Lessons from the Field: Provider Approaches to Impacting Reproductive and Maternal Health
December 8, 2021
Transcript

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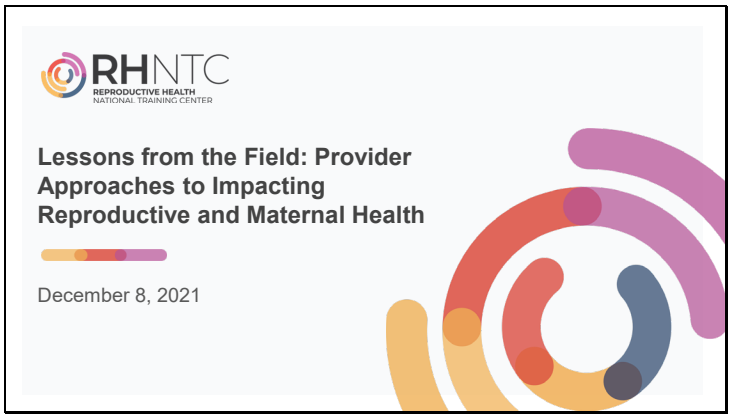

[Jennifer] Alright, great. Hello everyone. My name is Jennifer and I'm with the Title X reproductive health national training center. And I'd like to welcome you today to today's webinar, "Lessons From the Field: Provider Approaches to Impacting Reproductive and Maternal Health". So just a few housekeeping items before we begin, everyone on today's webinar is muted, but we will have time for questions and answers. So you can ask questions at any point during the webinar using the chat feature, and we'll answer the questions at the end of the presentation. The recording and the slides and a transcript for today's webinar will be available on rhntc.org within just a few days. There is closed captioning available, and you can turn that on at the bottom of your screen today during the session, if you'd like. Your feedback is extremely important to us, and it's enabled us at the RHNTC to make quality improvements in our work based on your comments. So if you could please take a moment to open the evaluation link in the chat and consider completing the evaluation real time as we go along today, then you can submit it before you log off the session. We appreciate your feedback. And this presentation was supported by the Office of Population Affairs and the Office on Women's Health. Its contents are solely the responsibility of the presenters and do not necessarily represent the official views of OPA, OWH, or HHS.

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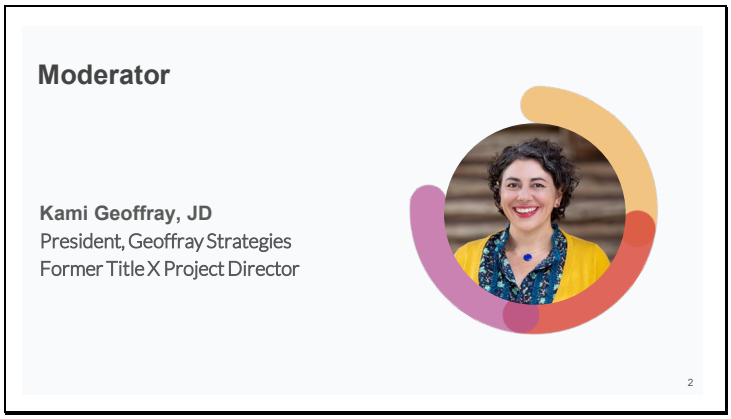

We're really excited to hear from a diverse group of Title X sub-recipients today in a session moderated by a former Title X grantee. Kami Geoffray is the president of Geoffray Strategies, a consulting firm based in Austin, Texas, offering policy and strategy solutions for healthcare clients. Kami has almost 15 years of experience as an advocate and strategist in government, legal, and nonprofit sectors on both the state and national level with a focus on reproductive health policy and programs, and many of you know Kami. She most recently served as the chief executive officer of Every Body Texas, where she spent five years overseeing the administration of the second largest Title X family planning services program in the nation. So I'll turn it over to you now, and thanks for being with us Kami.

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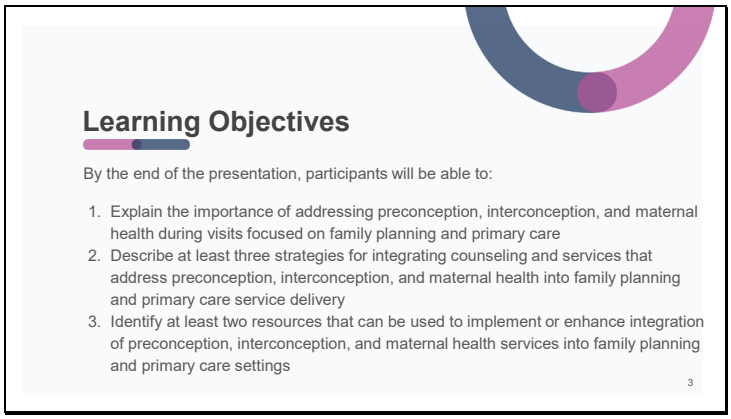

[Kami] Thank you, Jennifer, and thank you to the RHNTC team for making space for this conversation today. I'm really excited to be highlighting some experiences from the field in Texas, and we have outlined a few learning objectives for today's session. We are going to start by explaining the importance of addressing preconception, interconception and maternal health during visits focused on family planning care, as well as primary care. We're going to hope by the end, you will be able to three strategies for integrating counseling and services that address preconception, interconception and maternal health into family planning and primary care service delivery. And finally, we are going to make sure you can identify at least two resources that you can use to implement or enhance integration of preconception, interconception and maternal health services into your family planning and primary care settings.

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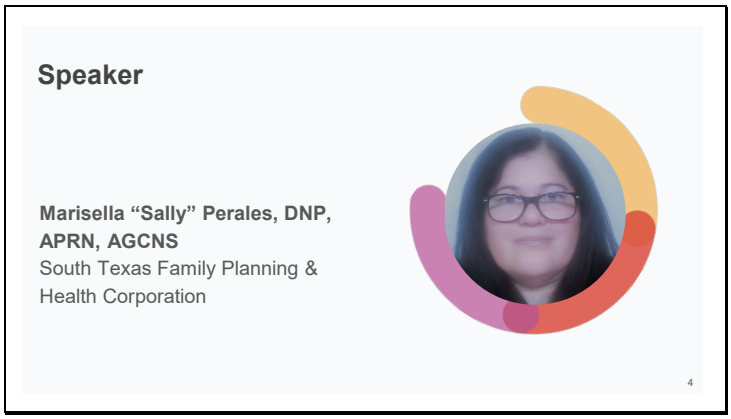

So our first speaker today is going to be Sally Perales. She is the clinical service director for South Texas Family Planning and Health Corporation in Corpus Christi, Texas, Sally actually volunteered for South Texas Family Planning for a decade before joining the staff earlier this year, she even completed her clinical hours for her nursing degree by providing Title X services there. She's a veteran of the US Navy. She served as a hospital corpsman for nearly a decade and worked with the veterans administration. She is incredibly proud to serve the community in which she was raised. And we are looking forward to hearing about the services she's delivering at South Texas Family Planning.

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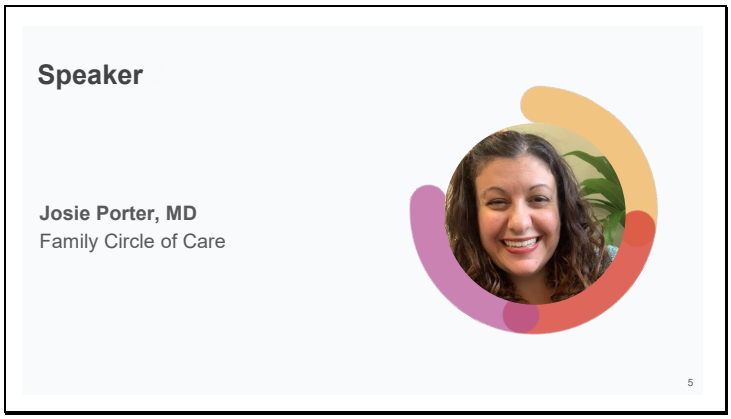

Our second speaker today is Josie Porter. Dr. Porter is the chief medical officer for Family Circle of Care in Tyler, Texas, which is in east Texas. Josie is a Tyler native. She practices in nurse in labor and delivery prior to attending medical school at the University of Texas health science center. She joined Family Circle of Care health center in 2014 after she completed her OBGYN residency at Wake Forest University in Winston-Salem, North Carolina, and practiced for a few years in Raleigh, North Carolina, she served as the department's lead OBGYN and became chief medical officer in 2018. She really enjoys giving back to the community and providing quality medical care with empathy and compassion, especially delivering babies and empowering patients to make choices that help them achieve their goals. So we are going to learn about how she ensures everyone receives quality care in her clinic.

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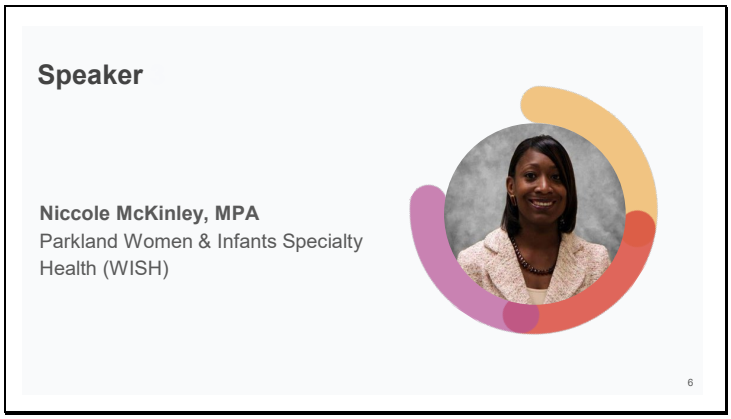

And next we will hear from Nicole McKinley. Nicole is the operations administrator for the women's and infant specialty health or WISH division of Parkland Health and Hospital system in Dallas, Texas. Nicole has been at Parkland for 15 years and 14 of those years have been in the WISH division. The WISH division is responsible for 12,000 deliveries annually in Texas, and provide services to 30,000 unduplicated family planning patients each year. Nicole oversees the business and financial operations, and she also really works to make sure that the community voice is represented in all the work that they do at Parkland.

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So first up we are going to hear from Sally and she is going to talk on the topic of integrating and preconception care into family planning service delivery.

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[Sally] Hello everyone. And thank you Kami for the introduction. Currently I work as Kami mentioned with the South Texas Family Planning Health Corporation. We are a family planning agency serving 19 counties in south Texas, including the Coastal Bend with six service sites as we go into our 50th year of service to the community. All our service sites are located within the demographics of the patients we serve to include urban, rural, and one site is located within a subsidized housing facility. Currently we serve more than 17,000 unduplicated family planning clients every year. Mainly we serve our uninsured and under-insured clients from families with low incomes. We saw the opportunity to integrate early preventative primary care into family planning service with the support of limited state funding. Currently in Nueces County, 11.3% adults age 18 and older have a diagnosis of diabetes compared to the national rate of 7.5%.

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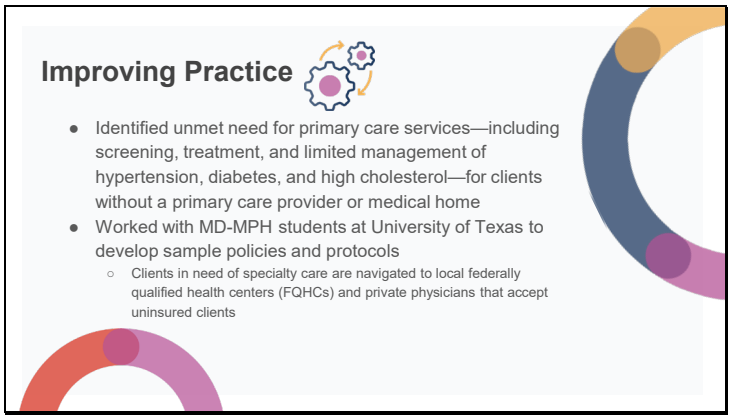

For years, we have been providing many primary health care and acute care services such as providing treatment for strep, flu, ear and eye infections, upper and lower respiratory infections and other similar illnesses in addition to comprehensive women's health care. By improving practice, South Texas Family Planning Health Corporation identified there was a need to increase primary care services which included the screening treatment and limited management of hypertension, diabetes, high cholesterol for clients without a primary care provider or medical home. We also collaborate with organizations such as Methodist Healthcare Ministries, Wesley Nurse Program to provide continuous diabetic education and the Texas A&M agriculture life extension service, which provides nutrition education for our patients. We offer a study platform for students enrolled in UT's doctor of medicine, master's of public health program to develop sample policies and protocols. Our agency's mission and capacity supports the integration of early intervention of hypertension, diabetes, and hyperlipidemia, which are prevalent throughout south Texas.

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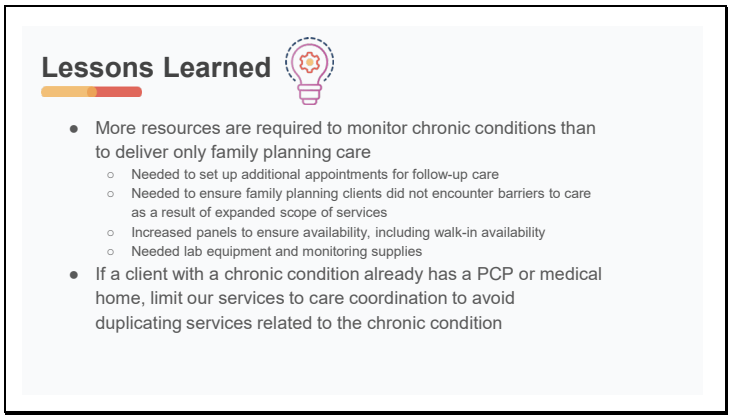

[Kami] Sally, I'm just jumping in because we've had a couple of people say they're having a little bit of a hard time hearing you. So if you can just speak up just a tiny bit that's fine. We can hear you. You're just a little bit quiet. So thank you.

[Sally] Just give me one moment.

[Kami] I think if you just speak up, we just don't want to miss any of the great information that you have to share with us.

[Sally] I have my IT specialist with me right now. So can you hear me a little louder now? Wonderful. Regarding lessons learned, we have learned more resources are required to monitor chronic conditions versus primarily delivering family planning and reproductive health care. We have insured our family planning clients to include new clients seeking care do not encounter barriers due to expanded scope of service. We have increased our client panels to ensure availability for scheduled and walk in appointments in addition to appointments which are needed for primary followup care. Other resources we have purchased include lab instruments to perform A1C, glucose, CMPs, and lipid panels. These compliment the labs we are already performing such as pregnancy, HIV and HCV antibody test, UAs, hemoglobin and hematocrit tests, which are completed onsite during the same visit and we provide results during the same visit also. For clients with PCP and medical homes, we limit care coordination. We ask patients about medical home during the patient comprehensive medical history intake to ensure we are not duplicating services. As for lane care and patients requiring specialty services, our psych case managers who are certified by the state as community health care workers, navigate clients to primary medical doctors or hospitals with indigent services.

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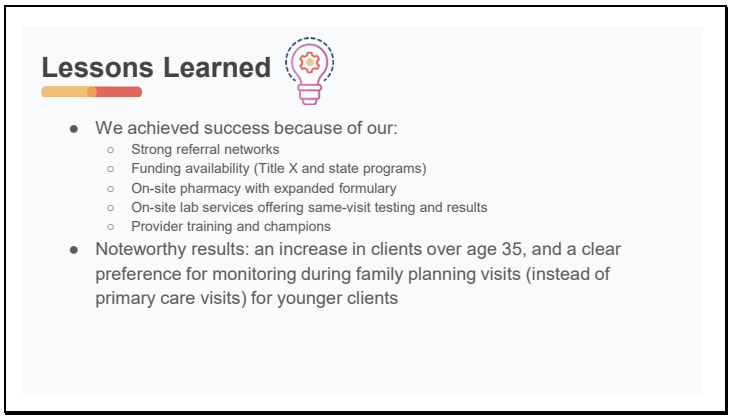

Some contributing factors for our success include strong referral networks, funding availability from Title X and state programs, having an onsite pharmacy with class D pharmacy medications and expanded formulary, our onsite lab services providing point of care testing and results are available during the same visit. We also have provider training and champions at every site. Some changes we have observed include an increase in clients over the age of 35 and younger clients that prefer being monitored during family planning visits. I just wanted to close and say, thank you so much for the time. And it has been an honor and privilege to speak today. Since I am a product of Title X, thank you everyone out there for providing that care and continuing to serve the communities you're in.

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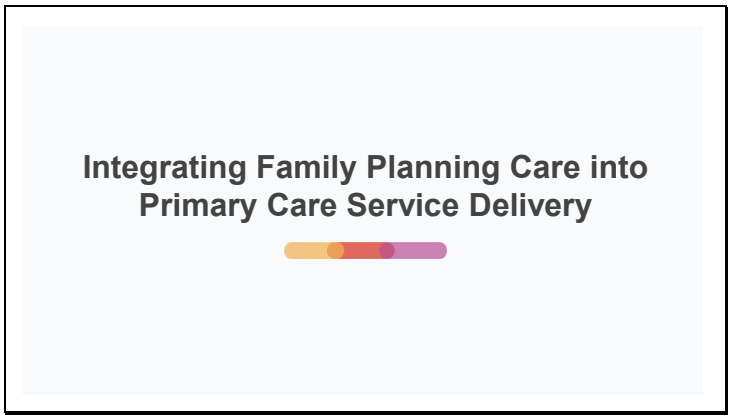

[Kami] Thank you, Sally. So next we're going to hear from Dr. Porter and she is going to share how she has been working to integrate family planning here into the primary care line at the FQHC that she is serving as chief medical officer of in east Texas.

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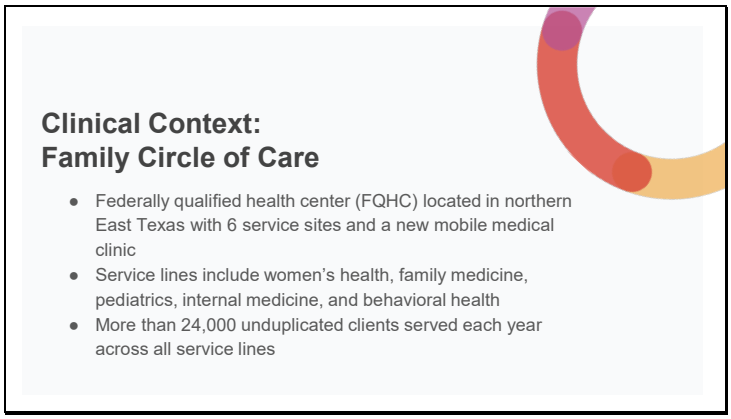

[Josie] Hi everybody. Thanks for the opportunity to share what we're doing. So we're a federally qualified health center up in Tyler, but we've got four clinics in Tyler and then one in Athens. And one in Jacksonville. We started with OBGYN, just women's health in general, added on pediatrics and family medicine, and in the last year have added behavioral health and an internal medicine program as well. Within that course, we became an FQHC I believe in 2013, shortly before I arrived. And in the past year we served 24,000 unduplicated clients across all service lines. We take care of patients of all ages and genders and added a new mobile medical clinic this past year as well.

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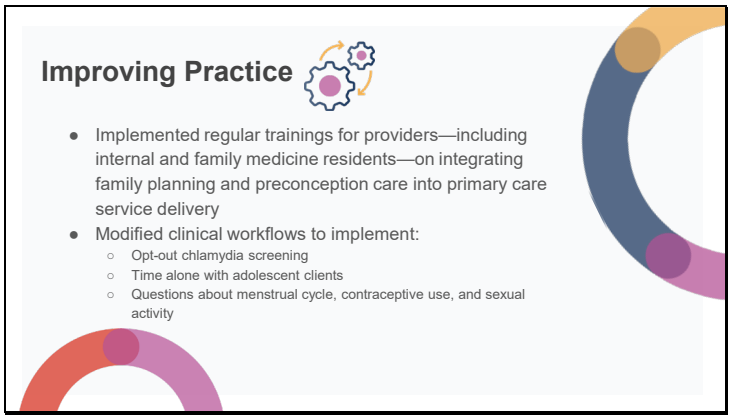

I took over as medical director in 2018 and having an OB as a medical director across multiple service lines lets me focus on educating the things I'm good at and then resourcing out the stuff that I'm not necessarily as trained in. And one of the early things that I think helps us is recognizing that everybody did not get the same training coming in to where we are to see patients. I'm very comfortable in family link, but family medicine, internal medicine, pediatrics, doesn't always see the family planning and reproductive health as part of their area. So the first thing we do is education. I have a session at each of our regular quarterly provider trainings on it, updating something one way or the other. We actually consider all of our sites Title X locations. So all of the staff have to participate in the mandatory trainings. We've done a couple of in-person mandatory trainings as well pre COVID and some targeted training sessions. When we started the internal medicine program, we have internal medicine residents here and I've had family medicine residents rotate through within OB since I think the clinic started in '93. And so I do education with them as well. But when the internal medicine program started, I actually sat down and gave education with each one of them, which is the same one-on-one training I do with onboarding for each new provider that goes into reproductive life planning, goes into how do you ask patients these questions? How do you document it in a way that captures it for the Title X reporting that we need to do? And why is it important to you? In pediatrics, how did we make a difference in teen pregnancy if pediatrics isn't asking the questions and talking? If you don't screen for things, how do you know that they're there? In internal medicine, and family medicine too, with adults, what sort of things within reproductive health care would impact your care of a patient? If you have a patient that you're having trouble getting their blood pressure controlled, would you use certain meds versus not if they're trying to get pregnant or if they're not trying to get pregnant? Or do you want them getting pregnant in the middle of you trying to get their blood pressure, their diabetes under control? If they're a teenager and they're coming in with a complaint of something, do you need to know if they're pregnant or not or if they're trying for pregnancy or at risk for other things, to be able to figure out how do I truly treat that sore throat? Am I doing all the testing that I need to do? That sort of thing. And then also teaching them the implications of why asking the questions about their pregnancies actually matters to their long-term care. Things like severe preeclampsia during a pregnancy is an equal risk factor to diabetes as far as cardiac disease. How often do I need to be screening someone for diabetes if they had gestational diabetes? We modified our clinic workflows to add chlamydia screening in the pediatric and across the board departments, but especially in pediatrics was the big change that needed to happen for chlamydia being opt out annually rather than opt in. We did training for both staff and providers as far as making sure that it is set up with the expectation that all teenage clients are going to have both time alone with the provider and time with the parent or adult that brought them, and then training on how you ask the questions, but

asking when their last period was is part of getting vital signs, asking are they active when they last had unprotected sex, in my world, asking those questions as the patient's getting roomed lets me determine whether they're a candidate for emergency contraception or not. And then kind of guides me down that halfway of being able to educate as well.

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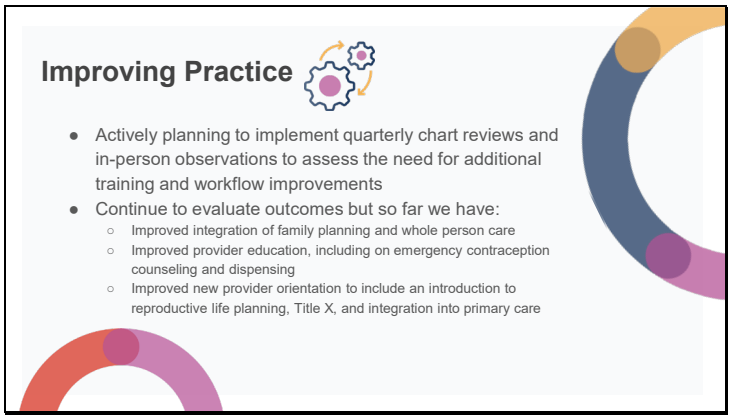

So how do I know that what the practice that I'm doing in my OBGYN clinic has generalized out to the other locations? We actually used the baseline from our self audit tool sent to us by Every Body Texas and are in the process of developing forms for doing our own internal chart reviews and in-person observations just like when you get a site visit from your grant recipient to be able to say, is the care happening the way it needs to across the board, not just within women's health, and be able to fix problems as we find them, within this, I think we've done a really good job of increasing the comfort level of family medicine and internal medicine and pediatrics to being able to ask those questions and understanding it's expected and all sites have emergency contraception. When I do my one-on-one new provider orientation, actually sit down with them with a binder and a PowerPoint and they get handouts. It doesn't just include reproductive life planning. It includes all of their expectations for supervision and documentation and what committees they can be on and all of those things as well, and quality measures, how those are measured. I believe it's important to give people the expectations for what I want from them and then give them the tools to do them and then follow back up to see how they're doing and what support they need on it.

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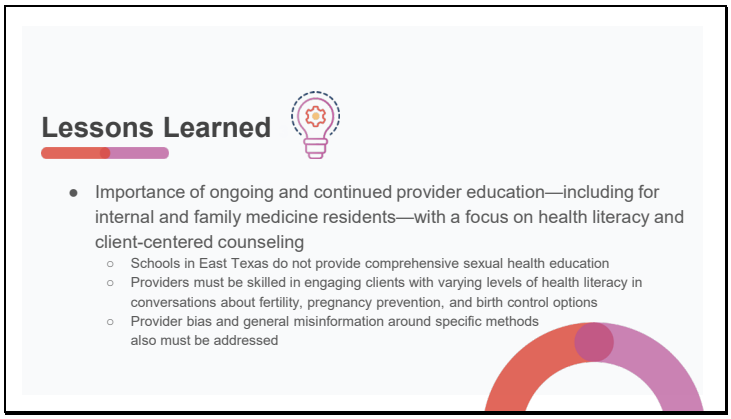

As this is going on, it's been interesting. One of the biggest hurdles we run into is people aren't speaking the same language and the fact that a lot of east Texas does not get comprehensive sex ed. So when I go in to talk about emergency contraception with a patient, most of the time, they don't understand how the menstrual cycle works. They don't understand how emergency contraception works. They think it's a pill to cause an abortion, not a pill that can help prevent them from getting pregnant in the first place, if it was an accidental whoops with a condom or unprotected sex. So I actually have the patient hop up, we draw on the table paper about the menstrual cycle, and then show them where emergency contraception works, how it works, how it doesn't work. And so part of my provider education has been to draw that out with them as well, a friend who is a practicing specialist in the area, when I was explaining this to her, she said, this is stuff I haven't done since residency, but that's exactly the point. These are internal medicine residency patients. They need to know how to do these things and then be able to integrate it and carry it forward as far as the practice goes, if they're staying in primary care as well, but then understanding how to have those conversations and remembering that it's always your part as well. Even if it's a checkbox to say, do I know what she's doing? Yes or no. Because guiding that helping people make their goals makes it patient centered and it's not patient centered if I just go, that's not my problem. That's somebody else's business.

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[Kami] Thank you, Josie.

[Josie] Thanks for the opportunity.

[Kami] I always love hearing about how you are coming up with new ways to engage providers and clients. And I think that's also a great segue to talk with Nicole about some of the work that she is supporting in Dallas around improving preconception care through community engagement in the area, specifically with young college folks. So Nicole, I'll toss it to you.

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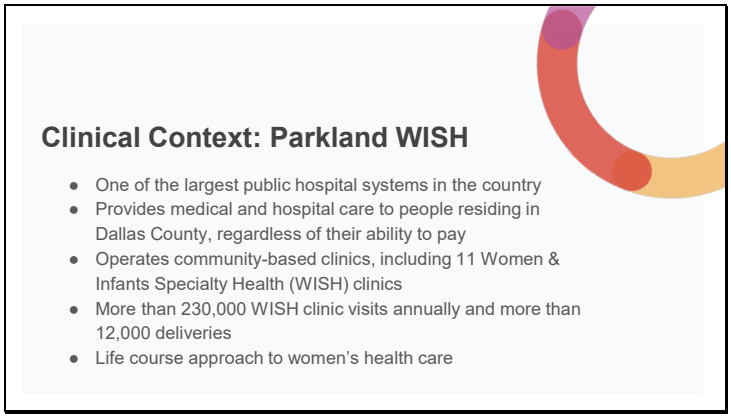

[Nicole] Thanks for allowing me an opportunity to talk about some of the work that we are doing here at Parkland. And as Kami mentioned, we're one of the largest public health systems in the country. We provide medical and hospital care to people that reside in Dallas County and in surrounding areas, but in Dallas County specifically regardless of the ability to pay the hospital for this area and a huge part of the care that's delivered to the underserved in Dallas County, we operate several community-based clinics across Dallas County, which includes 11 women health centers which are part of the women and infant specialty health division at Parkland, in excess of 230,000 clinic visits annually, more than 12,000 deliveries. And on average, 30,000 unduplicated family planning patients within our program, we take a life course approach to women's health care in that within those clinics, we provide prenatal care along with family planning and gynecology services. We also are co located with many of our community oriented primary care clinics where we're able to cross refer patients when we have identified health conditions such as diabetes, hypertension, other chronic conditions that would be evaluated and managed by a primary care provider. And so that kind of puts our patients into a system of continuity as it relates to care. In addition to that, we have specialty women's infants and specialty health clinics on our main campus where we also provide care for highly complicated OB patients, as well as complicated GYN services or abnormal GYN services that may require surgical service. So our patients have this continuity of care that allows them to be seen within our system to address all of their healthcare needs.

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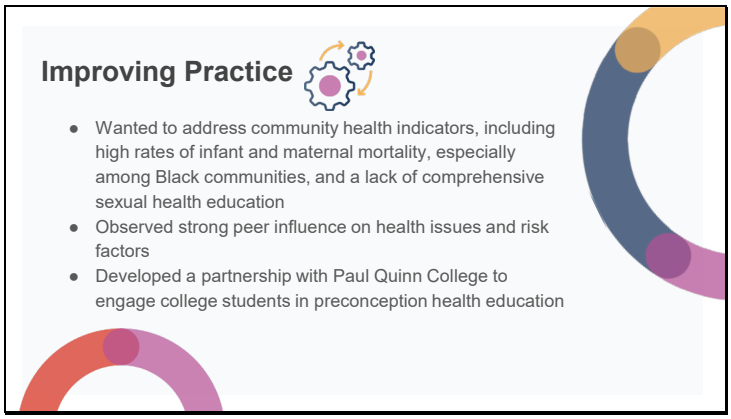

So in terms of improving our practice, what we saw, kind of a conglomerate of things, we saw of course within our family planning program over time and looking at our history of service delivery, that we did not see a huge volume of adolescents within our service lines across our clinics, even though we saw 30,000 patients in a year on average. That percentage of adolescents was less than 15% of our total population. So one of the efforts to be able to increase that population, understanding that the need for that population is great. We wanted to look at how we could address some of the community health issues related to engaging the adolescent population. Along with that, we have seen over time, high rates of infant mortality and maternal mortality in Texas. And we've looked at those rates within our county, especially among the black communities. And so in looking at that in correlation with looking at our decreased volume or lower volume of adolescents, we kind of looked at sexual health education and preconception health as an opportunity because we continue to see that there was a deficit in being able to have people who understand the importance of preconception health as it relates to pregnancy and childbirth and how family planning kind of intersects that. And so in Dallas County, of course, in our public school system, abstinence was really the only approach to sexual health education that many of our adolescents who were in the public school system were receiving. And so there was clearly a deficit in sexual health education from a comprehensive perspective. So with that in mind, we observed that there a program that had been piloted a couple of years before, and there was positive impact related to the influence of peers on health issues and risk factors, and being able to share information with their friends or with their peers. And so what we did was two things, one through the identification of this from community engagement, for many of the partners that we have in the Dallas community, and also submitting a proposal to get funding to be a part of the Healthy Texas Moms and Babies project through the department of state health services in Texas, we were able to develop a partnership with Paul Quinn. There's a focus on historically black colleges and universities to address the huge disparity as it relates to the black community. We were able to initiate communication with them because of previous community work that we had done and relationships that we had built to engage their college students who were on a health tracker who had interest in the health field and doing a preconception health education course.

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And so within this course, what we, as part of the project through the department of state health services, we hired a peer educator who received her certification as a community health worker. We took the model from the office of minority health as our resource to be able to develop a health and wellness course focused on various components of preconception health. And it was a 15 module course. It started out being an in-person course that we would come out and have our peer educator to present to those individuals we were able to gain interest from, we did a few interest meetings on their campus to get the interest and participation. Due to COVID, of course, it set us into the creative thinking of how could we still deliver this very important information though being able to do it in person was not optimal and the way that the students at the university were having to adjust to how they were going to be taking classes, all of those things were of course part of our process in determining that we wanted to apply an online module to be able to push out the education course. And so what we did was we offered the students who completed the modules an opportunity to be able to receive a community health worker certificate that would serve as continuing education units for them when they renew their community health worker certification. It was approved by the department of state health services, which is important because you have to have so many hours that are approved through the department of state health services in Texas. And in addition to that, to incentivize them to participate, but also to complete the module, we worked with our department here through our education program to have a spot for an internship for the summer for one of their participants who completed all of the modules and the exam to use for the certificate for community health worker. And so it's a great opportunity to be able to educate young people who have not had that education and know all of the information related to contraceptive and reproductive health. The modules that stick out to me that were a part of this course include introduction to them on what the PPE program is, the social determinants of health, infant mortality as a public health priority, being able to identify how to find out the issues within your community, mapping through that and where you start, the health disparities that we talked about related to infant mortality, maternal mortality, and how those correlate with the social determinants of health, preconception health. And it's a one-on-one session of helping them understand the connection between preconception health and poor birth outcomes, reproductive life planning, counseling that they can do and how to help identify if their peer may need some professional help with some of the things that they're experiencing and situations that they've gone through, sexual health and STIs, men's health, healthy relationships, intimate partner violence, as well as marketing and community outreach so that they can take what they've learned and push that out to the community. So it's been a year for us to get the staffing on board and to be able to get the curriculum pushed together that's interactive that we could push out in an online setting using Canvas, which is what the university uses. We have not been able

to get through the entire pilot and do evaluation, but we are anticipating that we'll be able do that in the spring is what we are looking towards and incorporating the learnings that we have for that into future program design, so that we can take what we've learned, take the outcomes that we've seen, the things that we want to be able to measure and then extend that out to other college campuses in Dallas County and in this area. So we have a huge community college circuit that we want to be able to tap into. And so that would be our next phase of this work that we've done so far.

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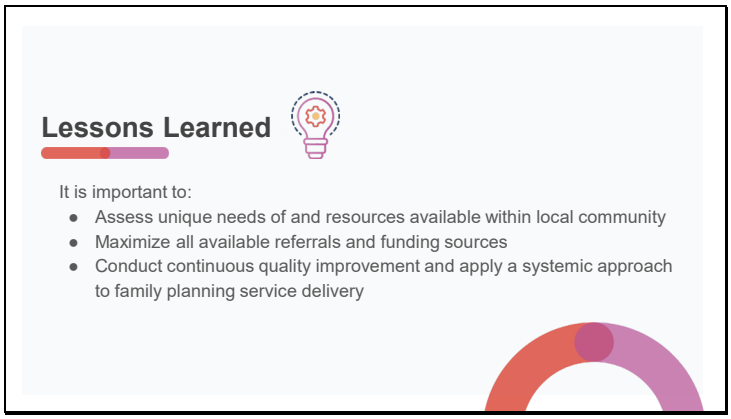

So in terms of lessons learned, I think it's important for us to assess the unique needs and resources available within our local community. We recognized that there are different needs for different populations. We serve a very broad population, but we wanted to focus not only on the childbearing woman, but the woman who is very young who hasn't actually had a baby, who hasn't been pregnant in an effort to be able to link them to family planning services to help with reproductive life planning, to be able to understand and share that information with their peers, but also to maximize all the available referrals and funding sources. We have a variety of sources of funding that support family planning. In addition to Title X, we have state funding, we have state programs. We have potential patients who are Medicaid eligible that we can help to navigate through to application and enrollment in some of those resources. And so being able to maximize that also community programs that have case management services like we have Dallas Healthy Start, who is a big participant in this peer education work, as well as nurse family partnership. We have a victim intervention and prevention rape crisis program. So being able to connect these young people that we've done this work with to those resources and for them to be able to share that with their peers, as well as being able to share that information out in the community and then to conduct continuous quality improvement and apply systemic approach to family planning service delivery.

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[Kami] Thanks, Nicole, I am looking forward to hearing about what you guys learned and how you're going to scale this. I think one of the things working with you all throughout the years, you guys are very well resourced compared to a lot of Title X clinics that you are doing a lot of work that can absolutely be done on a scale. So thanks for sharing about that new pilot and look forward to learning more as you learn more. So we have saved time for some questions obviously. And so I'm going to invite people to put things into the chat now, if you haven't done that yet, we'll give you a few minutes to get the chat going, but first we're going to welcome Meg Shan with the RHNTC to talk about a few of the resources that RHNTC has developed that can support Title X agencies to implement or enhance integration of preconception, interconception and maternal health services into their family planning in primary care settings. Similarly to what the sub-recipients on this call have shared today. So Meg, I'll pitch to you.

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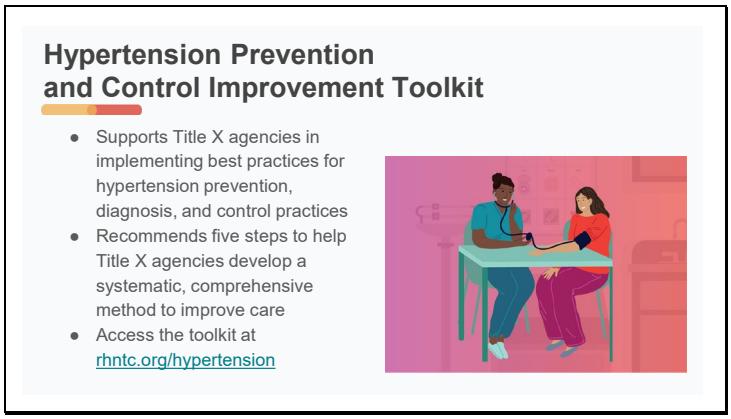

[Meg] Thanks Kami. And thanks also to Sally, Josie, and Nicole, it's really, really great to hear about the fabulous work that you're doing. So we here at the RHNTC have been working really hard to support your work as Title X agencies in integrating hypertension screening and treatment into family planning services. We've developed a hypertension prevention and control improvement toolkit to support you in implementing best practices for hypertension prevention, diagnosis and control. The toolkit walks users through five recommended steps. And these steps come together to develop a systematic and comprehensive method to improving control of hypertension and to improving care. And the steps and processes are not prescriptive. They can be adapted for each of your agency's needs. You use what works for you. You modify what you can use in a different way. So let me tell you a little bit about it. The steps include, first of all, assessing your program's hypertension prevention and control efforts. And so one of the things, one of the tools that is really helpful is this organizational self assessment. It's a checklist basically, and it tells you what you're doing well and where your gaps are so you know where to focus your effort in terms of where you can tighten up a little bit. It also includes sample policies around hypertension, how to integrate hypertension services so you don't have to reinvent that wheel and also a metrics calculator to track your performance over time as part of quality improvement efforts. The second step is training the staff, because if you're a family planning program, some of these elements focusing on hypertension prevention and control, they might be new to the staff. And so we've got a brand new e-learning course, which provides a really good foundational knowledge set about hypertension, its prevalence, et cetera, and how to integrate services into family planning programs. Also a video and a training guide to lighten that load for you. We also have included a step to address the integration of hypertension prevention and screening into all client visits with counseling and education job aids that sort of pull out for you the big points that should be included in counseling and education for our clients, and also support for accurate blood pressure measurement. I don't know about you folks who might work in a clinical setting, but I see hypertension and I see blood pressure being measured using not such perfect technique a lot, and it really does have an impact on how we provide care moving forward for our clients. Step number four is to strengthen support for clients with, or at risk for hypertension, with tools like a diagnosis and management algorithm. The diagnosis of hypertension is actually not as straightforward as one might hope. And so the diagnosis and management algorithm just walks you through the steps in a very straightforward way and it also provides guidance on the next steps of management for people who are diagnosed with hypertension. It also includes a blood pressure log that clients can fill out at home if they're doing self monitoring of their blood pressure at home, so that when they come in, they can just hand it to their care provider and have a good conversation based on where their blood pressure is at. The fifth step is to integrate hypertension into community participation and project

promotion activities with, for instance, a tool for engaging diverse community partnerships to try to address hypertension prevention and control at the community level. So if you want to access this toolkit and we hope that you do, please go to the RHNTC website at rhntc.org and search using the term hypertension toolkits.

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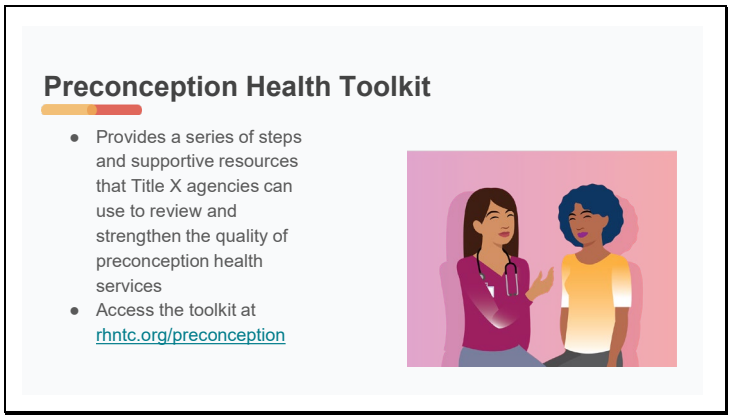

We've also created a preconception health toolkit that provides a series of steps and supportive resources that Title X projects can use to review and strengthen the quality of the preconception health care services that they offer. And the template of this toolkit is a lot like the hypertension toolkit. We offer sample policies so you don't have to write those from scratch, program assessment and QI tools, training resources, and resources to support your referral process. And we also offer resources to support your collaboration with community partners so that we can strengthen preconception health at the community level. To access this toolkit, please go to rhntc.org and search using the terms preconception toolkit. And if you have any questions or comments about these or any other RHNTC resources, please send us an email at rhntc@jsi.com. And when you're logged into your RHNTC account, you can also give resources that you use a thumbs up or thumbs down and you can also leave a comment. And we would love to see your constructive comments about these tools. What is helpful, what could be improved. We will use your comments to improve these tools and others that we're going to develop. So thank you.

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[Kami] Thanks Meg. So we have time for Q&A, and I am seeing a couple of things from the chat. First question, it seems to be for Nicole. So someone was asking about the preconception health modules that you were describing that you guys are using with Paul Quinn. They are wondering if those modules are available to access. Do you want to share a bit about the source materials for that and how you guys are rolling that out?

[Nicole] They're not somewhere where you can access them currently. We only have them loaded into the Canvas for fall plan. What we would like to be able to do is once we get through that pilot, be able to see where we need to make some changes or adjustments before we forge ourselves forward with putting those out in a more public forum for those to be accessible.

[Kami] Great. Thank you. We've also got a question asking if any of the programs are using an integrated electronic health record to support tracking referrals and to make health information for the clients portable, making sure all the providers and players have up-to-date information. That is definitely a big ask in a state like Texas, but I'm going to see if anybody is using their HRs to think about these kind of community-based referrals or other referrals to other providers.

[Josie] We are on epic and being an FQHC, we have to track our referrals as we go. So oftentimes that process, we've got embedded referral clerks in our sites, and we have community health worker at each site as well. So if I can directly send an order for a referral for a program, I'll go ahead and directly send it. It sometimes takes a bit of jumping through hoops to get new orders added for every program. So my default is to refer to community health worker and then put in the comments what I need them to send them to. And then that gets them out of my exam room and in with the community health worker. And I can move on to the next patient while my CHW is helping get them plugged in with the programming in our community partners that we have. Within our EMR we have MyChart as well. We're not great with it as far as pushing out a lot of information but they can get back to us as well. We also have a hypertension grant that we're doing with HRSA. So we have a CHW who managing, I believe the last number I've seen is about 160 clients that have poorly controlled hypertension with machines at home that are sending readings in and specific education and stuff that circles back to the provider as well.

[Kami] Great. Nicole, I don't know if you want to add anything from Parkland's perspective.

[Nicole] So we have a pretty robust and internal system of referral more so from a medical perspective, because we are such a large system. We do also have Care Everywhere where if

you're participating, you're able to see medical records through the electronic medical record from other participating health systems for the comprehensive care of patients. We have been working on more of a community based component that will allow us to be able to have more reach in terms of referral within community engagement and involvement. So we don't have anything concrete that we can actually push out, but we are working towards a model of something that will allow us to be able to have that referral system from a community perspective outside of Parkland, some of our community programs, we're going to be adding into our electronic medical records so that data collected and referrals and those sorts of things can be tracked there and captured there. So we're in the ballpark, but we haven't gotten to a place where we have anything that we could actually put out.

[Kami] Thank you. Sally, do you have anything to add?

[Sally] We're similar to Nicole's system and we're working forward and adding more integration with the population that we serve. Also our system allows for us to graph and follow up so it gives the provider easy access to all their bloodwork and data, which is entered during the visit. So there's no delay of care there. Thank you.

[Kami] Awesome. Sally. So as you were presenting, I was thinking about how your clinic expanded the scope of services and improve the workflow. And I'm wondering if you could just talk a little bit about how South Texas Family Planning and Health Corporation got the word out about those expanded services you shared that you saw an increase in certain populations. So could you just talk a little bit about the changes you all made to your outreach initiatives or your messaging, or how you engaged different communities after you made the shift in the service delivery?

[Sally] Well, we are so fortunate and blessed to have Ms. Cynthia Gonzalez working with us, and she runs our outreach program. And it's wonderful because we do faith-based, we do education at the school districts, we also collaborate with other organizations, such as First Friday and Radiology Associates to pull our client. So we're very fortunate also with Methodist involved too, and the universities, Texas A&M and UT to help and assist in doing our outreach programs. But we have a wonderful team at South Texas Family Planning, and I think it was a great benefit to be in a subsidized housing facility where we are within our demographics that we serve and it's really easy access. So I would say the outreach there is by person to person too, thank you.

[Kami] Awesome. Thank you. So Nicole, the pilot you described was designed in response to community health indicators. So you talked about the high rates of infant and maternal mortality that you all saw, especially among black communities. I am wondering if you could share a little bit more about some other interventions that your program and the WISH clinics at Parkland have supported to improve black maternal and infant health in the Dallas area.

[Nicole] So one of the projects that we have currently, we've recently launched it. Well, we launched it in October of 2020. It was a result of our 2019 community health needs assessment that Parkland did that found a high incidence of comorbidities related to maternal death and infant death in several zip codes served by Parkland. So we saw this correlation between these comorbidities, whether that be hypertension, diabetes, maternal death, and infant death. And so what we know from our population that we serve at Parkland is that more than 90% of the women who deliver at Parkland use Medicaid funding, but we also know in Texas is that Medicaid coverage currently ends after 60 days post delivery, although the state hopefully will soon be changing that with approval to extend the coverage up to six months postpartum, that's

historically what we have seen here in Texas is that once that 60 days is over, that mom's coverage ends. More than half of all the maternal deaths in Texas occur in the gap between where the Medicaid coverage ends and the first year postpartum. With black women having the highest risk of pregnancy related mortality in Texas, as many as 40% of women don't even attend one postpartum visit. So in response to that, what we did was we developed the extending maternal care after pregnancy program. And this program is basically a program that extends care for the mom for a full year after delivery. And it incorporates various components that we feel are critical for the mom to be as healthy as possible and to have a medical care home during this time. So it involves the use of a mobile van and a multidisciplinary team who can assist with providing either home visiting services, psychosocial service through community health workers, as well as advanced level providers to deliver health care, whether that be on a mobile van, in the communities where these occurrences or incidences are at highest prevalence. And we selected about 10 to 15 ZIP Codes where that was the case, as well as through the community clinics where they're able to get their postpartum care and initiate family planning. And then also to be able to connect them through the community health workers and the home visiting to social services and other resources that will allow them to be healthy, also ensure the health and wellbeing of their children, which would include linking them to resources like childcare, being able to educate them on breastfeeding and also to be able to link them to contraceptive services so that they don't have an unintended pregnancy before they're ready to conceive again. And based on individual needs, everybody doesn't have exactly the same needs, but using this multidisciplinary team would allow us to be able to address many of their needs, whether that be medical, psychosocial or otherwise. And so we've had that program initiated since October of 2020, we're in a year, we've looking at lessons learned, looking at metrics that we wanted to be able to focus on and looking at how we can improve upon what we've already done going into year two.

[Kami] Awesome. And I'm seeing a question about whether there are plans to participate in plans to expand Medicaid past 60 days postpartum. So first off, just want to acknowledge that yesterday was the White House maternal health advocacy day. The first time we've seen this maternal health day of action through the White House, and that there are lots of great initiatives happening in the Medicaid space, including an option to extend Medicaid postpartum to 12 months after delivery through a state plan amendment starting in April 2022. Texas is not at this moment taking that option. They are planning to use an 1115 waiver, Medicaid waiver to extend for six months of coverage. That is what passed in our legislature this session. And many of the folks on this call and presenters here have long informed our legislature around the challenges we have faced with maternal mortality, with lack of healthcare and interconception and preconception periods and poor health outcomes for moms, for babies and for families. And so we are excited to see some improvement in the coverage opportunities in our state, but we are not at this time maximizing those improvements. I think it's really encouraging to see the federal administration seek those opportunities out. And I think there'll be a lot of great movement in this space. So thank you to Parkland for innovating in that space and being a leader in our state around making sure people have everything they need in those critical months after delivery. So I'm not seeing anything else in the chat. So I think I'm going to go ahead and toss that to Jennifer to do a wrap for us.

[Jennifer] Thank you so much Kami, and thank you to all of you, all of the panelists. I'm sure I'm not alone at all in finding today's session both informational and inspirational. And I really just appreciate all of your varied perspectives and for joining us today, thank you for both sharing with us and for all that you're doing as well.

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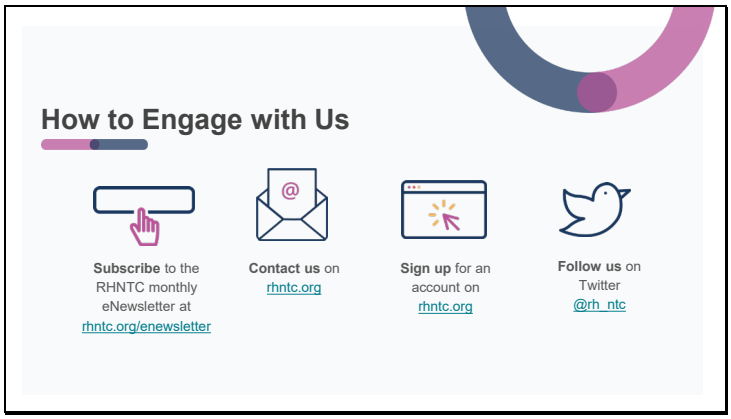

Before we go, I'd like to ask just please make sure that everyone is signed up for, and that all of your staff are signed up for the RHNTC's monthly newsletter at rhntc.org. And follow the RHNTC on Twitter @RH_NTC, and we will have materials from today's session available in the next few days on rhntc.org, as we always do after webinars. And once more, we hope that you'll take just a moment to fill out the evaluation form after the webinar ends, we really do appreciate your feedback and we use it to inform future webinars. If you have any questions, you can contact RHNTC via email at rhntc@jsi.com. And I hope that you'll all join me in once again thanking our panelists and for joining us today, this was really a great session.

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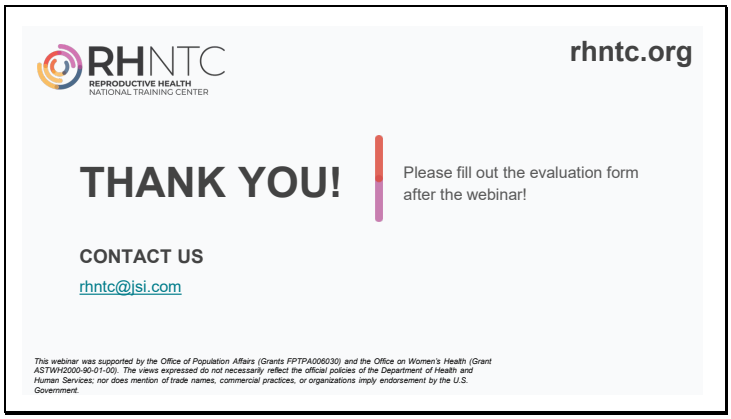

And thank you to everyone for joining us today. This concludes today's webinar. Thank you.