Cross-Cutting: Social Determinants of Health Initiatives

Objective 6.3: Increase the proportion of MCH-led activities that address social determinants of health (SDOH) to reduce disparities and improve health outcomes for MCH populations by 15% annually through 2025.

Activities During Federal Fiscal Year 2023

*Becoming a Mom (*BaM®*) Health Equity Opportunity Project (HEOP):* Historically, the rate of infant mortality in the Black non-Hispanic population has been significantly higher than in other racial/ethnic groups. According to the KDHE Annual Summary of Vital Statistics, 2022, the Black non-Hispanic infant mortality rate in 2022 was 9.1 deaths per 1,000 live births – which was about double the rate of White non-Hispanic births. While the gap is narrowing in recent years, additional resources are still needed to focus strictly on reaching and supporting this population.

Utilizing lessons learned through the first two cohorts of the MCH Health Equity Opportunity Project, Title V granted six Health Equity Opportunity Projects (HEOP) to local BaM® programs. Utilizing the Kansas Healthy Communities Action Toolkit, mini-grant opportunities have been made available to programs interested in targeting high-risk disparity populations with service provision through unique cross-sector partnerships and the development and implementation of approaches to address social determinants of health and leading chronic disease risk factors among BaM® participants, as well as decreasing risks associated with chronic disease processes associated with pregnancy.

The first BaM® HEOP was awarded in July 2022 to *Baby Talk*, a long-standing Kansas Perinatal Community Collaborative (KPCC) implementing the BaM® prenatal education program. *Baby Talk* has formed a partnership with the Wichita Black Nurse Association (WBNA) to provide BaM® classes in a trusted, faith based, setting within the black and brown community. Funding for the MCHEOP has provided three WBNA nurses with Labor and Delivery experience to teach *Baby Talk* classes, as well as recruiting participants alongside the *Baby Talk* program. First classes were scheduled for October 2022. The Wichita Black Nurse Association (WBNA) stays committed to their partnership with the *Baby Talk* organization to grow and strengthen this targeted initiative. The project has continued to be sustained through 2023 through a combination of MCH ATL funds and other locally generated funds.

As of July 2023, five additional BaM® HEOP awards were granted to local communities. Focus of these projects included: expanding services to reach a broader Spanish-speaking population (Lawrence-Douglas Co. HD); providing TA to support the development of additional *Becoming a Dad* fatherhood initiatives across KPCC/ BaM® sites (Delivering Change); improving physical and mental health, fostering peer support and encouraging positive connections between pregnant and postpartum women through trauma-informed yoga (Riley Co. HD); adapting BaM® curriculum and resources for English Language Learners, low-literacy populations, and for provision through a one-on-one format in special circumstances (Seward Co. HD and Catholic Charities of

NEK). Project kick-off occurred in July 2023, with check-in calls scheduled on a quarterly basis. Here is a September 2023 email excerpt from our Riley County Project:

> *I just have to update you on our first Perinatal Yoga Class! We had 17 people in attendance, and it was a very diverse group! The total doesn't include the 5 infants and 1 toddler who attended childcare 😉. I attached a couple pictures! We are super excited on the turnout and felt like it was a WIN!!! We have some tweaks to make and learned a lot! I would really like to thank you for connecting us with Jennifer Wise as well! She was very helpful in creating measurable, yet non-intrusive pre/post test questions to capture data for our goal and objectives! Thanks!*

Birth Defects Education: Education material relevant to core, recommended, and extended birth defects has been in development by the Kansas Birth Defects Coordinator in collaboration with the Education and Outreach Coordinator with the goal of bringing attention to resources and education provided by the state and other national organizations. These materials are not yet ready for distribution, but will contain facts, diagnosis information and prevention items (if any depending on the birth defect) and will be sent to physicians and families. Outreach of birth defects continues to be delivered to subscribers of the Newborn Screening newsletter.

SDOH in KPQC/FTI: As part of the Alliance for Innovation on Maternal Health (AIM) Postpartum Discharge Transition patient safety bundle (for more information see Perinatal/Infant Report) birth facilities enrolled in the FTI were trained to screen all

maternal discharges for the Social and Structural Drivers of Health (SSDOH) using a

standardized tool. In an effort to be in alignment with local MCH programs, the American Academy of Family Physicians (AAFP) SDOH tool was provided as an example of a screening tool that FTI facilities could implement. Because every facility has a different electronic medical record, some SSDOH screening questions already exist within their facility system. Ultimately, each FTI facility can establish their own SSDOH screening tool, however the core components to be included in a SSDOH screening tool are based off guidance from the American College of Obstetricians and Gynecologists (ACOG) Committee Opinion Number 729.

In addition to universal screening, it is the referral and follow up that follows a "positive" screening result that is vitally important to improve maternal health outcomes. The Perinatal Referral Workflow was created to help FTI sites visualize what should happen following a "positive" screening result in the inpatient setting. The Perinatal Referral Workflow also assists FTI facilities to identify who their community resources are and where gaps may exist.

Local MCH Agencies:
The following are examples of how some of the local MCH grantee agencies have made progress toward objective 6.3 during the reporting period.

- MCH Home Visiting programs became required to screen for social determinants of health during this period. A screening tool based on the American Academy of Family Physician's Project ONE was provided in DAISEY and local MCH grantee agencies were allowed to use another tool to support alignment among their other agency programs. A copy of the form can be found at
- The Cultural Competency training from the Institute for the Advancement of Family Support Professionals was promoted to MCH Home Visitors via the MCH listserv.
- City-Cowley County Health Department participated in a video about social determinants of health and how CCCHD and partners seek to address those for a healthier community.

Plans for Federal Fiscal Year 2025

Black Maternal and Infant Mortality: In Kansas, Black maternal and infant mortality rates far exceed those of mothers and infants of other races. Black mothers in Kansas are more likely to die from hypertensive disorders or subsequent complications. Additionally, Black mothers are more likely to experience pre-term labor which may result in complications with delivery or even death of an infant. In an effort to address these urgent issues, Title V has taken a multi-pronged approach to addressing these disparities.

- Mothers and Support Persons: As part of collaborative efforts between home visiting and BaM programs, and the KPQC's FTI project, the state Title V team will continue to work towards garnering fiscal support for a Perinatal Home Blood Pressure Monitoring Pilot Project (in conjunction with the MCH Maternal Warning Signs Initiative and supplemental Perinatal Hypertension Patient Education Guide) in FY25. Efforts will also include follow-up on a recommendation that has been submitted to Medicaid to expand coverage for perinatal women to obtain an

automatic blood pressure, rather than only the manual, to increase compliance/utilization of at-home monitoring activities. This approach will empower mothers to monitor their signs and symptoms and provide education about when to reach out to a health care provider, go directly to an emergency department, etc. Ultimately, the goal of the project is to ensure that no mothers, or infants, are lost due to complications that occur from hypertensive disorders that could have been prevented via early intervention.

- For Providers: As part of the Kansas Perinatal Quality Collaborative's Fourth Trimester Initiative, all participating birthing centers and hospitals across the state, accounting for over 93% of births in Kansas, will continue to receive training related to bias and birth equity utilizing the Kansas Birth Equity Network (KBEN) curriculum. More specifically, the training will focus on the experience of Black mothers in the state and provide personal anecdotes told by mothers who experienced bias during recent birthing experiences. Additionally, the KPQC will partner with the Preeclampsia Foundation's MoMMAs Voices to offer three virtual learning opportunities for FTI sites featuring patient family partners sharing their personal stories. MoMMAs Voices focuses on empowering patients through advocacy and centering the patient voice at the heart of all healthcare related decisions. MoMMAs Voices aims to enhance patient-provider partnerships and improve overall maternal health outcomes. Learn more in the Perinatal/Infant plan.
- Addressing Systemic Issues: Through the Maternal Anti-Violence Innovation and Sharing (MAVIS) Project, a subcommittee has been established for the Maternal Mortality Review Committee. This subcommittee reviews cases related to violent maternal deaths (homicide, suicide, and poisoning/overdose) and cases that involve potential bias. To better identify disparities and the role of SDOH in relation to maternal mortality, the subcommittee utilizes a review form to support the committee in making consistent determinations when recognizing when and how SDOH impact Kansas maternal mortality. All subsequent cases reviewed in the subcommittee will be incorporated into the annual KMMRC report, including recommendations to address bias in the healthcare system.

SDOH Screening & Health Equity: The Title V Team will develop a plan to coordinate partnership and support opportunities with the Heartland Health Equity Regional Council for the annual Heartland Health Equity Summit. The conference brings in a variety of community and public health stakeholders to develop health-focused partnerships that address issues of health equity, explore strategies to preserve the health of our communities, understand perspectives and address community/population health, provide opportunities for community health workers to grow and develop, and highlight patients and families as health care partners.

SDOH in KPQC/FTI: As part of the Alliance for Innovation on Maternal Health (AIM) Postpartum Discharge Transition patient safety bundle (for more information see Perinatal/Infant Report) birth facilities enrolled in the FTI will screen all maternal discharges for the Social and Structural Drivers of Health (SSDOH) using a standardized tool. Core components to be included in a SSDOH screening tool are

based off guidance from the American College of Obstetricians and Gynecologists (ACOG) Committee Opinion Number 729.

What happens after a “positive” SDOH screening is almost more important than the screening itself. The Perinatal Referral Workflow is created to help FTI sites visualize what should happen following a “positive” screening result in the inpatient setting. The Perinatal Referral Workflow also assists FTI facilities to identify who their community resources are and where gaps may exist.