained from questionnaires administered prior to the start of the focus group. Frequencies may not sum to 49 due to missing data for some questions. * Number includes only those children that the participant gave birth to.

Most participants (76%) reported they were generally in good, very good, or excellent health, while 20% reported that their health was fair, and 4% said they were in poor health. Although most participants reported that their overall health status was at least good, a substantial proportion also reported high levels of stress or social isolation. Approximately 33% of participants reported they felt very stressed during the past two weeks, and about 16% reported they often or always felt isolated from others. When participants were asked where they usually go for health care, the most common response was doctor's office or health center (57%), followed by hospital emergency room (47%), or an urgent care center (12%). One respondent also reported that they did not currently have a place for health care. Additional details can be found in Table 2.

Table 2: Health Characteristics of 2019 IOMM Focus Group Participants (N = 49)

	Frequency	Percentage
Health Status		
Excellent	4	8%
Very good	11	22%
Good	22	45%
Fair	10	20%
Poor	2	4%
Usual Care Provider*		
Doctor's office or health center	28	57%
Hospital ER	23	47%
Urgent care center	6	12%
Do not currently have a place for healthcare	1	2%
Stressed During Past Two Weeks		
Not at all	5	10%
A little bit	8	16%
Somewhat	12	25%
Quite a bit	8	16%
Very much	16	33%
Frequency of Feeling Isolated from Others		
Never	14	29%
Rarely	10	20%
Sometimes	17	35%
Often	4	8%
Always	4	8%

Note: All data are self-reported and obtained from questionnaires administered prior to the start of the focus group. Frequencies may not sum to 49 due to missing data for some questions. *Some women selected more than one response option for this item, resulting in a total number of responses that is greater than 49 and total percentage greater than 100%.

Qualitative analysis of the focus groups from Assessments II and III highlight respondents' experiences with the health care system and illustrate potential reasons that may explain all or part of the disparities between women with Medicaid and those with private insurance as outlined above. The following figure crosswalks the

themes identified in the focus groups related to barriers in accessing preterm birth prevention, tobacco cessation, and optimal spacing to the experience of pregnancy care in the OPAS.

Summary of Key Barrier Themes

Themes Identified in Community Assessments II & III

ODM identified six key themes that focus group respondents (n=62) said keep African American women receiving Medicaid benefits from optimally accessing interventions intended to prevent infant mortality. The themes aligned with Assessment I findings and centered around the health system environment:

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

These themes were prevalent among focus group and key informant respondents across all three intervention types, and all three periodic assessments: prematurity prevention, tobacco cessation, and optimal birth spacing. Assessment III findings included the three themes above, and three new themes emerged specific to the participants' environments:

- Lack of social support.
- Lack of Medicaid coverage of alternative providers and services.
- Lack of community resources.

OPAS and community assessment findings are discussed in more detail below.

Supplemental Insights About Barriers from the 2017 OPAS

Results from the 2017 OPAS reveal disparities that correlate with in the type of insurance held by pregnant women. The second and third SB 332 community assessment findings from the OEI counties (Butler, Cuyahoga, Franklin, Hamilton, Lucas, Mahoning, Montgomery, Stark, and Summit) provided insight into these disparities while also confirming themes identified during the first (SFY 2018) periodic community assessment conducted in Athens, Cuyahoga, Franklin, Hamilton, and Ross counties.

According to the 2017 OPAS results, when compared to women with private insurance, women with Medicaid were:

- More likely to experience pre-pregnancy depression (27.2% vs. 10.7%) and anxiety (35.0% vs. 18.3%) before pregnancy.
- More likely to make postpartum birth control plans during the prenatal period ((85.7% vs 74.0%).
- More likely to smoke during the last three months of pregnancy (51.0% vs. 31.5%).
- Less likely to have a pre-pregnancy OB/GYN visit (56.8% vs. 71.4%).
- Less likely to have a postpartum visit (87.10% vs. 96.90%); non-Hispanic Black women enrolled in Medicaid (88.79%) were less likely to have postpartum visits than non-Hispanic white women enrolled in Medicaid (92.02%).

Sub-Barriers Specific to Prematurity Prevention Interventions

Preterm birth, defined as infants born prior to 37 weeks, is the leading cause of newborn death. According to 2017 ODH infant mortality data, approximately 32% of all infant deaths were due to preterm birth.[vii] Large racial

disparities exist in the rates of prematurity-related causes of infant death. Ohio's Black infant deaths, related to prematurity, were at a rate of 5.5 per 1,000 live births, and white infant deaths due to prematurity were at a rate of 1.6 per 1,000 live births. [viii] A large part of this racial disparity and infant mortality is preventable. Research studies have shown that the earlier a pregnancy is identified, the earlier preterm birth risk can be identified and treated.[ix] However, 2017 OPAS results show that women with Medicaid are less likely than those with another source of insurance to experience delays in initiation of prenatal care (85.03% vs. 95.09%).[x] Assessment II and III findings indicate some of the reasons why women of reproductive age with Medicaid are more likely to delay prenatal care. According to both assessment focus group respondents, the reasons identified are: lack of empathy; ineffective communication; no individualized care from the provider; general mistrust of the health care system; stressors related to having a healthy baby; access to and preference of prenatal vitamins; and OB/GYN scheduling delayed the receipt of care during pregnancy. The top access barriers identified by focus group respondents are associated with provider issues, Medicaid coverage, and a general mistrust of the health care delivery system.

Lack of Empathy and Trust

Community focus group respondents reported a general mistrust of the health care system, as well as a lack of compassion and judgment pertaining to individualized care from health care providers, as barriers to prematurity interventions. Participants said they felt judged based on race, age, socioeconomic status, number of children, father involvement, and insurance status. Focus group respondents also mentioned not trusting the health care system, not trusting the efficacy of medications and protocols due to the lack of independent research conducted specifically for the health of African Americans. They also expressed a general mistrust of the health care system regarding present or past experiences. Focus group participants shared the following:

> *"[…] So, if my home life is stressed… that [should] make you more inclined to help me with this pregnancy if you know what's going on in my life. But if I don't even feel comfortable enough to tell you that, I'm not going to tell you about my symptoms. I'm not going to tell you about my stress…[and] my baby's not going to be healthy because of all the stuff that I've got going on internally…It's like they want you to come after the fact, and they tell you everything that happened when you should have been there from step one if the care was [better] managed."*

> *"Just be there for me; for my health and my baby's health. Don't be so judgmental and make me feel like I'm not a person…"*

> *"It could be that maybe we're rushing through things. Just because someone doesn't have the same type of insurance or they live in a different neighborhood than another patient…doesn't mean that we should discount that patient or cut their needs short. We need to provide the same type of quality care for everyone."*

Women participating in community focus groups also reported the lack of access to a single consistent obstetrical provider familiar with their individual needs, preferences, and ability to relate to their personal experiences. This lack of relatability and consistency of care prohibits the building and maintenance of

relationships between providers and patients. Respondents shared that seeing multiple obstetric providers at clinics and FQHCs did not encourage building a trusted relationship with their providers.

Lack of Effective Communication and Stressors Associated with Having a Healthy Baby

Community focus group respondents described a lack of effective communication by providers as a barrier to prematurity prevention. This lack of effective communication took the form of inadequate explanation of next steps and medication side effects, as well as failing to provide detailed instructions and expectations in non-medical terms. Respondents often noted that poor communication and unclear instructions made it difficult to understand why the doctor wanted them to take or not take certain actions. Respondents shared experiences demonstrating providers use of unclear and complicated language that could not be easily understood. Additionally, specific details not properly communicated were needed to explain conditions, medications, and/or treatment plans. One participant shared:

> *"Don't assume…When I first became pregnant, I didn't care if they thought I was ignorant. Please explain everything to me and don't assume that I know that afterwards I'm supposed to go see this person or I'm supposed to go to a certain type of visit, or I need this type of breast pump. Explain in detail to me."*

Respondents provided examples that indicated a preference for verbal communication in addition to written discharge instructions, as well as the need for providers to continue to improve upon their communication skills and be prepared with interpretative services for individuals whose primary language is not English. Feedback from the women included the following comments:

> *"And [do] not just hand us a lot of papers... they usually just hand you the information. They don't go over it. If you're a first-time mother…you don't have time to sit down and read a notebook's worth of pamphlets."*

> *"I'm a visual person [referencing preferred learning style] and a hearing [person], so I'd rather you talk to me about what you want me to know instead of just handing me some paper….nine times out of 10, I'm not going to read it."*

Focus group respondents also described being stressed about the health of their babies before and after pregnancy. During pregnancy, respondents indicated they were stressed because they wanted to do everything in their power to ensure their unborn child would be born healthy, and that they would be able to properly care for them after birth. Other focus group respondents expressed being overwhelmed by news of Black infant mortality and maternal mortality; they worried during their pregnancies that their babies would become statistics.

Delay in Prenatal Care Initiation and Aversion to Medication

An aversion to medication was identified among participants as well as medications prescribed during pregnancy. In discussing medication adherence, it was common for participants to not take prescribed progesterone, iron, vitamin C, and prenatal vitamins. A deeper discussion into prenatal vitamins confirmed that prenatal vitamins are covered by Medicaid, making access to prenatal vitamins easy. However, participants disliked the options for vitamins, noting that the pills were large, had an unpleasant smell, and induced nausea.

Participants preferred to use the gummy prenatal vitamins, which are not covered by Medicaid. Feedback from one participant:

> *"I love natural medicine. I like taking organic medicine, eating organic food, or using natural methods. I would do anything to avoid taking… medicine, because I know anything I grow is good for me."*

Participants, after confirming their pregnancies, presented at a wide range of gestational ages ranging from one week to seven months at the time of prenatal care initiation. Notably, participants were able to get care from a clinic sooner than from a traditional OB/GYN office. Participants stated they were not able to get care as soon as they wanted because clinical practice sites did not allow women to schedule appointments sooner than 8-10 weeks gestation. Delay in the initiation of prenatal care caused additional stress for participants who experienced past poor birth outcomes. Participants also shared being turned away for prenatal care by providers due to being too far along in gestational weeks.

Time was also a barrier for participants receiving care. Participants indicated they had difficulty scheduling and going to appointments based on their work schedules. The women also experienced being discharged from care due to having missed appointments. Scheduling feedback includes the following:

> *"…having to wait eight weeks to see a doctor, after I found out I was pregnant, was really hard for me, especially after I lost a baby. I was scared that I was going to lose another one, and now they are telling me I have to wait eight weeks to see a doctor."*

> *"…I called and scheduled an appointment and they said, 'We'll see you when you're 13 weeks.'…I'm three weeks pregnant, so I thought…you want to wait until the second trimester to see me?"*

Based on 2017 OPAS data, women with Medicaid were less likely than women with private insurance to attend prenatal (85.03% vs. 95.09%) and postpartum (87.10% vs 96.90%) care as early as they preferred.[xi] In Assessment II, 31% of focus group respondents noted general mistrust of the health care system due to past or present experiences and ineffective provider communication, which were noted as barriers to prematurity prevention interventions and early prenatal care. Approximately 21% indicated stress associated with having a healthy baby as a barrier to accessing care. The women in Assessment II were apprehensive about medical providers because of generational mistrust of the health care system, as well as fear of providers judging them and not understanding their needs. Adding to this apprehension, and lack of available resources, African American women with Medicaid often were unaware of what ideal prenatal care entailed. Further, if a woman doesn't understand what actions to take after discussing a care plan with the provider, the patient discharge summary is a stressor and a barrier to obtaining future services related to prematurity prevention. With methodology changes for Assessment III, similar percentages were not able to be captured for comparison with Assessment III results. However, based on qualitative data, respondents in Assessment III shared similar experiences.

Sub-Barriers Specific to Tobacco Cessation Interventions

2017 OPAS data revealed that more than 84% of Ohio women with Medicaid reported smoking prior to becoming pregnant, greater than 50% continued to smoke during the last trimester of pregnancy, and 68% reported smoking after pregnancy.[xii] Qualitative data from Assessments II and III highlighted barriers that made it difficult to access tobacco cessation services and quitting. The top three identified barriers to quitting tobacco use during pregnancy from the second assessment were lack of recognition of tobacco as an addiction, lack of support for lifestyle changes, and lack of effective provider communication, as detailed below**.** The top identified additional barriers from Assessment III included stress, lack of available cessation resources, and being judged by providers.

Lack of Recognition as an Addiction

Approximately 73% of Assessment II focus group respondents perceived the lack of recognition of tobacco use as an addiction and tobacco cessation treatment as the most prevalent barrier to quitting tobacco use. Assessment II respondents described a disconnect between the health system's treatment of tobacco use and the treatment of other addictive substances. Focus group respondents perceived addiction treatments for opioid, heroin, and alcohol use to be more intense and accessible, as well as providing more expert, peer, and community support and counseling to address mental and psychological components of addictions than tobacco use and addiction. Focus group respondents desiring to quit felt inhibited due to the lack of intensive level of services and supports, as well as the forgiveness associated with treatment for other addictions. Their observed discrepancies in the ease of accessing treatments for substance use disorders are evident in the following statements:

> *"Just cover the choice of medication that works best for each individual… Because it's part of an addiction…. if they're trying to stop heroin [referencing free Narcan available everywhere] …why not try to stop the cigarette smokers or the weed smokers [referencing the same way]? ...prescribe medications to help those folks."*

> *"Yeah, they hand that out freely [referencing Narcan]. When they get out of prison, they hand them Narcan. Personally, I think it's a double standard because if you're handing out Narcan […] why not do the same for smokers if you're so concerned about the rates of infant' births and deaths? Why wouldn't you want to prepare a mother for that too? Because stress does come from, the majority of the time, either before pregnancy or after pregnancy."*

Lack of Social Support Lifestyle Changes

Focus group respondents discussed how addictive tobacco is and the psychological effects one has as a result of smoking. Continued support from a professional, family member(s), or someone who has been able to quit in the past could assist with the psychological effects of tobacco cessation. Focus group respondents shared how different everyday life events trigger the mind to think the body needs tobacco. Participants also mentioned the

need for mental health services to deal with the underlying causes of tobacco use. Respondents shared the following about smoking:

> *"Mental health is huge, and it plays a factor [in] pregnancy outcomes. […] People smoke because something is usually wrong, and they don't know how to articulate it or express the issue. So sometimes the cigarettes just give them what they need to numb their feelings…and there's probably a deeper issue that is going on in their heads. I believe that if mental health concerns were addressed, people would not smoke."*

> *"I feel like nobody really wants to smoke. It's not a want. Nobody wants to keep damaging their lungs and harming themselves and putting their kids in a horrible environment...nobody wants that—it's all mental. You really have to think that smoking relieves some stress for that two minutes that you're doing it. But it's really not doing anything for you. […]and if you had something, somebody to talk to, or somebody where the information was public, that would give you more of a mental reason to stop."*

Respondents also discussed the psychological components of addiction and that set parameters from the community could assist with controlling impulses to smoke. Examples included how knowing negative consequences associated with smoking, such as employment or housing rules, helped them to temporarily abstain from smoking. One respondent indicated that not being able to smoke during an eight-hour work shift helped to prevent cravings.

Participants also expressed lack of social and emotional support for lifestyle changes as a top barrier preventing them from participating in interventions intended to reduce tobacco use. Assessment II participants revealed lack of support, included the lack of personal support from family members, friends, and community; but also included a lack of support from services intended to assist with quitting. Respondents expressed having to care for grandparents, parents, children and partners and not having enough personal emotional support and coping mechanisms for self-care.

Similarly, Assessment III participants shared that stress was a major barrier to quitting. When asked to elaborate, participants described many sources of stress, including single parenting, balancing parenting with either work or school, living in poverty, and family dynamics. These stressors, on top of mothering at least one small child, made it very difficult for women to quit smoking. Participants from both community assessments also expressed a lack of support group services, programs, or CenteringPregnancy® programs in their communities to assist with lifestyle changes. Qualitative focus group results validated the 2017 OPAS findings that smoking during pregnancy was due to the lack of support at the personal, community, and system level for behavioral change.

Lack of Community Resources

When the topic of resources to quit smoking was presented to participants, they were asked about specific resources (e.g. cessation programs, medication, counseling) and if they had ever heard of them or used them. Baby and Me Tobacco Free is one such resource that is available to pregnant women. Very few of the participants had even heard about this program, much less used it as a resource to quit smoking. However, in

the cases where a participant knew about the program and described it to the group, there seemed to be general interest among the participants.

Overall, the participants shared characteristics they would like to have in a tobacco cessation program. They mentioned policy approaches to addressing tobacco use, such as banning the sale of tobacco, and raising the age for legal purchase. They also mentioned incentive programs that would reward smokers for quitting, similar to how weight-loss programs offer incentives for loosing weight for chronic conditions such as diabetes. These incentives could be in the form of money or a type of rewards program in which women could purchase something in exchange for quitting. Some participants recognized the importance of participating in a smoking prevention program. Given how difficult it is to quit smoking, they believed that a priority focus should be on preventing initiation among young adults. Focus group respondents expressed the need for a support group contact, similar to a centering program, that they could access to learn about strategies to cope with cravings, stress, etc. Participants referenced wanting multiple quit options, not just a quit line or phone service. One respondent indicated:

> *"I would give [tobacco cessation programs] two options. 1 - You can have the option of taking the medication with an online or a phone support system, or 2 - Some people are better with support when they're in class in a small group where you have steps and techniques to help you. For example, some might need help to initially say, 'don't smoke one in the first 30 minutes of the day,' and then by the next week, 'don't smoke one in the first four hours of the day period.' Some people would need that level of detail, others wouldn't. Everybody's different and unique. You should give multiple options."*

Participants of Assessment III focus groups specifically discussed some of the other incentive programs that Ohio Medicaid or an MCP has for pregnant women or mothers of small children, as well as incentives that WIC and other social service programs offer. A few participants suggested that Medicaid offer formal smoking cessation programs for pregnant women. There also were discussions, in this section of the focus group as well as in others, about having the motivation to quit smoking. Related to Medicaid, some participants said the program does not need to do anything because if a woman wants to quit, she will quit.

Lack of Effective Communication

Lack of effective communication was another access barrier to tobacco cessation interventions. This lack of effective communication was due to the lack of individualized programs and insufficient marketing materials informing participants of local programs. When asked about existing local and state tobacco cessation programs, focus group participants varied by location in their knowledge of and perceptions about the usefulness of available resources. Some respondents expressed hearing about the Ohio Tobacco Quit line through radio and television advertisements and written communication in gas stations, doctors' offices, as well as other local resources.

Focus group respondents, despite awareness or exposure to the Ohio Tobacco Quit line advertisement, expressed not understanding what the program was or the services it provided. A majority of respondents expressed not knowing about the Ohio Tobacco Quit Line, Baby and Me Tobacco Free, or any other local programs. They only knew about national campaigns. Focus group respondents stressed the need for information available in one centralized location about the harmful effects of tobacco use during pregnancy and

tobacco cessation programs on a larger scale. There also was lack of knowledge regarding simple steps to follow if interested in quitting tobacco use. Focus group respondents suggested larger advertising campaigns, applications for telephones, or text messages from ODM to all high-risk pregnant women about health care best practices, and behaviors to avoid that might harm mom and/or baby. Focus group respondents shared the need for mass distribution of all types of media informing pregnant women of the harms of smoking.

Focus group respondents shared how dealing with stress, lack of social support and living with daily stressors and general isolation leads to relying on tobacco use as a coping mechanism. The above qualitative data from women with Medicaid who participated in the focus groups' highlights the lack of available services targeting African American women to provide social and systematic support, mechanisms for coping, and mental health and addictive treatment services to handle their daily life stressors. Given the high prevalence of self-reported depression and anxiety, it may not be surprising that tobacco cessation is particularly difficult for pregnant women.

Sub-Barriers Specific to Optimal Birth Spacing Interventions

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 subsequent infant mortality. OPAS results from 2017 revealed that:

- During prenatal visits, women with Medicaid were more likely than women with other insurance types to be asked about their plans to use birth control after delivery (85.7% compared to 74.0%).[xiii]
- Medicaid insured Women were less likely to have a postpartum visit after delivery (87.10% compared to 96.90%).[xiv]
- Non-Hispanic Black Women were less likely to attend postpartum visits when compared to Non-Hispanic white Women for all Ohio women who responded to OPAS (88.79% compared to 92.02%).[xv]

Assessments II and III confirmed a shared negative experience but differed in other barriers to optimal birth spacing as detailed below:

Community Assessment II	Community Assessment III
Negative experiences or perceived negative side effects of birth control	Negative experiences or perceived negative side effects of birth control
Lack of information and resources on contraceptive side effects	Lack of individualized care
Lack of effective communication from the provider	Aversion to birth control use

Negative Experiences or Perceived Negative Side Effects of Birth Control

Close to 30% of focus group participants in Assessment II (Butler, Lucas, and Mahoning counties) and an overwhelming amount of Assessment III (Butler, Cuyahoga, Franklin, Hamilton, Lucas, Mahoning, Montgomery, Stark, and Summit counties) participants expressed many of the same barriers as prior assessments, a suspicion and/or mistrust of birth control, and a preference for natural birth control methods. Hormonal birth controls that were mentioned include intrauterine devices (IUDs), Nexplanon, the pill, the mini pill, NuvaRing, Depo Provera, and the patch. Participants who discussed negative side effects of birth control mentioned they had experienced depression, thoughts of suicide, menstrual abnormalities during use, passing out, weight gain, hair

loss, cramps, feeling pregnant, bone pain, headaches, future miscarriages, fertility issues, damaged tubes, and cysts. Ineffectiveness of birth control also was discussed, and women reported becoming pregnant while using birth control. Other factors described related to ineffectiveness or barriers to birth control use – such as birth control falling out or sliding (NuvaRing), or expulsion (IUD). These experiences resulted in the determination that the personal costs associated with using birth control methods outweighed the benefits. Below is one participant's response about birth control:

> *"…—I just think birth control itself needs to be revamped because there's so many horrible side effects. Whether it's the pill, the patch, Mirena, whatever it is, it's too much. And you're scared to take it, but I don't want to have any more kids."*

Lack of Information and Resources about Contraceptive Side Effects/Effective Communication with Provider

Focus group respondents identified a lack of information and resources about contraceptive side effects as another barrier to birth spacing and planning pregnancies. Some respondents also discussed never being educated on birth spacing or even hearing the terminology. Participants generally indicated fearing birth control because of stories of negative side effects, as well as not understanding how birth spacing impacts their health and the health of the baby.

> *"Going into my [obstetrician,] I told her what I wanted. I don't remember any conversation about risks or anything like that. It basically was just, 'Okay'... But I don't remember it being super detailed or very descriptive, or even knowing up front all those risks."*

Community focus group respondents also addressed the lack of effective communication between the respondent and their providers. Some participants indicated that providers' descriptions and explanations of birth control side effects were insufficient. Explanations were perceived as focusing on preventing pregnancy and often were either too technical or lacking the detail needed to fully understand contraception risks.

Lack of individualized Care

Across all community assessments, participants agreed birth control access was not a barrier. Most participants said they were very comfortable discussing birth control use with their providers, and that it was very easy to get a prescription for birth control. Yet across almost all focus groups, participants reported that providers pushed birth control use too much. Participants expressed feeling providers pushed what they wanted the patients to take vs. better understanding the beliefs and desires of the patient regarding their perception of family planning. Respondents also shared a general mistrust of the health care system and indicated that family planning was a personal choice. They described suspicions that providers push birth control so heavily because of the payments that they receive for prescribing birth control. Others shared feelings of racial discrimination in the context of birth control prescribing as a form of population control.

> *"They didn't tell me about my options until one of the prescriptions didn't work. They don't give you all of them on the table and say, 'Here, this is what I think is best for you, for your care, for your body. This is what I think is best for you.' It would have been nice to have options."*

Several respondents indicated receiving a lack of information regarding appropriate birth spacing. Respondents also expressed a lack of access to facilities that could provide a long-acting reversible contraception (LARC) method of birth control directly after birth, or the lack of opportunity for providers to perform sterilization procedures due to certain medical facilities' religious affiliations.

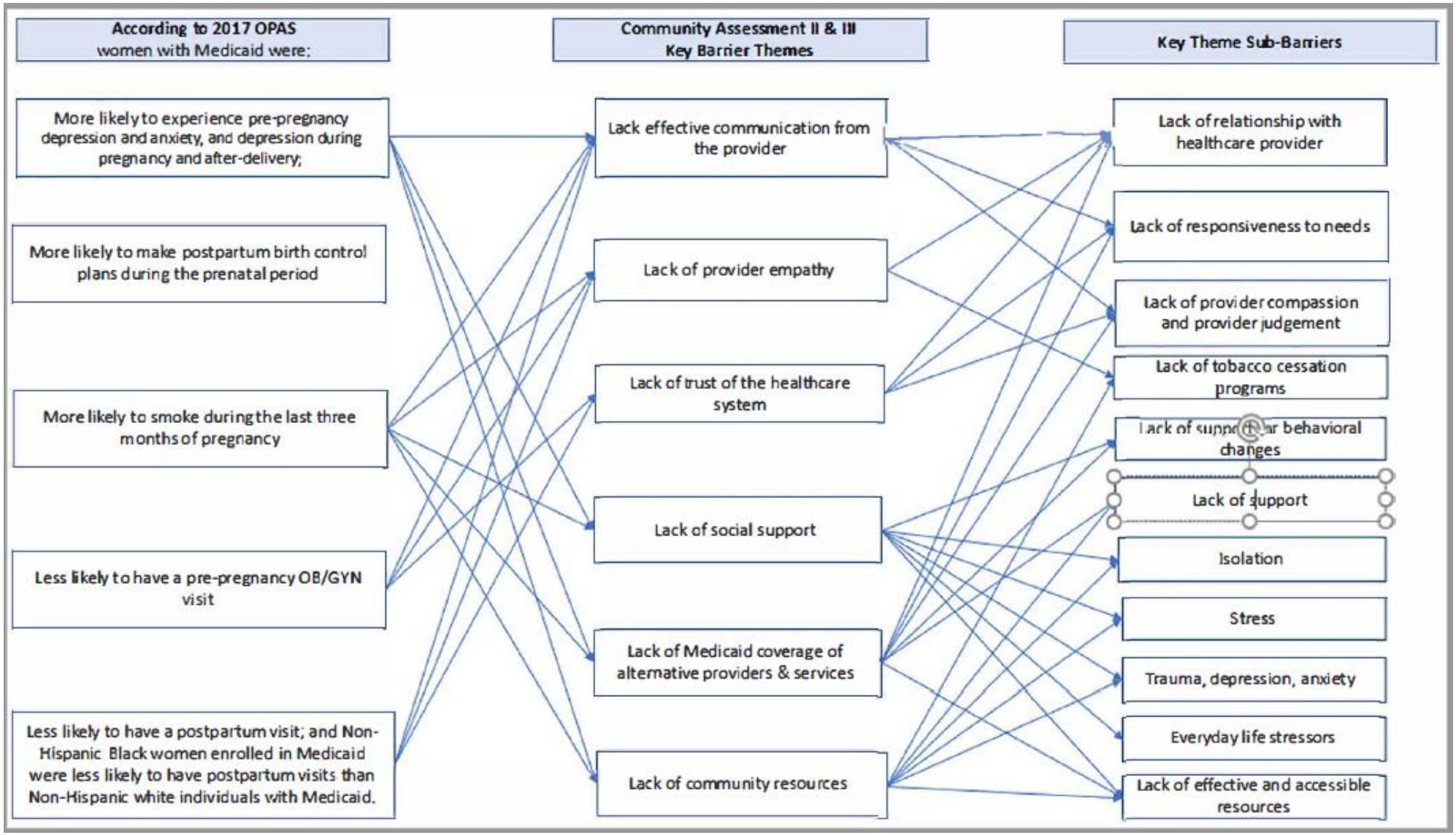
Focus group respondents recommended creating a financial incentive or penalty for providers based on how successfully they communicated with patients about birth control choices and their side effects.

Aversion to Birth Control Use

Assessment II and III participants shared an aversion to birth control use due to beliefs that birth control disrupts the body's natural cycle and hormonal balance, affects fertility when a woman is ready to become pregnant again, causes cancer, causes fibroids and cysts, and is a method of population control. Some participants stated their religious beliefs that a woman's body was created to have a menstrual cycle and children. Other non-hormonal forms of contraception mentioned were condom use and the natural family planning/rhythm method where a woman tracks her cycle and records her basal temperature. Many participants agreed that these would be ideal options and expressed a desire to have more education around natural family planning.

Crosswalk of OPAS Findings, Community Assessment Key Barrier Themes, and Key Theme Sub-Barriers

There is significant overlap between findings from the OPAS, Key Barriers identified through Community Assessments II and III, and Sub-Barriers identified across the types of barriers to positive outcomes that women encounter. The relationships between these overlapping findings is displayed below through a crosswalk diagram.



Conclusion and Recommendations

Ohio Community respondents from Assessments II and III provided qualitative data to supplement and provide more information for quantitative data of the 2017 OPAS findings, which indicated that Medicaid-insured women were less likely than privately insured women to receive early prenatal care, postpartum follow up visits, and to quit tobacco use during pregnancy.

According to analysis from both Assessments II and III, many of the barriers to interventions intended to reduce prematurity and infant mortality were associated with provider issues, Medicaid coverage, and health care system operations. A lack of empathy, trust and communication from health care providers, as well as a lack of easily accessible health care resources, and programs specific to the target population contributed to these challenges. In addition, Medicaid coverage of less-traditional providers and services directly impacted access to interventions intended to reduce prematurity and infant mortality.

Actions to Improve Barriers to Prematurity Prevention

As the single largest payor for maternal and infant services, ODM will work to ensure programs and policies address the needs illuminated through women's participation in the community assessments. Programs and policies that support building positive relationships between the patient, provider and health system while fostering effective communication can mitigate provider access barriers and improve continuity of care, thereby reducing barriers that prohibit high-risk women from participating in prematurity prevention, optimal birth spacing and tobacco cessation interventions.

The need for more effective patient provider relationships to improve continuity of care is evidenced by experiences shared by women with Medicaid regarding the perception of medical needs not being addressed, providers not being accessible, perceived feelings of judgement, lack of compassion, and lack of effective and respectful communication from the provider. Based on qualitative data from focus group participants, interventions to address identified barriers must look beyond clinical interventions to reduce the infant mortality health disparity in Ohio.

To address continuity in care and increase the relationship between the patient and provider, ODM plans to:

- Build on the infrastructure providing continuity of care by allowing the family to be heard. ODM's investment in comprehensive primary care (CPC) in which more than half of all Medicaid members are already attributed to a patient-centered medical home, is a strong step forward in promoting continuity of relationship and care. CPC and CPC for Kids practices are required to have a family advisory council to provide direct input into improving person-centered practice processes and the patient experience of care. In addition, the Family Provider Council was developed to obtain the perspective of individuals insured by Medicaid regarding their experience with providers.
- Develop a person-centered maternal and infant support program that is Medicaid-funded to address the special gaps experienced by women in the Medicaid program, in conjunction with existing home visiting and other community-based services.
- Explore the feasibility of an expanded, less-traditional workforce that may include new models of care and payment.
- Build on existing payment innovation with attention to special high-risk maternity populations through reporting and data feedback. ODM has created a bundle or episode-of-care upon which maternity care

payment is based with both positive and negative incentives for performance in both quality of care and cost. Augmenting the model to incorporate considerations for SDOH may also provide additional insights into closing the disparity gap. In 2019, the CPC program added an activity requirement to assess the patient experience, with a focus on ensuring all patient-facing staff are trained to provide culturally competent care.

- Continue to work in partnership with the MCPs to invest in community-derived efforts focused on improving preterm birth and infant mortality. Most of the efforts are anchored in the OEI communities and address racism and SDOH, as well as streamlined access to the health system. Several efforts deploy CHWs or navigators to enhance effective and culturally competent communication.
- Continue to work in partnership with ODH, OPQC, all academic centers, and the largest maternity hospitals. Simplifying key clinical information about the most effective preterm birth prevention options, such as the provision of progesterone and the optimal control of underlying chronic health conditions like hypertension to save lives. Modifying the ways in which care is provided and integrating care more conveniently into the lives of those at highest risk for poor birth outcomes can be tested and taken to scale for collective impact. Re-energizing this work with the MCPs and OPQC builds on prior quality improvement initiatives and holds promise for continued improvements in preterm births that can be measured at a Medicaid population level.

Actions to Improve Barriers to Tobacco Cessation

Respondents from all counties that were assessed shared that increasing the availability of easily accessible, convenient programs that use support groups, incentives, and companionship (in person or virtually) would better assist women with quitting the use of tobacco and tobacco products. The supplemental qualitative data from OPAS also indicates women with Medicaid need increased access to mental health care coordination and assistance with learning coping skills for daily life stressors.

- ODM is exploring the development of mobile technology-based applications with embedded supports to drive behavior changes such as tobacco cessation. While these efforts still are in the research stages, they hold promise for empowering women and linking them to incentives from the MCPs and community programs.
- ODM is working with ODH to coordinate and potentially integrate tobacco cessation programs and incentives with the MCPs to prevent competing incentives, service duplication or gaps, and extra confusion.
- Although all tobacco cessation services are covered by Medicaid, utilization is lower than expected due to time constraints within clinical settings, as well as workforce issues. Some of the community OEI efforts utilizing CHWs are funded for pathways to tobaccos cessation.

Actions to Improve Barriers to Optimal Birth Spacing

Qualitative data describing barriers to optimal birth spacing interventions emphasized lack of communication about birth control side effects.

- Prior focus groups indicated that the methods most effective for optimal spacing, including LARCs, were not easily accessible to the Medicaid population. In response to this data, efforts in recent years focused on improving same-day access for reversible methods, including payment and policy changes that

allowed for immediate post-partum delivery of LARCs. More recent focus group comments suggest that obtaining access to optimal birth spacing interventions is no longer a problem, although the number of respondents was not statistically representative. Instead, the recent views expressed by the focus groups suggests that providers and policymakers may need to better understand additional cultural and communication barriers that can prevent use of effective methods for optimal spacing.

- ODM plans to reassess the information and materials provided to women in the Medicaid program from the MCPs and the largest health systems.
- Supporting the continuity of care between obstetrical and primary care providers to ensure consistency in optimal spacing messaging, as well as follow-through with patient choices, will address some of the concerns expressed.
- Pharmacists can be tapped as a potentially more accessible source of timely information.

ODM has worked to retain pregnant women in the Medicaid program as a strategy to ensure access to needed care at this critical time in their lives. Improving the efficiency and usability of the eligibility system has particular impact on women at risk for poor birth outcomes, as access to preterm birth prevention, tobacco cessation, and optimal spacing is out of reach for most without coverage. Allowing for managed care on day one of enrollment has eliminated much additional confusion at the point of service, ameliorating access issues. Automating the notification of pregnancy status to adjust redetermination dates at the county so that women do not lose eligibility during pregnancy, has been one of the single most important changes impacting high-risk pregnant women. ODM continues to work on this process, creating a web-based version of the PRAF 2.0 to facilitate timely communication of pregnancy needs to expedite needed care.

As ODM has learned of the patient experiences that shape the care for women at risk for poor birth outcomes, the agency has even greater resolve to continue to build trust between clinicians and health systems, and the communities they serve. ODM has developed virtual reality scenarios with Ohio's academic centers to help build awareness of implicit bias, facilitating greater empathy for a culturally diverse patient population. As professional burn-out is so closely associated with a less personal approach to patient care, additional efforts in leveraging technology to minimize the administrative work to meet documentation requirements may free up time for clinicians to build better rapport.

Appendix A – Progress Toward Barrier Mitigation

Supplementing the 2017 OPAS results through qualitative community assessments in Athens, Cuyahoga, Franklin, Hamilton, and Ross counties was effective in identifying access barriers to interventions intended to prevent prematurity and infant mortality. ODM welcomes the opportunity to address barriers experienced by women with Medicaid insurance. ODM is working with partners across state and local agencies to identify additional strategies to mitigate identified barriers and increase access to interventions intended to prevent prematurity, reduce tobacco use, and promote optimal birth spacing.

Below are updates to areas ODM has been able to influence internally over the past six months.

Social Determinants of Health

Transportation	• Safe, reliable and adequate transportation was identified in all periodic community assessments as a barrier to care. • Contracted MCPs are testing various transportation arrangements including Lyft for high risk pregnant women. • Two MCPs have voluntarily contracted with the city of Columbus for the SMART City Perinatal Transportation Assistance (PTA) pilot targeting pregnant women enrolled in Medicaid that are less than 32 weeks pregnant, for on-demand transportation. • Both MCPs are providing on-demand transportation using a mobile application on selected participants' mobile devices for approved rides deemed necessary for pregnant women. • Other contracted MCPs also are testing various modifications, such as SMART Columbus, to transportation services specific for pregnant women.
Child care	• Child care was mentioned in all periodic assessments as an access barrier to interventions intended to reduce infant mortality. Highlighted as a key barrier in Community Assessment III.
Community Health Workers (CHWs)	• ODM continues to encourage the MCPs to use CHWs, or other professionally trained personnel, in an effort to identify and address the many social conditions experienced by women; and, most importantly, to establish a longitudinal and trusting relationship. • ODM is incorporating additional guidelines into the provider agreement to require contracted MCPs use the linked vital statistics/Medicaid file to identify women at-risk for poor birth outcomes with proactive outreach and intervention beyond conventional care management.

[i] Division of Reproductive Health, National Center for Chronic Disease Prevention and Health Promotion, CDC, March 2019
[ii] Ohio Department of Health, 2017 Ohio Infant Mortality Data: General Findings
[iii] Ohio Department of Health, 2017 Ohio Infant Mortality Data: Table 4 Ohio Neonatal, Postneontal, and Infant Mortality, by Rave and Ethnicity (2013-2017)
[iv] Ohio Department of Medicaid, SB 332 Barriers Assessment Semi – Annual Report I, September 2018
[v] Ohio Department of Health, Infant Vitality, About Ohio Equity Institute, 2019
[vi] Ohio Vital Statistics, 2018
Ohio Department of Health, 2017 Ohio Infant Mortality Data: General Findings
[viii] Ohio Department of Health, 2017 Ohio Infant Mortality Data: General Findings
[ix] Requejo, J., Merialdi, M., Althabe, F., Keller, M., Katz, J., & Menon, R. (2013). Born too soon: care during pregnancy and childbirth to reduce preterm deliveries and improve health outcomes of the preterm baby. *Reproductive health*, *10 Suppl*

[x] Ohio State University Government Resource Center (GRC), Ohio Pregnancy Assessment Survey, 2017 OPAS Dashboard
[xi] Ohio State University Government Resource Center (GRC), Ohio Pregnancy Assessment Survey, 2017 OPAS Dashboard

[xii] Ohio State University Government Resource Center (GRC), Ohio Pregnancy Assessment Survey, 2017 OPAS Dashboard
[xiii] Ohio State University Government Resource Center (GRC), Ohio Pregnancy Assessment Survey, 2017 OPAS Dashboard
[xiv] Ohio State University Government Resource Center (GRC), Ohio Pregnancy Assessment Survey, 2017 OPAS Dashboard
[xv] Ohio State University Government Resource Center (GRC), Ohio Pregnancy Assessment Survey, 2017 OPAS Dashboard