Perinatal Sub-committee Strategic Plan

DRAFT FOR PUBLIC COMMENT

10/21/24

Background

The Perinatal Sub-committee was created through a maternal health innovation grant from the Health Resources Services Administration (HRSA). The sub-committee is a subgroup of the Maternal and Child Health Advisory Task Force and is a multidisciplinary, diverse, and community-led committee building a shared vision for perinatal health. One of the main goals of this sub-committee was to create a strategic plan. Rather than starting from scratch, the sub-committee was committed to building off of and aligning with existing efforts. Over the past several years, there have been multiple state, county and community level initiatives on infant and maternal health that have produced recommendations. Rather than asking community once again what they wanted to see in a Perinatal Health Strategic Plan, the sub-committee and Minnesota Department of Health (MDH) contracted with an external consultant to review ten reports to better understand what suggestions have already been made to the state to decrease perinatal health disparities. After months of prioritization, adapting, and editing, the sub-committee created the following recommendations.

Please note that these recommendations are reflective of the wisdom and expertise of sub-committee members. While MDH played a supportive role, they are not responsible for the creation of this content.

Focus considerations

The sub-committee will proactively promote and collaborate with community organizations and health systems over the next three years to advance equity, justice, and systemic changes in perinatal care. Focus is especially needed where existing systems do not fully support the desired experiences and outcomes for Black/African American and Native American and Indigenous communities.

- **Promote strategies**: Emphasize that the sub-committee's role is to actively promote strategies rather than merely adopting them. This highlights the proactive nature of the committee's work.
- **Collaborate**: Stress the importance of collaboration with community organizations and health systems. This aligns with the need for working alongside existing entities, as discussed in the small group discussions.
- **Advance equity and justice**: Highlight the overarching goals of advancing equity and justice in perinatal care.

- **Drive systemic change**: Emphasize the sub-committee's role in influencing systemic changes within the health care and social services systems to address disparities and improve perinatal health experiences.
- **Encourage community involvement**: Reflect the call to action by actively involving those who are doing the work.

Anti-racism statement

In our commitment to anti-racism in maternal health for the Black/African American and Native American and Indigenous communities, we (the sub-committee) vow to actively resist and dismantle systemic barriers while advocating for equitable access to quality care. This involves addressing institutionalized discrimination and biases, recognizing historical trauma, and prioritizing policies, resources, training, and effective interventions that center the needs of marginalized communities.

Our goal is to create a future where every woman and birthing person, regardless of race or ethnicity, receives the support and care necessary for optimal maternal health outcomes and experiences. Anti-racism is embedded throughout the recommendations presented in the strategic plan.

Target population statement

These recommendations focus on communities who identify as Black/African American and Native American and Indigenous because these communities face the highest perinatal health inequities. However, not every community has representative data and people hold intersectional identities. Therefore, this was designed to be a living document that can be tailored to best suit a communities' need.

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Draft recommendations

1. Traditional wisdom

Acknowledge and respect cultural practices and land acknowledgement, particularly those of Black/African American heritage and Native American and Indigenous heritage, and other communities that have been historically disenfranchised. Includes the use of traditional knowledge keepers, elders, and cultural healers—during the preconception, pregnancy, and postpartum periods, while tailoring it to the individual needs of women and birthing people. This responsibility lies with health systems, state agencies, organizations, and individuals.

Action steps:

a. **Trauma**: Provide opportunities to address the impact of traumatic experiences and identify cultural strengths and communal supports.

b. **Land and community building**: Honor space and people's contributions to the land and community building.

c. **Racism as a public health crisis**: Establish racism as a public health crisis and develop strategic plans to address the impacts in program, policy, and practice.

2. Community leadership

Require Native American and Indigenous, and Black/African American individuals in leadership and decision-making roles.

Action steps:

a. **Structural racism**: Change the balance of power and rules to tackle structural racism by inserting multiple community leader voices in top tier systems.

b. **Lived experience**: Position community members with firsthand experiences in leadership roles, ensuring lived experiences are prioritized in driving positive change.

c. **Community-driven solutions**: Engage in dialogues with the affected communities to understand and implement solutions, and fund culturally specific community-led programs that address resource gaps and support equitable care continuously.

3. Education and training requirements

Implement ongoing education and training requirements for health systems, organizations, individual care teams, state agencies, and law enforcement about bias, trauma, social determinants of health, and culturally respectful care through a person-centered approach.

Action steps:

a. **Bias**: Conduct training and education by recognizing and addressing both conscious and unconscious biases in service delivery, including but not limited to health care providers, social service providers (social workers, family home visitors, etc.), and community

service providers. Implement systematic changes addressing root causes of bias and discrimination, holding both systems and individuals accountable.

b. **Cultural sensitivity**: Develop culturally sensitive policies for mandatory training modules that are required educational components for clinicians.

c. **Discrimination and systemic racism**: Provide health care providers and care teams with annual, required anti-bias training to address discrimination and systemic racism in health care. The trainings will be co-created with communities most impacted and will focus on how racism is perpetuated, bias, trauma, and culturally respectful care and will recognize and address both conscious and unconscious biases in health care delivery. Trainings on trauma-informed care should consider:

   i. What are providers doing to ensure they deliver trauma-informed care?

   ii. What training is provided? What ongoing support is there for employees?

   iii. Identify ways to address and improve the culture of the organization to be equitable and anti-racist.

   iv. Review internal policies, procedures, and practices.

   v. Mission statement, values, commitment to anti-racist organization, working to address internal and external issues.

   vi. Is there a feedback process for clients to provide input or suggested improvements?

d. **Law enforcement**: Train law enforcement on working with women and birthing people (mobile crisis unit instead of imprisonment).

4. Diverse workforce

Diversify the health care workforce in medical systems, health care centers, medical schools, nursing schools, and midwifery schools, particularly by increasing the number of Native American and Indigenous, and Black/African American doctors, midwives, doulas, nurses, social workers, and cultural advocates. Support education and training for minority health care professionals. Develop and support alternative pathways to careers in culturally specific health care fields (e.g., cultural healers).

Action steps:

a. **Training and certification for Native American and Indigenous and Black/African American doulas**: Provide education and training to postpartum doulas within the Native American and Indigenous, and Black/African American communities, focusing on care collaboration, advocacy, and certification as doulas. Ensure that educators of color are hired for these trainings. Develop specific strategies such as scholarships, outreach programs, mentorship opportunities, and culturally relevant marketing materials to encourage people of color to attend such trainings and pursue certifications.

b. **Funding**: Pass legislative measures to fund health care workforce programs that include mentorship and support once in those roles. Funding includes creating programs that

connect people for better education opportunities, aiming to build a more diverse group of health care workers who can serve women and birthing people across the state.

c. **Education**: Implement an easier process for certifications and licensure of non-western trained health professionals to be able to practice in the U.S.

d. **Perinatal mental health training**: Establish and fund training programs where communities of color and American Indian and Indigenous community members can affordably gain training for perinatal mental health community health workers, peer recovery specialists, and/or doulas, or other similar roles.

e. **Training for community members**: Provide economic development opportunities and training for community members on policymaking processes and engagement.

f. **Community leadership**: Provide funded internships/apprenticeships/understudy opportunities for future leaders. Restructure/assign leadership to have cultural accountability partners or coaches.

5. Accountability

Enhance personal and professional accountability for equity in health care.

Action steps:

a. **Accountability for professional conduct**: Audit documentation for bias (i.e. racism, colorism, tokenism, sexism, ableism, classism, homophobia etc.) and weaponizing of charts. For example: collect stories or surveys from patients upon discharge about bias experiences or acts of racism. Include audits as part of performance reviews/salary increases/promotions, etc.

b. **Licensing**: The renewal of licensure for health care providers includes an audit of documented encounters (i.e. acts of racism). For example, if a health care professional has “x” number of encounters, their recertification will be impacted by a probationary action as determined by the corresponding professional association (i.e. American Medical Association).

c. **Incident reporting**: Establish anonymous reporting mechanisms for women and birthing people on the perinatal journey to report bias incidents. Ensure protection against retaliation for those who report. Connect people for collective action by facilitating listening sessions and providing updates on corrective measure taken to support individuals who have experienced trauma.

d. **Psychological, cultural, and emotional safety**: Hold the system accountable to create a safe space for affected communities and providers to speak up without harm or repercussions. Establish a process to address the concerns raised.

e. **Racism integrated into risk assessment**: Include an ongoing assessment of racism within the regular risk assessment conducted by providers. Take caution when including race as a factor in the risk assessment.

6. Health care system policies and practices

Ensure that health care systems take responsibility for making changes in policies and practices to remove bias, racism, and discrimination in health care.

Action steps:

a. **Rules and laws**: Create rules and laws to eliminate the disparities in the health of mothers and babies, especially focusing on the needs and cultural understanding of Black/African American and Native American and Indigenous communities.

b. **System change strategies:** Modify rules around giving birth in prison, make sure Medicaid covers support from doulas, and make it easier for people to understand and use their insurance.

c. **Data reporting**: Require providers, health systems, and health plans to report maternal depression Healthcare Effectiveness Data and Information Set (HEDIS) measures.

d. **Strengthen perinatal programs and training**: Improve access to health care professionals, money, and resources to help with programs focused on the health of mothers and babies. (e.g. strengthening community health worker curriculum to include content and training on maternal and child health topics including perinatal health, especially on substance use disorder, mental health, self-advocacy, and options for a combined childbirth educators/community health worker/doula certification).

e. **Tools and/or data**: Provide and require anti-racism tools to be standardized in health systems (pilot strategies such as Patient Reported Experience Measure of Obstetric Racism (PREM-OB) or Irth App within a health system and lead evaluation within health system and individuals receiving care.

7. Advocacy, policy, and legislation

Improve birthing outcomes in health care systems (including clinicians and nursing staff) for Black/African American and Native American and Indigenous women, birthing people, and children through advocacy, policy, and legislation. Adapt community and relational standards based on feedback and expectations.

Action steps:

a. **Advocacy\in care coordination**: Fund cultural advocates to provide culturally sensitive care coordination.

b. **Expand definition of care providers**: Expand the utilization and scope of practice of community health workers as trusted messengers that can be integral to continuity of culturally sensitive care. Develop systems of support for these health workers to receive reimbursement and conduct visits outside of medical/clinic office settings.

c. **Civic engagement for communities most impacted:** Train young advocates to support the health of Native American and Indigenous, and Black/African American babies. Offer opportunities for economic growth and teach community members how to participate

in making policies. For example, hosting community events advocating for change, providing training to community members on policy making such as how to draft and sponsor bills, how bills become laws, and rally around issues impacting Black/African American and Native American and Indigenous communities when legislation in session.

d. **Protect families**: Promote policies that support keeping families intact, especially when women and birthing people are seeking treatment for adverse mental health conditions, substance use disorder, or while incarcerated.

    i. **Child welfare system**: Advocate for child welfare reform to address racial disparities in child removal and use alternative resources (e.g., early childhood and infant mental health specialists). Respect and reclaim culture to protect children and families. Increase the number of Native American and Indigenous, and Black/African American foster parents to promote the best interest of the child and to promote stability and security.

    ii. **Prison policy**: Reform prison policies to increase support for women and birthing people, and their families, while incarcerated – including improved and mandated breast/chest-feeding policies, increased time allowance and space to engage with family members, and whole family mental health and wellbeing services.

    iii. **Substance use disorder treatment**: Establish more family treatment programs for substance use disorder that allow children to remain with their caregiver while completing treatment.

    iv. **Community advocates**: Support individuals' and/or families' healing though increasing and promoting the use of community advocates.

e. **Comprehensive community engagement**: Conduct community engagement integrated throughout the legislative processes, including policy development and planning, data collection and analysis, and dissemination and evaluation.

f. **Meeting needs to make participation possible**: Develop systems of support through funding and policy to meet the needs of community members to access services and engage in systems-level work, including transportation, childcare, and compensation for time/expertise.

g. **Fathers' involvement**: Recognize and support fathers, caregivers, and/or partners in maternal health, both at the individual and policy levels.

h. **Violence prevention**: Prevent violence against Black/African American and Native American and Indigenous women, birthing people, and children by advocating for policies, support programs, and resources such as:

    i. Advocate for public safety measures to reduce over-policing in Black/African American and Native American and Indigenous communities.

    ii. Push for state and local organizations to recognize and describe racism as a form of violence.

iii. Invest in measures to identify and assess intimate partner violence during prenatal care and postpartum periods.

iv. Encourage the development and support of regional and state offices dedicated to addressing Missing and Murdered American Indian Women and Girls, fostering collaboration between state and Tribal communities.

v. Inclusion: Revise policies at homeless shelters to accommodate women and birthing people.

8. Culturally responsive data practices

Create data practices that are culturally sensitive and co-created with communities.

Action steps:

a. **Data collection and research**: Conduct culturally sensitive data collection and research that centers Tribal data sovereignty, community driven data practices, and data desegregation.

b. **Accountability to community**: Conduct responsive data practices. Honor community research protocols such as consultation with Native American and Indigenous Tribal authorities and/or elders, timely return of data, community feedback loops, and action-oriented strategies with community accountability measures.

c. **Perinatal-related data**: Expand public health data strategies to include substance use, alcohol use, mental illness, and intimate partner violence before, during, and after pregnancy.

d. **Intersectionality and agency**: Recognize people may identify in multiple communities and elevate autonomy for those that identify as such or who have historically not participated in reporting.

e. **Awareness**: Empower communities by raising awareness and confronting systemic issues, ensuring a better understanding of how racism impacts perinatal health outcomes and patient experiences.

9. Access to substance use disorder and mental health services

Improve access to culturally responsive substance use disorder and mental health care services, particularly with providers who have specific training in perinatal mental health and wellbeing.

Action steps:

a. **Substance use disorder and mental health services**: Improve treatment and prevention programs for substance use disorder and mental health issues during and after pregnancy through culturally responsive approaches and integrated care.

b. **Trauma-informed, culturally responsive services**: Increase accessibility of trauma-informed and culturally responsive programs, including substance use disorder and crisis mental health services and general referral services for individuals in crisis.

c. **Reimbursement**: Establish pay for perinatal community health workers/peer recovery support, similar to current policies with doulas, such as Medicaid reimbursement and sustained grant funding for community programs.

d. **Qualified professionals**: Increase the number of providers with credentials in perinatal mental health/reproductive psychiatry through Postpartum Support International and other organizations, through outreach and education support at local higher education institutions, health care organizations, and community programs.

e. **Hotline**: Support funding for a statewide perinatal mental health hotline, like other states, and spread awareness and use of the hotlines through community outreach and communications materials.

f. **Crisis mental health services**: Increase availability of crisis mental health services in the perinatal period through outreach and funding support to health care organizations and community programs.

10. Funding for substance use disorder and mental health

Increase funding in federal, state, and local levels for communities disproportionately impacted by substance use disorders and mental health conditions to fund efforts that address impacts on women and birthing people.

Action steps:

a. **Funding for community organizations**: Innovate funding to support community-led organizations to develop trauma-informed, culturally responsive models of care for harm reduction and safety, focused on cultural empowerment and culturally responsive care.

b. **Training**: Increase available funding from federal sources to enhance training for diverse workforces related to mental health, wellness, and substance use disorder.

c. **Buprenorphine**: Provide funding to increase the number of providers that are trained, competent, and confident prescribing buprenorphine in women and birthing people. people.

d. **Funding flexibility**: Increase amount of funding to communities that is flexible, accessible, and sustainable.

e. **Remove barriers** to receiving and renewing funds for non-traditional applicants.

f. **Navigating funding**: Provide training to community members on how to navigate and access government dollars.

g. **Simplifying funding applications**: Minimize barriers for communities to access government funding opportunities through simplified and culturally responsive grant application processes and notifications of funding opportunities.

11. Screenings and prevention

Improve screenings and preventions for maternal health to make them consistent and non-biased.

Action steps:

a. **Education**: Expand educational efforts to include substance use, alcohol use, mental illness, and intimate partner violence before, during, and after pregnancy. Utilize network of community health workers, doulas, peer support specialists, and recovery coaches.

b. **Screening and referral**: Provide holistic care for maternal health and improve screening and referral processes to address intimate partner violence, substance use disorder, and mental health during pregnancy and postpartum periods.

c. **Reimbursement**: Reimburse for screening outside of global prenatal care payment.

12. Access to services

Increase access to essential services by securing additional funding, expanding the availability of health care providers, and allocating resources to support holistic care.

Action steps:

a. **Referrals**: Increase access and availability of general referral services for individuals in crisis, along with making trauma-informed and culturally responsive mental health care and substance use disorder treatment more accessible.

b. **Service integration**: Provide easy access to health care services and programs, including integrating services for seamless access by offering multiple providers and services in one spot.

c. **Essential resources**: Invest in approaches to give people access to essential resources like food, transportation, and community-based support without disrupting existing trusted relationships. Create free or low-cost, reliable transportation options for women and birthing people and expand access to services like WIC and prenatal care. Fund wrap-around community-based resources from prenatal through early childhood.

d. **Connecting hospitals with communities**: Build systems where hospitals work with community partners to provide integrated care resources and engage health care providers, including supporting stronger connection and care coordination between medical doctors, nurses, midwives, doulas, and community health workers.

13. Care for people who are incarcerated

Enhance support for women and birthing people who are incarcerated.

Action steps:

a. **Culture/language**: Consider the cultural and linguistic diversity of women and birthing people who are incarcerated.

b. **Addressing the needs of pregnant people who are incarcerated:** Address the unique challenges faced by women and birthing people who are incarcerated, calling for improved health care services, support, and accommodations.

   i. Access to medication assisted treatment and prenatal, postpartum, and preventative care.

c. Access to community health worker/doula/peer recovery specialist, home visitors.

d. Bi-directional, continuum of care support for re-entrance to community.

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