Chris Steller

From: Kochanski, Alexis R (DHS) <Alexis.Kochanski@state.mn.us>
Sent: Monday, April 15, 2019 6:15 PM
To: sen.michelle.benson@senate.mn; sen.jim.abeler@senate.mn; sen.jeff.hayden@senate.mn; sen.john.marty@senate.mn; Chris Steller; James Nobles; Frans, Myron (MMB)
Cc: LaRissa Fisher; Andrea Todd-Harlin; Bailey Strand; Tom Brennan; Inderia Falana; Elspeth Cavert
Subject: 4/15 Submission of DHS Legislative Reports
Attachments: MSOP Legislative Report_Quarterly 2018_final.pdf; FY19 2nd Quarter Report on AMRTC MSH CBHHs.pdf; ICHRP Leg. Report.pdf

Dear Legislators,

Please find the following legislatively mandated reports attached:

1. Minnesota Sex Offender Program: Annual Performance Report (2018)

2. Quarterly Report on Anoka Metro Regional Treatment Center (AMRTC), Minnesota Security Hospital (MSH) & Community Behavioral Health Hospitals (CBHH)- Second Quarter FY2019

3. Integrated Care for High Risk Pregnancies

Please let me know if you have any questions or how I can be of further assistance.

Thank you.

Alexis Russell Kochanski, MPH
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Chris Steller

From: Kochanski, Alexis R (DHS) <Alexis.Kochanski@state.mn.us>
Sent: Monday, April 15, 2019 6:18 PM
To: Rep.Tina Liebling; Rep.Rena Moran; Rep.Joe Schomacker; Rep.Debra Kiel; James Nobles; Frans, Myron (MMB); Chris Steller
Cc: Krysta Niedernhofer; Alyssa Fritz; Pat McQuillan; Chris McCall; Danyell Punelli; Doug Berg; Elisabeth Klarqvist; Joe Durheim; Randall Chun; Sarah Sunderman
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DEPARTMENT OF HUMAN SERVICES

Legislative Report

Integrated Care for High Risk Pregnancies

A Pilot Project to Improve Medical Assistance Birth Outcomes

Office of the Medical Director

January 2019

For more information contact:

Minnesota Department of Human Services
Office of the Medical Director
P.O. Box 64983
St. Paul, MN 55164-0983

651-431-2836

For accessible formats of this information or assistance with additional equal access to human services, write to DHS.info@state.mn.us, call 651-431-2836, or use your preferred relay service. ADA1 (2-18)

Minnesota Statutes, Chapter 3.197, requires the disclosure of the cost to prepare this report. The estimated cost of preparing this report is $9,500.

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Table of Contents

I. Executive summary

Integrated Care for High Risk Pregnancies Initiative Established to Reduce Disparities

In 2015 the Minnesota Legislature directed the Department of Human Services to implement a pilot program to improve birth outcomes, the Integrated Care for High Risk Pregnancies (ICHRP) Initiative. The program uses grant funds to promote integrated care and enhanced services to women at risk for adverse outcomes of pregnancy, through the use of perinatal care collaboratives. These care collaboratives support interdisciplinary, team-based needs assessments, infrastructure planning, and implementation of integrated care and enhanced services for pregnant mothers in targeted populations. Teams include community-based healthcare, social service, and paraprofessional providers.

ICHRP is demonstrating feasible approaches to providing community-led integrated care, which can be supported in the long term through modifications and enhancements to Medical Assistance benefit design.

Minnesota has excellent birth outcomes overall, with among the lowest rates nationally for prematurity, low birth weight, and infant mortality. Also, opiate use during pregnancy is generally much lower in Minnesota than elsewhere. However, our state has some of the nation's worst disparities for these outcomes for African Americans and American Indians. ICHRP works to reduce these disparities by directing resources to these two demographic groups. For African Americans, low birth weight births are targeted in the Twin Cities metro. For American Indians, maternal opiate use is targeted in communities served by our state's five largest tribal nations, including women living on or near the reservations and women in the urban core.

Prematurity, low birth weight and neonatal opiate withdrawal are the leading causes of costly neonatal intensive care unit admissions, and these adverse birth outcomes are known to be strongly associated with behavioral risks and disadvantaged social conditions. ICHRP's integrated care teams screen for these psychosocial risks in high-risk populations. They then coordinate community-supported interventions to reduce those risks.

ICHRP Funding Pilot Programs to Demonstrate Community-Led Collaborative Care

The Minnesota Department of Human Services awarded grant funds to five tribal organizations focused on improving outcomes of infants exposed to maternal opiate use, and to three community organizations in the Twin Cities focused on decreasing low birth weight births in mothers from the African American community.

Tribes use their collaborative structures effectively to streamline tribal resources and coordinate services so that client barriers to recovery are minimized. As collaboration evolves, tribes are also leveraging new relationships to bring in additional partners (e.g. hospitals, law enforcement, and medical providers), thus helping to reduce stigma and raise awareness while widening the circle of support that is available for Native women who are

pregnant and struggling with addiction. Even though practice models differ from one tribal ICHRP grantee to the next, there are essential features of community-led collaborative care that are shared across programs.

All five tribes are now incorporating peer recovery coaches into their program models. This involves training and certifying Native Americans with lived experience in recovery and parenting to support outreach and engagement through harm reduction activities, conducting outreach and intervention in tribal health clinics to engage pregnant women in treatment, and keeping clients engaged in their community. Grantees are very focused on identifying at-risk mothers early and reducing barriers to obtaining needed care. Some of these barriers are related to fear, stigma and shame that inhibit pregnant women from seeking help.

ICHRP grantees are concentrating their attention on working more closely with prenatal providers and child protection agencies to reduce these barriers. Programs establish an organizational climate and professional reputation that fosters trust and assures women that they will not be criticized, judged or shamed for seeking help for their addiction. Tribal ICHRP programs employ multiple outreach and engagement strategies to encourage pregnant women with SUDs to engage in treatment and supportive services. In addition to helping women abstain from drug abuse during pregnancy, grantees are also preventing child removal and family disruption.

To support the development of community capacity to address low birthweight births among African Americans, an African American ICHRP Advisory Council was convened to guide a request for proposals process to solicit applications for grant funds to implement ICHRP. The Council is recruited from diverse leadership in the community and has formed an effective mechanism for a direct dialogue with DHS. The Council continues to meet regularly to monitor progress of ICHRP and advise grantees.

Together the grantees and their partners are creating better integrated pathways and stronger partnerships to address African American high-risk pregnancies. Each of the clinic-based implementation sites is now engaging clients with a multidisciplinary team, using paraprofessionals in a personalized, high-risk maternal support role. These paraprofessionals are either local doulas or community health workers. Pregnant African American clients are recruited from across the geographically defined target area. Many of the clients receive their prenatal care from one of the community clinics operated by the grantees. However, grantees have developed relationships with over a dozen other clinic partners. This enables using a networked coordinated care model. With this approach, the clinically focused aspects of prenatal care can be provided by a range of available obstetric caregivers, while the culturally centered psychosocial support services are coordinated by the ICHRP team, using a paraprofessional in a connective navigator role.

> *The ICHRP Initiative shows that community-based leadership can be identified and engaged, and that community leaders and clinicians can guide evidence-based collaborative care for high-risk pregnancies. The collaborative care model is working in both Native American and African American communities.*

Policy Options for Sustaining the ICHRP Initiative

Current levels of grant funding for ICHRP are sufficient for continuing the existing pilot sites' activities until sustainable, long-term funding from Medical Assistance is devised and made available. Many aspects of Medical Assistance benefit design exist under federal statute to provide additional levels of coordination and service

provision to populations at higher risk for adverse outcomes. To sustain the benefits of the ICHRP model of community-led, collaborative care to reduce Minnesota's disparities in birth outcomes, DHS proposes four recommendations related to the Integrated Care for High Risk Pregnancy Initiative:

1. Make use of potentially available ongoing Medical assistance funding options to adequately support community-led collaborative care for high-risk pregnancies. This type of care coordinates needed services through integration of community-based paraprofessionals into the care team.
2. Support community leadership for collaborative care recognizing the aspects of health that are best addressed by integrating with culturally based community resources to support mothers and families. In this regard, support ICHRP by continuing to recognize the role of tribal governments in program administration, and through continued support of the African American Integrated Care for High Risk Pregnancy Advisory Council.
3. Consider the model of program development and community involvement used by ICHRP to address other major disparities issues. Monitor this model for disparity reduction over time as more data becomes available.
4. Establish a reasonable timeframe for adopting ongoing funding options.

II. Legislation

MINNESOTA STATUTES § 256B.79, INTEGRATED CARE FOR HIGH-RISK PREGNANT WOMEN.

Subdivision 1. Definitions.

a) For purposes of this section, the following terms have the meanings given them.
b) "Adverse outcomes" means maternal opiate addiction, other reportable prenatal substance abuse, low birth weight, or preterm birth.
c) "Qualified integrated perinatal care collaborative" or "collaborative" means a combination of (1)members of community-based organizations that represent communities within the identified targeted populations, and (2) local or tribally based service entities, including health care, public health, social services, mental health, chemical dependency treatment, and community-based providers, determined by the com-missioner to meet the criteria for the provision of integrated care and enhanced services for enrollees within targeted populations.
d) "Targeted populations" means pregnant medical assistance enrollees residing in geographic areas identified by the commissioner as being at above-average risk for adverse outcomes.

Subd. 2. Pilot program established.

The commissioner shall implement a pilot program to improve birth outcomes and strengthen early parental resilience for pregnant women who are medical assistance enrollees, are at significantly elevated risk for adverse outcomes of pregnancy, and are in targeted populations. The program must promote the provision of integrated care and enhanced services to these pregnant women, including postpartum coordination to ensure ongoing continuity of care, by qualified integrated perinatal care collaboratives.

Subd. 3. Grant awards.

The commissioner shall award grants to qualifying applicants to support inter-disciplinary, integrated perinatal care. Grants must be awarded beginning July 1, 2016. Grant funds must be distributed through a request for proposals process to a designated lead agency within an entity that has been determined to be a qualified integrated perinatal care collaborative or within an entity in the process of meeting the qualifications to become a qualified integrated perinatal care collaborative. Grant awards must be used to support interdisciplinary, team-based needs assessments, planning, and implementation of integrated care and enhanced services for targeted populations. In determining grant award amounts, the commissioner shall consider the identified health and social risks linked to adverse outcomes and attributed to enrollees within the identified targeted population.

Subd. 4. Eligibility for grants.

To be eligible for a grant under this section, an entity must show that the entity meets or is in the process of meeting qualifications established by the commissioner to be a qualified integrated perinatal care collaborative. These qualifications must include evidence that the entity has or is in the process of developing policies,

services, and partnerships to support interdisciplinary, integrated care. The policies, services, and partnerships must meet specific criteria and be approved by the commissioner. The commissioner shall establish a process to review the collaborative's capacity for interdisciplinary, integrated care, to be reviewed at the commissioner's discretion. In determining whether the entity meets the qualifications for a qualified integrated perinatal care collaborative, the commissioner shall verify and review whether the entity's policies, services, and partnerships:

1) optimize early identification of drug and alcohol dependency and abuse during pregnancy, effectively coordinate referrals and follow-up of identified patients to evidence-based or evidence-informed treatment, and integrate perinatal care services with behavioral health and substance abuse services;
2) enhance access to, and effective use of, needed health care or tribal health care services, public health or tribal public health services, social services, mental health services, chemical dependency services, or services provided by community-based providers by bridging cultural gaps within systems of care and by integrating community-based paraprofessionals such as doulas and community health workers as routinely available service components;
3) encourage patient education about prenatal care, birthing, and postpartum care, and document how patient education is provided. Patient education may include information on nutrition, reproductive life planning, breastfeeding, and parenting;
4) integrate child welfare case planning with substance abuse treatment planning and monitoring, as appropriate;
5) effectively systematize screening, collaborative care planning, referrals, and follow up for behavioral and social risks known to be associated with adverse outcomes and known to be prevalent within the targeted populations;
6) facilitate ongoing continuity of care to include postpartum coordination and referrals for interconception care, continued treatment for substance abuse, identification and referrals for maternal depression and other chronic mental health conditions, continued medication management for chronic diseases, and appropriate referrals to tribal or county-based social services agencies and tribal or county-based public health nursing services; and
7) implement ongoing quality improvement activities as determined by the commissioner, including collection and use of data from qualified providers on metrics of quality such as health outcomes and processes of care, and the use of other data that has been collected by the commissioner.

Subd. 5. Gaps in communication, support, and care.

A collaborative receiving a grant under this section must develop means of identifying and reporting gaps in the collaborative's communication, administrative support, and direct care that must be remedied for the collaborative to effectively provide integrated care and enhanced services to targeted populations.

Subd. 6. Report.

By January 31, 2019, the commissioner shall report to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services policy and finance on the status and progress of the pilot program. The report must:

1) describe the capacity of collaboratives receiving grants under this section;

2) contain aggregate information about enrollees served within targeted populations;
3) describe the utilization of enhanced prenatal services;
4) for enrollees identified with maternal substance use disorders, describe the utilization of substance use treatment and dispositions of any child protection cases;
5) contain data on outcomes within targeted populations and compare these outcomes to outcomes statewide, using standard categories of race and ethnicity; and
6) include recommendations for continuing the program or sustaining improvements through other means beyond June 30, 2019.

Subd. 7. Expiration. This section expires June 30, 2019.

History: 2015 c 71 art 11 s 45

III. Overview of the Integrated Care for High Risk Pregnancies (ICHRP) Initiative

Legislation enacted

In 2015 the Minnesota Legislature directed the Department of Human Services to implement a pilot program to improve birth outcomes, the Integrated Care for High Risk Pregnancies (ICHRP) Initiative (Minnesota Statute § 256B.79). ICHRP reaches pregnant women who are medical assistance enrollees, are at significantly elevated risk for adverse outcomes of pregnancy, and are in targeted populations. Such targeted populations are defined as pregnant women residing in geographic areas identified as being at above-average risk for adverse outcomes. Adverse outcomes include low birth weight, prematurity, maternal opiate addiction, and other reportable prenatal substance abuse. The program uses grant funds to promote integrated care and enhanced services to these women through the use of integrated perinatal care collaboratives. These care collaboratives support interdisciplinary, team-based needs assessments, infrastructure planning, and implementation of integrated care and enhanced services for pregnant mothers in the targeted populations.

Via these funds providers, local service entities and communities work together to achieve healthier birth outcomes. ICHRP is demonstrating feasible approaches to providing community-led integrated care, which can be supported in the long term through modifications and enhancements to Medical Assistance benefit design.

Minnesota has excellent birth outcomes overall, with among the lowest rates nationally for prematurity, low birth weight, and infant mortality. Also, opiate use during pregnancy is generally much lower in Minnesota than elsewhere. However, our state has some of the nation's highest disparities for these outcomes for African Americans and American Indians. ICHRP works to lower these disparities by directing resources to these two demographic groups. For African Americans, low birth weight births are targeted in the Twin Cities metro. For American Indians, maternal opiate use is targeted in communities served by our state's five largest tribal nations.

Maternal opiate use in the American Indian community

Medical Assistance data show very high rates of prenatal maternal opiate use on or next to the tribal reservations of White Earth, Red Lake, Leech Lake, Mille Lacs, and Fond du Lac nations. These areas have shown an average rate of prenatal maternal opiate use of 9.8%, compared to the statewide average of 1.5% for all Medical Assistance births. Chronic opiate use during pregnancy can result in newborns showing signs of opiate withdrawal, termed Neonatal Abstinence Syndrome (NAS). Many of these newborns require intensive hospital care to safely treat their symptoms. Most are involved in the child welfare system. Twenty-four percent of NAS newborns are born prematurely.

NAS has rapidly increased in Minnesota, as diagnosed neonatal opiate withdrawal in the Medical Assistance population has risen from 0.5% of all births in 2010, to 1.4 % in 2015. While Medical Assistance covers around

43% of all of Minnesota's births, approximately 80% of the state's newborns with NAS are Medical Assistance births. Of these NAS newborns, there is an eight-fold higher rate of NAS among infants born to American Indians. About nine in ten of Minnesota's American Indian births are within Medical Assistance.

Compared to the five identified tribal areas, there are no other areas in the state with comparably elevated rates of prenatal maternal opiate use. Therefore, in addition to the targeted area in the core Twin Cities metro described previously as having significantly high risk for low birth weight births, these five northern tribal areas were designated as being eligible to receive targeted ICHRP grant funds due to high risk for maternal opiate use.

Low birth weight in the African American community

Low birth weight is noted when the weight of a live born infant is less than 2500 grams (about 5.5 pounds). Low birth weight is often linked to prematurity (babies that are born too early), and may also be due to intrauterine growth restriction (babies that are small for their gestational age). Infants with low birth weight are at substantially higher risk of death in their first year (infant mortality) and also have substantial risk for long term disability.

Low birth weight is an indicator of unhealthy pregnancies. It is influenced by nutrition, environmental and behavioral stressors, and receipt of quality prenatal care. These same factors are known to impact maternal health and mortality. Not all causes of low birth weight are understood, but it is well accepted that addressing both the psychosocial needs of women during pregnancy and providing early access to good prenatal care will together reduce risk for low birth weight and maternal complications.

Minnesota's high disparities in prematurity and low birth weight are concentrated in its Medical Assistance population. Within Medical Assistance births, the low birth weight rate is around 7.3% for whites, and around 13.5% for African Americans. (Rates of low birth weight for other racial/ethnic groups are similar to, or no more than two percentage points higher than, the white rate.) About 8 in 10 of Minnesota's African American births are to mothers who are insured within Medical Assistance.

Minnesota birth record data show that rates of low birth weight are significantly elevated in the core urban area of the Twin Cities, including first-tier suburbs such as Brooklyn Park and Brooklyn Center. These areas have shown an average Medical Assistance rate of low birth weight of 8.9% (Minneapolis), 8.7% (Ramsey County), and 9.2% (Hennepin County excluding Minneapolis, Bloomington, Richfield, and Edina). All of these areas' elevated rates are statistically significant, compared to the statewide average rate for all Medical Assistance births. There are no other areas in the state with comparably elevated rates of low birth weight births. Therefore, these areas (Ramsey County, and Hennepin County excluding Bloomington, Richfield, and Edina) were designated as being eligible for the targeted services supported by the ICHRP grant funds.

The core urban area of the Twin Cities, as described above, would not show a significantly elevated rate of low birth weight births, except for the fact that the rate of low birth weight births for African Americans is so significantly elevated, compared to other racial/ethnic communities. To improve birth outcomes significantly in the core urban area of the Twin Cities, we must reduce the disparity in birth outcomes experienced by African Americans. Therefore, the African American community was designated as a community targeted for services supported by ICHRP grant funds.

Integrated care model promoted by ICHRP

Prematurity, low birth weight and NAS are the leading causes of costly neonatal intensive care unit admissions, and these adverse birth outcomes are known to be strongly associated with behavioral risks and disadvantaged social conditions. ICHRP's integrated care teams screen for these psychosocial risks in high-risk populations. They then coordinate community-supported interventions along with medical interventions to reduce those risks.

Many partners on an integrated care team can enhance the value of supports and services needed by women at high risk for adverse birth outcomes:

- **Prenatal care clinicians** can provide early and regular screening for behavioral and psychosocial risks and might be involved in referral and follow-up activities for non-clinical supports and services.
- **Behavioral health practitioners** can care for ongoing or newly diagnosed mental health conditions.
- **Community-based organizations**, knowledgeable about culturally-based services and resources and representing the perspectives of local residents, can uniquely advocate and support high-risk women during pregnancy and beyond.
- **Social service entities** can assess specific resource needs and direct services and resources as appropriate.
- **Public health nurses** can perform additional needs assessments, make referrals for supports and services, and provide home visiting as appropriate.
- When substance use disorders are present, **chemical health treatment programs** and services are needed during and following pregnancy.
- When substance abuse disorders are present, and when deemed appropriate, **child protection** can elect to provide supportive case management services during prenatal care and will be formally involved to protect the infant's safety if substance use remains untreated following the birth.
- For American Indian women, services will also include those offered by **tribal nations**.

Frequently, these many entities are not integrated to the extent that they can communicate and cooperate in delivering the complex web of prenatal supports and services needed by the women they serve. They must each commit to build and maintain connectivity, lest care remain fragmented, inefficient and less effective.

Clinics providing prenatal care are often the first place of contact within the larger system of care for newly pregnant women. Prenatal care providers are expected to screen routinely for alcohol and substance use, tobacco use, depression, and domestic violence and abuse. Positive findings from screenings often necessitate referrals to other organizations. The extent to which clinics can coordinate these screening and referral activities varies greatly. ICHRP works to enhance the connectivity of prenatal care providers with the larger system of services and supports within local integrated care systems

It is challenging to identify and engage pregnant women early in their pregnancies and gain their trust to participate with the various service providers participating in the collaborative. The ICHRP model relies on community-based paraprofessionals, such as community health workers (CHWs), doulas, and peer recovery coaches. They help build client trust with service providers, advocate for clients' needs and help clients navigate

and access complex care systems. They can assist in risk screening and needs assessment and frequently accompany clients to appointments. They are from the community, have developed working relationships with the full range of local service entities, and are familiar with referral and appointment processes for different locations. In addition, they are able to make home visits and can provide education around a variety of topics relevant to pregnancy and parenting. For clients engaged in treatment for substance use, or those in ongoing recovery, paraprofessionals can provide support as trained recovery coaches.

ICHRP draws upon the knowledge, creativity, and cultural resources of community-based organizations to better serve their clients' needs. Grantees developed programs to achieve the goals outlined below:

- Improved identification early in pregnancy, and uptake into appropriate services, of women with psychosocial and behavioral risks for adverse birth outcomes.
- Improved effectiveness of treatment of opiate dependency and other substance use disorders during pregnancy, resulting in fewer newborns testing positive for exposure to illicit substances.
- Improved effectiveness of interventions to reduce psychosocial and behavioral risks related to low birth weight births.
- Improved use of community-based paraprofessionals (CHWs, doulas, care navigators, peer support specialists, etc.) in connecting clients to supports and services.
- Fewer out-of-home placements for infants.

For the purposes of the pilot project, a qualified integrated perinatal care collaborative is a group of service organizations that work together to improve services for pregnant women. A collaborative as such is not a legal entity, but is distinguished by its members' stated commitment to engage systematically with each other to address specific integrated care strategies. Each collaborative designates a fiscal agent to receive ICHRP grant funds. The fiscal agent for each of the ICHRP collaboratives is either a community-based organization (non-profit organization whose board members are from the targeted community) or a tribal government.

It is now well established that the disparity in adverse birth outcomes experienced by African American and American Indian women is related to the accumulated stresses of lived experiences with racism and violence, as well as historical trauma. Using a collaborative care approach systematically to identify psychosocial needs, and connecting women to wrap-around supports and services tailored to these needs, is known to lessen the immediate effect of these risk factors. This in turn improves the chances of carrying a pregnancy to full term with a normal birth weight.

Five of the target areas could be identified because of extremely high rates of maternal opiate use. In addition to opiate use, pregnancies in these reservation areas are also known to be affected by high rates of substance use in general; about a third of Minnesota Medicaid pregnancies among American Indians have a diagnosis of substance abuse. However, Substance abuse is not infrequently found to be a risk factor in women of all communities. In all ICHRP service areas, connecting clients with treatment and recovery supports is an important part reducing risks for prematurity and low birth weight. Regardless of where clients live, substance abuse is associated with a constellation of co-occurring psychosocial conditions, such as significant mental illness, homelessness and housing instability, partner abuse and violence, food insecurity, lack of transportation, and need for involvement of child protective services to ensure child safety and well-being.

Most women do not misuse substances, even in communities targeted for higher levels of misuse. In all communities, women can have numerous other unaddressed psychosocial risks. For women with significant levels of such risk, the comprehensive risk screening and mitigation that is provided by a community-directed collaborative care model is critical to lessening their chances of having an adverse birth outcome, and reduces the long-standing disparity for these outcomes their communities have experienced.

To address complex maternal health issues faced by child-rearing women in disadvantaged communities, governments and communities must partner to deliver holistic services. Communities need to have access to funding and support to develop, implement, and evaluate their own solutions to address these needs. ICHRP encourages innovative solutions and approaches to integrated care involving multiple partners.

IV. ICHRP Implementation

The Minnesota Legislature appropriated approximately $3 million for grant funding over two biennia, and $989,000 annually continues in the state's base budget. Using a competitive bidding process, the Minnesota Department of Human Services (DHS), through its Health Care Administration, awarded grant funds to five tribal organizations focused on improving outcomes of infants exposed to maternal opiate use, and to three community organizations in the Twin Cities focused on decreasing low birth weight births in mothers from the African American community.

Four tribal communities are using the funds to provide services to clients living on or near their reservation areas. The White Earth Nation, which had already established a successful collaborative care intervention for maternal opiate use (the Maternal Outreach and Mitigation Services or "MOMS" program), elected to direct its ICHRP funds to establish an urban version of MOMS in the Twin Cities. Grants totaling $1,564,000 went to the following organizations:

- Fond du Lac Band of Lake Superior Chippewa
- Leech Lake Band of Ojibwe
- Mille Lacs Band of Ojibwe
- White Earth Band of Chippewa
- Red Lake Band of Chippewa Indians

A corresponding portion of the ICHRP grant funds were directed to address significantly elevated rates of low birth weight births among African-Americans in the Minneapolis-St. Paul area. Grants totaling $1,334,000 went to the following organizations:

- The African American Babies Coalition, a part of the Amherst H. Wilder Foundation, Saint Paul
- Ramsey Prenatal Clinical Collaborative made up of Open Cities Health Center, West Side Community Health Services and United Family Medicine, the fiscal agent for which is Open Cities Health Center
- NorthPoint Health & Wellness Center Inc., a multi-specialty agency in North Minneapolis

Tribal ICHRP Pilot Programs Providing Collaborative Care for Maternal Opiate Use

ICHRP's tribal partners and DHS adopted three program objectives for their initiatives:

- Screening and Assessment – Pregnant women, substance-exposed infants and their families are identified in a consistent, uniform and timely manner across all systems.
- Joint Accountability and Shared Outcomes – Programs that intersect systems (e.g., health care, education, child welfare, etc.) reflect a collaborative practice approach to serving substance-exposed infants and their families.

- Services for pregnant women, substance-exposed infants and their family – Partners agree upon evidence-based practices and programs that meet the needs of the target populations and monitor use and effectiveness of these programs.

These objectives are grounded in a model[1] promoted by the National Center on Substance Abuse and Child Welfare (NCSACW), and reflect DHS' and the tribes' effort to blend into ICHRP the federally supported capacity building work already underway. In 2014, NCSACW had launched the Substance Exposed Infants In-Depth Technical Assistance (SEI-IDTA) program to advance the capacity of states, tribes, and their community partner agencies to improve the safety, health, permanency, and well-being of infants with prenatal substance exposure and the recovery of pregnant and parenting women and their families. DHS' Alcohol and Drug Abuse Division (now Behavioral Health Division) sought and received this technical assistance to support Minnesota's tribal communities. SEI-IDTA works to strengthen collaboration among child welfare, substance use disorder treatment, maternal and infant health care providers, early care and education, home visiting, and other key partners. This technical assistance was well-timed to support the implementation, beginning in 2016, of the five tribal ICHRP pilot programs.

Each tribe set up its collaborative structure to maximize resources. For three of the tribes (Fond du Lac, Red Lake, and Mille Lacs) a behavioral health entity helms the tribe's ICHRP program. In Fond du Lac, for example, the SUD treatment provider serves as the lead in making referrals to recovery case management services, behavioral health, medical and social services when a client is admitted to the program. Partners meet monthly about ICHRP clients to coordinate care and solve problems. In addition to holding regular team meetings about ICHRP in general, they hold weekly multidisciplinary case consultations regarding individual clients.

Mille Lacs takes a similar approach, also incorporating peer recovery coaches and law enforcement. They conduct weekly medication assisted treatment (MAT) recovery meetings that begin with case consultation. Fond du Lac plans to have the capacity in 2019 to support a fully integrated treatment plan in conjunction with a single-system electronic health record that will allow all departments to share that single plan.

In Leech Lake and White Earth, the tribal health department takes the lead in coordinating care on behalf of ICHRP clients with other tribal agencies, including mental health, opiate treatment resources, child welfare, home visiting and social services. For the White Earth Urban MOMS (UMOMS) program, primary partners also include the Indian Health Board, Minnesota Indian Women's Resource Center (MIWRC) and the Native American Community Health Clinic (NACC). Program staff meet weekly with these partners but are in communication daily to coordinate care.

Regardless of which agency serves as the lead, tribes use their collaborative structures effectively to streamline tribal resources and coordinate services so that client barriers to recovery are minimized. As collaboration evolves, tribes are also leveraging new relationships to bring in additional partners (e.g. hospitals, law

[1] https://ncsacw.samhsa.gov/files/Collaborative_Approach_508.pdf

enforcement, and medical providers), thus helping to reduce stigma and raise awareness while widening the circle of support that is available for Native women who are pregnant and struggling with addiction.

Even though practice models differ from one tribal ICHRP grantee to the next, there are essential features of community-led collaborative care that are shared across programs. These include:

- Ensuring that culture is at the core of policy, programming and daily interactions
- Utilizing peers with lived experience to facilitate outreach, engagement and retention of women and families in treatment, supportive services and community activities
- Keeping and treating families together as a unit, preventing the trauma of family separation
- Eliminating the stigma associated with substance use disorders and the need for help
- Breaking down silos within tribes and across local agencies through improved coordination and collaboration
- Engaging the support of tribal leadership, beginning in the planning phase, and preparing for sustainability in the face of anticipated (and unanticipated) changes in leadership and governance

These features originate from within the tribal community and can be further strengthened by support from non-tribal partners, including county and state agencies, community-based service organizations, and health care providers. The relationship between tribes and counties regarding child protection can be complicated. In addition to operating their own Indian Child Welfare (ICW) agencies, most of the tribes' reservations cross over multiple counties that administer child welfare and protective services that impact tribal members. There are also tribes such as Red Lake where child welfare services are primarily tribally-managed, and families living off reservation can elect to move onto the reservation to have their Children's Protective Services (CPS) cases handled by the tribe. Both tribe-county relationships and county-specific CPS practices vary widely, and many counties and tribes are working to improve connections so that families impacted by parental substance use disorders are offered more supportive options.

Some county child welfare offices have imbedded Indian Child Welfare Act (ICWA) units that notify the tribes of an open case with a member family, and others have policies that directly transfer these cases to the tribe. Some of the ICHRP grantees have informal agreements with county offices to keep children with their mothers when mothers are engaged in a tribal treatment program. For example, White Earth's UMOMS program is located in Minneapolis and works closely with Project Child, a Hennepin County-run child welfare program for women who are using drugs or alcohol before their 34th week of pregnancy. Project Child refers pregnant Native women to UMOMS for chemical health assessments and treatment services, as well as education, support, one-to-one counseling, referrals for help in the community, assistance with basic needs and parenting education. According to the UMOMS Program Director, Project Child staff are very solution-oriented, going "above and beyond" to avoid child removal and attending family meetings on the UMOMS campus to support coordinated care and case management.

Successes and Lessons Learned

In August of 2018, the SEI-IDTA technical consultant visited all five tribal ICHRP programs and conducted a structured interviews with staff from each program. The interviews identified perceived gaps and barriers to collaborative care, as well as strengths and accomplishments.

A consistent barrier reported by tribes was that some county CPS workers are perceived by tribal workers as hesitant to collaborate with tribal programs, especially in the early phase of program start-up. This creates additional barriers to relationship and trust building, although grantees acknowledge that each county is different. Interviewees shared a wealth of information and perspectives that continue to guide ICHRP's implementation and evaluation.

Judicial attitudes have a significant impact on options available to pregnant Native women. ICHRP grantees report that there is still much work to be done to reduce judicial and community stigma around opioid use during pregnancy, especially on the reservation where this bias is stronger than in the metro area. This extends to stigma associated with treatment. Both tribal and county child welfare staff are supporting integrated care plans that include medication assisted therapy (MAT) such as buprenorphine or methadone. MAT is considered the standard of care for managing maternal opiate use disorder. Compared to abstinence-based treatment, MAT significantly lowers maternal relapse and overdose risk, which also improves birth outcomes.

Some counties are perceived as very welcoming and others as disrespectful. In many cases, tribe-county relationships are informal and exist primarily at the practice level between direct service providers rather than at the systems level between policy makers. While practice-level collaboration accommodates some direct service coordination, lack of system-level collaboration inhibits a more strategic approach that can weather staff turnover and changes in administration.

Both on and off of tribal reservations, informal community-based supports are a vital part of the services available to Native pregnant women and their families. Clients are "referred" to cultural events and community gatherings in the same manner that they are referred to more formal clinical and social service supports. Peer recovery coaches are deployed to assist with follow-up, including transporting them to events when needed. Participation in these traditional ceremonies and cultural activities helps to counter the isolative tendencies for pregnant women who steer clear of more formal services. For example, Fond du Lac's Tagwii Recovery Center hosts weekly breakfasts for program alumni, who return week after week to take part in a growing recovery network on the reservation. In Mille Lacs, peer recovery coaches serve as the bridge to community supports. As the Mille Lacs ICHRP program director put it, "peer recovery coaches are so community-connected that it doesn't even feel like a referral. It's more like an invitation, or it happens the other way where the person in need knows how and who to ask for help." In some of the tribal ICHRP programs, successful clients have later progressed to become peer recovery coaches and counselors.

ICHRP's model relies heavily on paraprofessionals, and some grantees have found it difficult to hire these workers—particularly CHWs and peer recovery workers—because of workforce shortages. Accordingly, DHS has directed federal funds to support curriculum development and training for these paraprofessionals, in close coordination with the state-funded ICHRP program.

All five tribes are now incorporating peer recovery coaches into their program models. This involves training and certifying Native Americans with lived experience in recovery and parenting to support outreach and engagement through harm reduction activities, conducting outreach and intervention in tribal health clinics to engage pregnant women in treatment, and keeping clients engaged in their community. Minnesota's SUD System Reform has now gone into effect in late 2018, allowing Medicaid reimbursement for these peer recovery workers.

Grantees are very focused on identifying at risk mothers early and reducing barriers to obtaining needed care. Some of these barriers are related to fear, stigma and shame that inhibit pregnant women from seeking help. Grantees consider the primary factor inhibiting Native pregnant women from accessing prenatal care and from seeking treatment for a substance use disorder to be fear— fear of having their newborns (as well as older children) taken from the home, and fear of legal consequences (including incarceration). Stigmatization and shame is associated with addiction, especially in small communities where social connections are tight. For families that are involved in social services before the baby is born, clients are "very educated" that services are voluntary and therefore savvy about avoiding engagement in services prenatally that they perceive might subject them to more scrutiny. This makes it very difficult to intervene early in pregnancy.

Most Native pregnant women are referred to ICHRP programs by hospitals, courts, the Indian Health Board, other health providers, and CPS. In discussing access challenges, ICHRP grantees are concentrating their attention on working more closely with prenatal providers and CPS to reduce barriers related to fear, stigma and shame. For example, staff at the White Earth UMOMS program report they have "a huge push to repeat messaging that you won't get kids removed if you come for help. We've held firm to that model so the community knows it's true." These efforts are paying off, as evidenced by an increased number of women who are willing to sign up for voluntary cases to receive extra help and protection for their families.

In conjunction with the fear that women experience, providers and program staff are challenged with coordinating care for their patients in the context of federal data policies regarding patient privacy and confidentiality regarding substance use disorders. These policies can sometimes inhibit information sharing, a serious barrier to effective collaboration among medical and other service providers. Prenatal providers also express feeling caught between maintaining client trust and choosing to screen for a health condition (e.g. substance use disorder) that requires them as mandated reporters to notify CPS.

It is critical to find a non-judgmental physician or care provider with whom women feel comfortable. Programs must establish an organizational climate and professional reputation that fosters trust and assures women that they will not be criticized, judged or shamed for seeking help for their addiction. As one program manager put it, "Going to the clinic and not getting judged is critical. It is easier to say, 'I'm part of the MOMS program' rather than saying 'I'm an opiate user'"

Both patients and providers need education about treatment and access to treatment. Patients are apprehensive about adopting an "abstinence lifestyle," and women and their family members are not always sure about which resources are supportive as they begin a path to recovery. It is important to educate and empower women who are trying to find their voice to advocate for themselves.

Homelessness both on and off the reservation is a significant issue for substance-using pregnant women. For many reasons (e.g., space limitations, deferred building maintenance and insufficient capital funds), housing is not available to support long-term recovery. As one program manager noted, "We see every day that it is hard to focus on treatment with no roof over your head." Another manager shared the story of a current client that completed treatment and recently got custody of her children but is homeless with nowhere to go. Most low-income housing programs don't accept clients with assault or felony records, or any evictions in the last five years. This makes it very difficult to find safe, sober housing for a new mother and her young child, so they are not compelled to return to the using environment which may have led to them to addiction in the first place.

Tribal grantees agree that culture is foundational to healing and recovery for Native Americans. Culture is at the core of the different tribal ICHRP programs and services, and cultural considerations are written into their treatment plans. The most successful groups and services are those that incorporate culture—Families of Tradition (hosted by a peer recovery coach), cultural crafting, drumming, smudging, and other cultural practices into multiple aspects of the program. One grantee reflected that tribal culture is "coveted" and can be perceived as protected somewhat like a secret or a special privilege. This can feel shaming for those with addiction who perceive that they aren't pure enough to be allowed to participate. In response, at least one tribe is trying to weave cultural practice into programs with a bit less ceremony so that services feel more welcoming for individuals seeking treatment.

Tribal ICHRP programs employ multiple outreach and engagement strategies to encourage pregnant women with SUDs to engage in treatment and supportive services. These include incentives, community outreach events, designated outreach staff, and facilitated referral processes. However, the best engagement strategy is being able to show the success of the program itself. As one program leader observed, "Past successes tend to be the best kind of advertising. Our treatment coordinator is not there to turn you in or bring the cops, and this has established lots of trust in the community. Women will check in even if they are hiding out. It has taken us three years to build this level of rapport with the community."

In addition to helping women abstain from drug abuse during pregnancy, grantees are also preventing child removal and family disruption. Programs focus on improving overall health, social and economic outcomes for their clients. For example, Fond du Lac reported that 29 of its 32 graduates are now working full-time. In White Earth, 100% of the mothers engaged in the MOMS and UMOMS programs have been able to bring their babies home with them from the hospital. ICHRP grantees report that clients are frequently able to surmount overwhelming obstacles (including losing child custody, homelessness, extreme poverty, transportation challenges, and lack of sober family and friend supports) to engage successfully in treatment and recovery support services. These parents in recovery are inspiring hope among providers and those in tribal communities that change is possible in the context of a collaborative approach to care that is culturally rooted, non-judgmental, and community-driven.

Tribal ICHRP grantees initiated program operations in mid-2017. Building new capacity to implement collaborative care is a stepwise process that involves reconfiguring working relationships across partnering agencies and organizations. Some tribes have shown strong leadership commitment for supporting these new collaborative care arrangements. As a result, some of the programs are operational at a systems-level scale, and have been able to steadily expand their capacity for accepting new clients. For other programs periodic changes in elected tribal administrations have sometimes resulted in significant staff turnover. As a result, some programs are still at an earlier developmental stage, focused mostly on reconfiguring working relationships across partnering agencies and organizations. Although they are making progress developing their program infrastructure, these programs have smaller operational capacity for serving clients, and have not yet expanded to the scale needed to serve their populations.

ICHRP Pilot Program Providing Collaborative Care to prevent LBW Births among African Americans

In order to assure that this program was community-directed, DHS contracted with a facilitator, GrayHall LLC, to help bring Twin Cities community organizations and providers together to design a collaborative care project to address low birthweight births among African Americans. This organization was selected for its experience and familiarity with engaging with the African American community on issues of health and equity. GrayHall, a professional consulting team based in this community, was directed to recruit and convene an African American ICHRP Advisory Council ("Council"). Council members are from the African American community and have in-depth knowledge and understanding of current maternal and family health systems and operational issues. Beginning in 2016 the Council met monthly, and once the grantees began work meetings have been held quarterly.

The creation of this Council was crucial in the development of the African American portion of ICHRP. The Council is recruited from diverse leadership in the community, and took an ownership stake in the program that was deeper than previous efforts to engage community in addressing LBW disparities. The Council, with the facilitation support of Gray Hall, formed an effective mechanism for a direct dialogue with DHS and across the community that has addressed the impact of the social risk factors of racism and associated economic factors (e.g. poverty, poor housing). Also the Council directly addressed community perceptions about DHS and the quality and accessibility of maternity care services available through Medical Assistance. The net effect of these sometimes difficult conversations is reflected in a robust "Theory of Change" model it developed, but more importantly in the shared ownership of the program by the Council and the organizations it represents.

Based on the Council's input, in 2017 DHS issued a request for proposals to solicit applications for grant funds to implement the ICHRP project. The Council continues to meet regularly to monitor progress of ICHRP and advise grantees.

ICHRP Theory of Change and Logic Model

The ICHRP "Theory of Change" is a holistic conceptualization of how community-led collaborative change is applied to improving birth outcomes. It starts with contextual factors, moves to care principles, and then describes needed services and of their integration. The model finishes with the outcomes anticipated for families and specifies the systemic changes required. The ICHRP "Theory of Change" is presented in the appendix of this report.

Grantees convened at facilitated monthly meetings to apply the principles of the ICHRP "Theory of Change" to their collaborative activities. They worked together to create a more pragmatic logic model to help align daily activities to achieve long-term program outcomes. See Figure 1.

Figure 1: Logic Model

Integrated Care for High-Risk Pregnant African American Women

GrayHall facilitated the meetings of the three grantees, and grantees also met periodically with the Council to report their progress. Together the grantees and their partners are creating better integrated pathways and stronger partnerships to address African American high-risk pregnancies:

- **Care Team Training.** This is designed for paraprofessionals and primary care providers. The training improves knowledge and skills about psychosocial needs assessment. Trainers also show how to integrate paraprofessionals into teams providing wrap-around supports and services.
- **Capacity Building.** DHS staff worked with leadership of primary service providers and local government administrators to encourage support of ICHRP. The collaborative partners are working with paraprofessionals to better incorporate their skills and expertise into care teams. They also work with various other healthcare providers to assist understanding and use of culturally sensitive approaches when working with African American families.
- **Community Engagement**. The transfer of services and knowledge related to the ICHRP model among grantees, families and the general public is multi-directional. All participants gain valuable information about successes, challenges, and services related to high-risk pregnancies. As the broader community becomes familiar with ICHRP, barriers to accessing care are reduced, and there is increased recognition of the added value that culturally centered approaches to caregiving bring.
- **Multimedia campaigns.** This resulted in sharing of knowledge with the broader community through information sessions, social media, and other information sharing forums. Also, information was shared through various media with community leaders and local service providers.
- **Direct Client Services.** Services include outreach, drop-in moms' meetings, story-telling, psychosocial risk screening, collaborative care planning, referrals, follow up, and programs that engage fathers.
- **Program Evaluation and Gaps Analysis.** In March 2018 the Ramsey County Care Collaborative asked its clients to comment on barriers they face when obtaining care from clinics and hospitals. This focus group identified the following gaps in cultural sensitivity within current care systems: Lack of trust; no relationship with provider; inability to understand medical terms; difficulty with front desk/receptionist staff; difficulty with phone lines and scheduling staff; parking; insensitive nursing staff; lack of respect for cultural differences.

Cumulative Impact of Collaborative Activities

Grantees assessed the impact of their integrated care approaches both quantitatively and qualitatively. The cumulative impact from November 2017–October 2018 was assessed in terms of the total number of people reached across Hennepin and Ramsey Counties through all ICHRP Programming and Services:

- **Training and Capacity Building:** Over 85 clinic staff members participated in training activities. In addition, Certified Prenatal Educator training, a type of recognized training for doulas, was provided to 20 persons, including three males.
- **Mom's Services:** The grantees involved in clinical care connected clients to over 4,500 activities, resources, and direct services. These included outreach, screenings, group prenatal care, drop-in groups, and referrals to other provides and resources.
- **Multimedia Campaigns:** The ICHRP program conveyed information about the value of ICHRP services and how to access them, through community radio, neighborhood events, youth conferences, provider conferences, webinars, workshops, and newspaper announcements and articles. These combined efforts reached an estimated 30,000 people or more.

Each of the clinic-based sites (NorthPoint, West Side, and Open Cities) is now engaging clients with a multidisciplinary team using paraprofessionals in a personalized, high-risk maternal support role. These paraprofessionals are either local doulas or community health workers. They all have lived experience as a parent.

At NorthPoint, community health workers screen all clients and coordinate access to service referrals and other supportive resources. They have served more than 70 clients. This includes both clients receiving prenatal care at NorthPoint and clients receiving prenatal care from 14 external clinic partners. Group prenatal care is offered for those at NorthPoint. In addition, group events for pregnant moms and new parents are offered which support clients in learning about and transitioning to new roles and responsibilities. Information about a recent event, the IYA Empowerment Circle, is included in the appendix.

At West Side, the program has branded their collaborative care approach as Diva Moms. A short video was developed highlighting the impact of the program[2]. At this program, doulas are used as the designated paraprofessional. In addition to client navigation they provide in-person outreach. ICHRP partners also enjoy a strong relationship with the organization providing prenatal care for most ICHRP-eligible pregnancies in Ramsey County, resulting in a large referral source and a well-developed care coordination process. West Side also offers group prenatal care to women treated in West Side clinics. Additionally, drop-in groups for women are well attended, both by pregnant women and new mothers.

Open Cities has branded the program "Nubian Moms." Doulas provide paraprofessional support and coordinated support services both for clients receiving care in-house and for clients who get prenatal care at partnering clinics.

Pregnant African American clients are recruited from across the geographically defined target area, which is all of Ramsey County and Hennepin County (excluding Richfield, Bloomington, and Edina). Many of the clients receive their prenatal care from one of the community clinics operated by the grantees, i.e., NorthPoint, West Side, or Open Cities. However, grantees have developed relationships with other clinic partners. This enables using a networked coordinated care model. With this approach, the clinically focused aspects of prenatal care can be provided by a range of available obstetric caregivers, while the culturally centered psychosocial support services are coordinated by the community clinic, using a paraprofessional in a connective navigator role.

All clinical sites use the Prenatal Risk Overview (PRO) tool. The PRO is a highly standardized web-based interview for screening pregnant women for a variety of psychosocial risk factors. The Twin Cities Healthy Start program developed the PRO tool, which is available at no cost to health care and social service agencies that serve pregnant women.

The PRO screens for:

- Basic needs: telephone, transportation, food, housing
- Social support, sexual/physical abuse victimization by partner or other person

[2] https://youtu.be/XUfPn3-qLFA

- Mental health: depression, PTSD, anxiety
- Substance use: cigarette smoking, alcohol use, drug use
- Legal problems
- Involvement with child protective services

Typically the paraprofessional administers the PRO to the client, and the care team supervisor reviews results. A referral and care coordination plan is devised to connect the client to needed supports and services. The paraprofessional assumes a lead role in educating the client about the nature of her different support options, and in helping the client access and make use of these resources and interventions.

Summary of Pilot ICHRP Implementation

Eight grantees and their many partners are implementing ICHRP. They are daily showing the value of community-led collaborative care to mitigate psychosocial risks during pregnancy. In the northern half of the state ICHRP addresses maternal opiate use among American Indian women residing on or adjacent to the five tribal reservations. In the Twin Cities ICHRP reduces low birth weight births to African American women.

The ICHRP Initiative shows that community-based leadership can be identified and engaged, and that community leaders and clinicians can guide evidence-based collaborative care for high-risk pregnancies. The collaborative care model is working in both Native American and African American communities.

In light of this high concentration of maternal risk, targeted use of a collaborative care model such as ICHRP supports proactive case-finding and risk assessment, including detection of previously unknown substance use. The collaborative care model identifies and mitigates the constellation of other psycho-social risks associated with risk for prematurity and low birth weight in the African American community. ICHRP provides comprehensive, wrap-around support and services in a short period of time, which serves to reduce stigma, improve coping skills, stabilize critical aspects of the clients' living situations, and align supports with supervision and compliance. The ICHRP Initiative has been successful in developing a community-led project that translates directly to improved service models for women at risk.

V. Policy Options for Sustaining the ICHRP Initiative

ICHRP is a pilot project to demonstrate that community-led collaborative care structures can deliver targeted care for high risk pregnancies. We have worked to understand how the model can be supported under Medical Assistance benefits. Many aspects of Medical Assistance benefit design exist under federal statute to provide additional levels of coordination and service provision to populations at higher risk for adverse outcomes. Other states' Medical Assistance agencies have made use of these options to devise targeted benefits or programs for high risk pregnancies. This pilot clarifies the content needed to address Minnesota's disparities in adverse birth outcomes.

Current levels of grant funding for ICHRP are sufficient for continuing the existing pilot sites' activities until sustainable, long-term funding from Medical Assistance is devised and made available. Funding for the ICHRP Initiative is currently set at $989,000 per year in the agency's base budget.

Community leadership has been and will continue to be essential to serving African American women in the Twin Cities. The Council's work will need to continue with grant support coming from ICHRP funds presently in the base budget after client services become reimbursable under Medical Assistance.

Support for Community Leadership

Community leadership is essential to ICHRP's continued success. In the American Indian community, leadership has come directly from the five tribes receiving grant funds. Each tribe independently directs the ICHRP program for which it receives grants funds. There is no umbrella group overseeing the tribes' activities together, though the tribes' initiatives have some common elements.

For the part of ICHRP focused on high risk pregnancies in the African American community, leadership has come from an Advisory Council. The Advisory Council was recruited and convened early the project, and it informed the implementation of procurement and guided selection of respondents. The Council also worked to create the project's conceptual model (Theory of Change). It established and continues to take an active role in understanding and guiding the activities of the clinical practice sites. The Council's participation is essential to continuing ICHRP's work in the African American community. The Council should have the latitude to explore a collective impact strategy that considers strategic partnerships with non-profit organizations and public health, and may also consider formalizing its governance structure and becoming an autonomous organization itself.

Several states have supported public-private partnerships successfully to reduce disparities in adverse birth outcomes for African Americans. For example, the Ohio Institute for Equity in Birth Outcomes partners with state and local governments to intervene in geographically targeted communities with the highest disparities. In Maryland, Baltimore's collective impact strategy for maternal and child health, B'more for Healthy Babies, has reduced infant mortality citywide by nearly 40 percent in seven years. This public-private partnership leverages

public program funding with a diverse stream of private sector grant funding, and is directed with integrated community leadership.

DHS recommends that the African American ICHRP Advisory Council continue to be funded with ICHRP grant funds to guide and improve project implementation if and when Medical Assistance begins covering underlying ICHRP services. Funding from the currently appropriated ICHRP budget is sufficient to sustain the Council's work.

Potential Strategies for Reimbursing ICHRP Services through Medical Assistance

As the grant-funded program is proving effective, DHS is working to identify how best to support the direct service portions of the program inside the Medical Assistance benefit. Below we identify potential options and Minnesota DHS' history with those options.

Potential revision of enhanced pregnancy benefits to sustain ICHRP services to clients

The term "enhanced services" referred to in the ICHRP enabling language is specific to the federal Medicaid benefit structure. The COBRA Act of 1985 gave states the option to provide "enhanced pregnancy benefits" to pregnant women on Medicaid without also offering the same additional benefits to all Medicaid recipients. Minnesota elected this option several years after passage of the COBRA Act. The administrative details of enhanced pregnancy benefits are found in the state plan amendments, the managed care contract and the Medical Assistance provider manual.

Minnesota created a very specific enhanced pregnancy benefit set, based on knowledge available at the time. This is specified in rule 9505.0353, Prenatal Care Services. This rule, conceptualized over 30 years ago, is rarely used at this time. Furthermore, the existing benefits have little relation to current understanding of prenatal risk, which is now predominantly focused on early screening and follow up for psychosocial factors. There has been no connection between this benefit set and improved birth outcomes.

In Minnesota statute there is not a specific heading for enhanced pregnancy benefits. There is however, under Subd. 14(b) of Minn. Stat. § 256B.0625, a description of preventive services related to pregnancy. The last sentence in this section states, "Preventive services available to a woman at risk of poor pregnancy outcome may differ in an amount, duration, or scope from those available to other individuals eligible for medical assistance." This closely mirrors the language in federal Medicaid regulations related to enhanced pregnancy benefits found in 42 CFR 440.250(p). The federal enhanced pregnancy benefit gives states broad latitude in selecting services and benefit structure. Almost all state Medicaid agencies offer enhanced pregnancy benefits in up to nine different categories: prenatal risk assessment, targeted case management, home visiting, psychosocial counseling, health education, nutritional counseling, smoking cessation, substance abuse treatment, and dental care.

Several Medicaid agencies currently support interventions similar to ICHRP's approach, using the enhanced pregnancy benefit. These programs target high risk pregnancies, reducing psychosocial stressors through collaborative care coordination integrated with system navigation using supervised paraprofessionals. For

instance, Ohio's Medicaid program has created four maternal risk levels, with increased benefits tied to higher levels of risk. Benefits include access to integrated teams, which include paraprofessionals whom managed care organizations reimburse for care coordination services. These services, specified contractually, include identifying high risk women, assisting in linkages to health and social services, and tracking health or social issues to a measureable outcome.

Thus, enabling language already in state law and federal Medicaid regulations allow for broad flexibility to support a revised enhanced pregnancy benefit set for high risk women. This flexibility would allow coverage for current ICHRP services.

DHS recommends that redesign of enhanced pregnancy benefits be one of several policy options to consider as a means of sustaining ICHRP services through Medical Assistance.

Potential expansion of coordinated care through a health home

A second policy option to support the long-term sustainability of ICHRP is to consider the use of the federal health home option. The health home model is a provision of the Affordable Care Act (Sec. 1945 of the Social Security Act) and is available to states to serve the needs of complex populations covered by Medicaid. It supports a person-centered system of care that achieves improved outcomes for individuals and reduced costs to the health care system.

Health homes services are federally required to provide the following six core services:

- Comprehensive care management
- Care coordination
- Health and wellness promotion
- Comprehensive transitional care
- Individual and family support
- Referral to community and social services

All of these health home core services are also essential attributes of the ICHRP Initiative. In this regard, the health home model could potentially serve as an administrative and financing vehicle for supporting ICHRP within Medical Assistance. Under the federal health home criteria, states are able to propose specific eligibility criteria and seek funding for unique populations. DHS started with the behavioral health home services model in 2016, but has the option to seek approval for additional health home models.

The guiding principles of health home services for high-risk pregnancy could potentially be:

- Health home services are distinguished by the presence of a multi-disciplinary team that shares information and collaborates to deliver a holistic, coordinated plan of services and care. Paraprofessionals are used as part of the team, to bridge cultural barriers and to navigate clients within the service system.
- Health home services create an opportunity to meet the needs of individuals experiencing serious conditions such as substance use, mental illness, homelessness, and partner abuse, and by addressing the individual's goals for health and wellness during their pregnancy.

- Providers deliver health home services with a person-centered ecological perspective, considering the varying social factors that impact birth outcomes, and engage and respect the individual and family in his or her health care and recovery and resiliency.
- Providers deliver health home services using a strength-based approach and respect, assess, and use the cultural values, strengths, languages, and practices of the consumer and family in supporting the individual's health and wellness goals.
- Since pregnancy is a time-limited condition, and since women needing intensive supports and services during their pregnancies will likely need continuing provision of this type of care as a parent of an infant, the health home for high-risk pregnancy would be expected to find a long-term source of care coordination for postpartum clients. Depending on the client's condition and local availability of services, this could be a behavioral health home, community clinic, home visiting public health nurse, Certified Community Behavioral Health Clinic, or targeted case management service.

Through the delivery of health home services for high risk pregnancy, individuals would have their comprehensive physical, behavioral health, and social service needs addressed in a coordinated manner. This includes:

- a health wellness assessment in coordination with the client's prenatal care provider;
- subsequent development of a health action plan to address chronic conditions;
- ongoing coordination of care between behavioral and physical health;
- coordination with non-clinical services so that people will have their health care coordinated with social and community supports.

Health home services for high risk pregnancies would also support individuals and families in developing skills to improve health literacy, wellness and self-management.

DHS recommends that expansion of coordinated care through a health home be one of several policy options to consider as a means of sustaining ICHRP services through Medical Assistance.

Potential inclusion of ICHRP services in encounter rates

Federally Qualified Health Care Center (FQHC) and Indian Health Care (IHC) clinics receive an encounter rate for professional services by physicians, dentists, and nurse practitioners that is designed to pay for the cost of enhanced services provided by these centers. Although not directly billable as an individual service, the costs of ICHRP paraprofessional services and the infrastructure to support these services could be calculated into the FQHC/IHC encounter rates. As currently designed, these services are all provided through these clinical settings.

DHS recommends that including ICHRP services in encounter rates be one of several policy options to consider as a means of sustaining ICHRP services through Medical Assistance.

Potential expansion of coordinated care through managed care contracting

We must also consider how best to include DHS' managed care partners in supporting ICHRP. One possibility is to consider contractual incentives for payers to use ICHRP services for high risk pregnancies. This could be limited to clients residing in high-risk geographic areas, such as those already identified by ICHRP. For example,

Ohio Medicaid uses contractual incentives to have managed care organizations engage community-based care coordination organizations to find high risk women and connect them to supports and services, using paraprofessionals as an essential team component. The Ohio Medicaid program supports 14 projects located in predominantly urban areas, serving African-American pregnant women at risk for poor birth outcomes.

This policy option could be considered along with other policy approaches— e.g., redesign of the enhanced pregnancy benefit, or expansion of the heath home model. If a change is made to Medical Assistance benefits to support ICHRP services, access to these services might still be improved through managed care contractual incentives.

Timeframe for ICHRP Sustainability

The DHS base budget has sufficient funding to continue the pilot programs at current levels. With Legislative and CMS support, it would be reasonable to expect ICHRP could be supported through Medical Assistance benefit changes by the end of state fiscal year 2021. As noted above, continued grant support will be required thereafter for the African American community leadership component of ICHRP infrastructure.

VI. Report recommendations

DHS proposes four recommendations related to the Integrated Care for High Risk Pregnancy Initiative:

1. Make use of potentially available ongoing Medical assistance funding options to adequately support community-led collaborative care for high-risk pregnancies. This type of care coordinates needed services, through integration of community-based paraprofessionals into the care team.
2. Support community leadership for collaborative care recognizing the aspects of health that are best addressed by integrating with culturally based community resources to support mothers and families. In this regard, support ICHRP by continuing to recognize the role of tribal governments in program administration, and through continued support of the African American Integrated Care for High Risk Pregnancy Advisory Council.
3. Consider the model of program development and community involvement used by ICHRP to address other major disparities issues. Monitor this model for disparity reduction over time as more data becomes available.
4. Establish a reasonable timeframe for adopting ongoing funding options.

VII. Implementation language

MINNESOTA STATUTES 256B.79 INTEGRATED CARE FOR HIGH-RISK PREGNANT WOMEN.

Subdivision 1. Definitions.

a) For purposes of this section, the following terms have the meanings given them.
b) "Adverse outcomes" means maternal opiate addiction, other reportable prenatal substance abuse, low birth weight, or preterm birth.
c) "Qualified integrated perinatal care collaborative" or "collaborative" means a combination of (1) members of community-based organizations that represent communities within the identified targeted populations, and (2) local or tribally based service entities, including health care, public health, social services, mental health, chemical dependency treatment, and community-based providers, determined by the commissioner to meet the criteria for the provision of integrated care and enhanced services for enrollees within targeted populations.
d) "Targeted populations" means pregnant medical assistance enrollees residing in geographic areas identified by the commissioner as being at above-average risk for adverse outcomes.

Subd. 2. Pilot program established.

The commissioner shall implement a pilot program to improve birth outcomes and strengthen early parental resilience for pregnant women who are medical assistance enrollees, are at significantly elevated risk for adverse outcomes of pregnancy, and are in targeted populations. The program must promote the provision of integrated care and enhanced services to these pregnant women, including postpartum coordination to ensure ongoing continuity of care, by qualified integrated perinatal care collaboratives.

Subd. 3. Grant awards.

The commissioner shall award grants to qualifying applicants to support interdisciplinary, integrated perinatal care. Grants must be awarded beginning July 1, 2016. Grant funds must be distributed through a request for proposals process to a designated lead agency within an entity that has been determined to be a qualified integrated perinatal care collaborative or within an entity in the process of meeting the qualifications to become a qualified integrated perinatal care collaborative. Grant awards must be used to support interdisciplinary, team-based needs assessments, planning, and implementation of integrated care and enhanced services for targeted populations. In determining grant award amounts, the commissioner shall consider the identified health and social risks linked to adverse outcomes and attributed to enrollees within the identified targeted population.

Subd. 4. Eligibility for grants.

To be eligible for a grant under this section, an entity must show that the entity meets or is in the process of meeting qualifications established by the commissioner to be a qualified integrated perinatal care collaborative. These qualifications must include evidence that the entity has or is in the process of developing policies,

services, and partnerships to support interdisciplinary, integrated care. The policies, services, and partnerships must meet specific criteria and be approved by the commissioner. The commissioner shall establish a process to review the collaborative's capacity for interdisciplinary, integrated care, to be reviewed at the commissioner's discretion. In determining whether the entity meets the qualifications for a qualified integrated perinatal care collaborative, the commissioner shall verify and review whether the entity's policies, services, and partnerships:

1) optimize early identification of drug and alcohol dependency and abuse during pregnancy, effectively coordinate referrals and follow-up of identified patients to evidence-based or evidence-informed treatment, and integrate perinatal care services with behavioral health and substance abuse services;
2) enhance access to, and effective use of, needed health care or tribal health care services, public health or tribal public health services, social services, mental health services, chemical dependency services, or services provided by community-based providers by bridging cultural gaps within systems of care and by integrating community-based paraprofessionals such as doulas and community health workers as routinely available service components;
3) encourage patient education about prenatal care, birthing, and postpartum care, and document how patient education is provided. Patient education may include information on nutrition, reproductive life planning, breastfeeding, and parenting;
4) integrate child welfare case planning with substance abuse treatment planning and monitoring, as appropriate;
5) effectively systematize screening, collaborative care planning, referrals, and follow up for behavioral and social risks known to be associated with adverse outcomes and known to be prevalent within the targeted populations;
6) facilitate ongoing continuity of care to include postpartum coordination and referrals for interconception care, continued treatment for substance abuse, identification and referrals for maternal depression and other chronic mental health conditions, continued medication management for chronic diseases, and appropriate referrals to tribal or county-based social services agencies and tribal or county-based public health nursing services; and
7) implement ongoing quality improvement activities as determined by the commissioner, including collection and use of data from qualified providers on metrics of quality such as health outcomes and processes of care, and the use of other data that has been collected by the commissioner.

Subd. 5. Gaps in communication, support, and care.

A collaborative receiving a grant under this section must develop means of identifying and reporting gaps in the collaborative's communication, administrative support, and direct care that must be remedied for the collaborative to effectively provide integrated care and enhanced services to targeted populations.

Subd. 6. Report.

By January 31, 2019, the commissioner shall report to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services policy and finance on the status and progress of the pilot program. The report must:

1) describe the capacity of collaboratives receiving grants under this section;

2) contain aggregate information about enrollees served within targeted populations;
3) describe the utilization of enhanced prenatal services;
4) for enrollees identified with maternal substance use disorders, describe the utilization of substance use treatment and dispositions of any child protection cases;
5) contain data on outcomes within targeted populations and compare these outcomes to outcomes statewide, using standard categories of race and ethnicity; and
6) include recommendations for continuing the program or sustaining improvements through other means beyond June 30, 2019.

~~**Subd. 7. Expiration.**~~

~~This section expires June 30, 2019.~~

Appendix A

Theory of Change

Minnesota Department of Human Services
Integrated Care for High Risk Pregnancies Initiative
ICHRP Advisory Council

Theory of Change

Background Factors

TARGET POPULATION
- African American Families at or above average risks for adverse pregnancy outcomes
- Pregnant women who are medical assistance enrollees
- High prevalence of high risk pregnancies
- Histories of inadequate integrated care
- High utilization of crisis and institutional services
- Disproportionate healthy pregnancy outcomes

CONTEXT
- Adverse outcomes such as reportable low birth weight, preterm birth, and/or prenatal substance abuse
- Scarcity of integrated care
- Multiple pressures to contain medical costs
- Increased acceptance of disproportionate pregnancy outcomes at institutional levels
- Increased demand for community-based, culturally specific services
- Challenges managed care providers face in effectively serving African American families

PHILOSOPHY
- Family-centered service delivery, especially including dads
- Fusion of best practices of community-based services, managed health care, and social services
- Sustained provider involvement and collaboration
- Funding model and financial incentives promote greater accountability, flexibility and cooperation

ASSUMPTIONS
- High risk pregnancies are expensive
- Segregated and uncomplementary services impedes integrated response
- Without integrated and complementary services across systems and the African American community, fewer successful pregnancy outcomes
- Integrated care will produce better pregnancy and system outcomes
- Strengths and needs of target population are highly individualized
- Target population has right, desire and ability for successful pregnancies

WHAT WE WANT: Integrated Care Interventions

PRIMARY PROVIDERS
- Accountable for family and system outcomes
- Engagement/relationship development with families, especially including fathers
- Individualized assessment, goal-setting and service planning
- Intensive interactions in the home and community
- Flexibility to address unmet needs
- Integrated care to meet basic needs and achieve goals related to healthy pregnancies and families and self-reliance
- Assistance accessing health supports and services
- Identification of integrated care support team members
- Leadership of integrated care support team

ICHRP TEAMS
- Vehicle for coordinating integrated care for high risk pregnancies including health care, housing systems, public health, social services, mental health, chemical dependency treatment, and other community-specific services
- Interdisciplinary, team-based needs assessments unique for each mother and family
- Deliver direct services where appropriate
- Engage informal supports where needed
- Identify and resolve barriers to cooperation

ICHRP SERVICES
- Provide culturally appropriate/specific models and settings
- Maximize family choice among ICHRP services
- Facilitate successful family/provider relationships
- Provide ICHRP support as a bridge to successful pregnancy outcomes
- Integrated child welfare case planning with substance abuse treatment planning and monitoring, as appropriate
- Effective systematized screening, collaborative care planning, referrals, and follow up for behavioral and social risks known to be associated with adverse outcomes
- Referrals for interconception care, continued treatment for substance abuse, identification and referrals for maternal depression and other chronic mental health conditions, continued medication management for chronic diseases, and appropriate referrals to county-based social services, public health, or nursing services
- Implementation of ongoing quality improvement activities, including collection and use of data from qualified providers on metrics of quality (e.g., health outcomes and processes of care, use of other data that has been collected)
- Effective ways of identifying and reporting gaps in the collaborative's communication, administrative support, and direct care that will be remedied so the collaborative continues providing effective integrated care and enhanced services

IF WE: Provide Systems Interventions (County, City, Faith, African American Community) to Improve Birth Outcomes and Strengthen Early Parental Resilience

- Agreements and technology to share information in ICHRP support teams
- Independent evaluation of program effectiveness
- Organized funding and aligned incentives
- Promoting policymaker engagement and commitment
- Developing and maintaining stakeholder involvement, including mothers and their families
- Providing a central point of accountability

IT WILL LEAD TO: Intended Community Outcomes

MOTHERS/DADS/FAMILIES
- Integrated interdisciplinary perinatal care and enhanced services, including postpartum coordination to ensure ongoing continuity of care
- Healthy pregnancies
- Physical and behavioral health
- Housing stability
- Quality of life
- Community involvement
- Effectively coordinated referrals and follow-up to evidence-based or evidence-informed treatment with behavioral health and substance abuse services
- Attainment of self-determined goals
- Services provided by community-based providers who bridge cultural gaps within systems of care and integrate community-based paraprofessionals such as doulas and community health workers as routinely available service components

COMMUNITY/PROVIDERS
- Increased involvement in families' health education and development (e.g., include information on nutrition, reproductive life planning, breastfeeding, and parenting; prenatal care, birthing, and postpartum care; and document how patient education is provided)
- Improved relationships among family members, community partners, and health care providers
- Healthy mothers, infants and families

System Outcomes

ICHRP & SERVICE OUTCOMES
- Accountability
- Engagement of families, providers and informal supports
- Coordination
- Responsiveness
- Appropriateness
- Cultural competence
- Continuity of care
- Provider satisfaction
- Community ownership

COST AND SYSTEM OUTCOMES
- Increased healthy pregnancy outcomes
- Decreased crisis and institutional care
- Improved community health
- Increased information to health providers and policy makers

Minnesota Department of Human Services
Integrated Care for High Risk Pregnancies Initiative
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Logic Model

Minnesota Department of Human Services
Integrated Care for High Risk Pregnancies Initiative
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Appendix B

Integrated Care For High-Risk Pregnant African American Women

Logic Model





Resources/Inputs	Service Prevention/ Intervention	Outputs	Participant Outcomes	Impact
State Funding	Coordinated Integrated Care (health, housing, social services, chemical dependency in a culturally responsive, family-oriented process)	Babies/Families Served in Prenatal and Postnatal Care (number served, type of birth outcomes)	Reduction in high risk pregnancies Integrated interdisciplinary, culturally specific perinatal care with behavioral health and substance abuse services.	Healthy pregnancies, infants and families
Leveraged resources through public-private partnerships	Broad-Based Family-Oriented Services (Outreach, Drop-In Mom Meetings, Story Telling, systematized screening, collaborative care planning, referrals, follow up, father programs/services; Creating awareness of social trauma, generational stress, epigenetics—especially impacts on brain chemistry and brain development)	Composition of the Care Collaborative Teams (paraprofessionals, social services)	Enhanced services, including postpartum coordination for Mothers/ Dads/Families, Healthy quality of life, trauma recovery	Improved behavioral health
Interdisciplinary, Team- Based Staffing	African American and Broader Community Communication Campaign (conferences, public service announcements, webcasts, print materials, research, practice recommendations)	Engaged Care Providers (number involved, type of birth outcomes)	Effectively coordinated referrals and follow-up of identified patients	Increased involvement in family health education (nutrition, reproductive life planning, breastfeeding, parenting; prenatal care, birthing, and postpartum care)
Educational Materials	Paraprofessionals Training and Integration into ICHRP Teams	Strengths of the Collaborative as a Whole (efficiency, leadership, decision making)	Community involvement	Improved relationships with health care providers
Engaged and Committed Policymakers	Coaching and Training for Primary Care Providers in Psychosocial health care strategies (Assistance in implementing ongoing quality improvement activities, facilitate successful family/provider relationships		Integrating community-based paraprofessionals (doulas, CHWs)	Improved coordination, responsiveness
			Increased skills and resources for participants (e.g. housing stability)	Increased knowledge among health providers and policy makers
				Cultural humility/personal accountability
				Community ownership
				Decreased crisis and institutional care
				Reduction in high risk pregnancies
				Reduction in Medicaid costs

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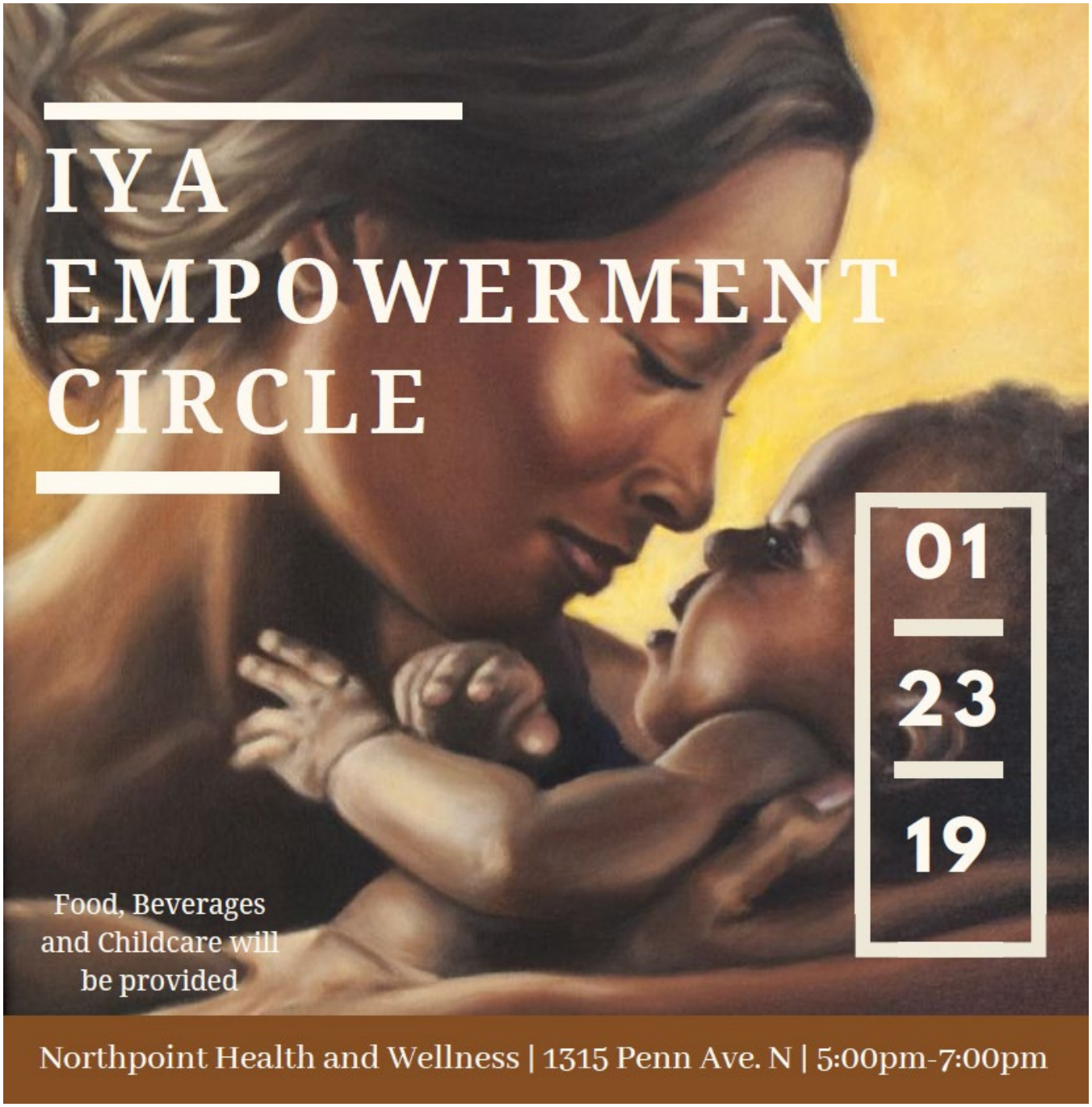
IYA
EMPOWERMENT
CIRCLE
01
23
19
Food, Beverages
and Childcare will
be provided
Northpoint Health and Wellness | 1315 Penn Ave. N | 5:00pm-7:00pm

Appendix C

Iya Empowerment Circle

You are invited to ICHRP Northpoint's 2nd Iya Empowerment Circle at Northpoint Health and Wellness!

Incentives will be provided to attendees!

Topics Include:
Transitioning to Motherhood with
Dr. LaVonne Moore
APRN, CNM, DNP, IBCLC

To RSVP & for transportation, please contact the ICHRP team:
phone: 612-767-9179
email: ichrp@northpointinc.org

NORTHPOINT
Health & Wellness Center