

**AMCHP Annual Conference, 2010**

**Moving Ahead Together:**

**Celebrating the Legacy, Shaping the Future of Maternal and Child Health**

**Policy Put into Action! When MCH Is a Priority**

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SANDRA SCHWARZ: Good morning welcome to Policy Put into Action! When MCH Is a Priority. I'm Sandra Schwarz; I'm the Program Manager for Reproductive and Perinatal Health in the Title V Agency at the New Jersey Department of Health and Senior Services. Robyn D'Oria is the Executive Director of the Central New Jersey Maternal and Child Health Consortium. I'd like to thank Dr. Hicks my Director for coming and Shirley Smith our supporter from region, too.

All right, Robyn and I have nothing to disclose. I wish. As many of you know the National Women's Law Center released a document in 2007 making the grade on women's health. We were fortunate or unfortunate whichever the case may be, our newly appointed commissioner for the Department of Health and Senior Services happened to be an attorney so she read the document. Although she wasn't a health professional she'd had a long standing history and experience in policy and planning. She requested that we develop a position paper on prenatal care so that she could look at that as one of her main focuses in her tenure as commissioner. As you can see our trends in first trimester prenatal care remained relatively flat if not decreasingly slightly.

We had racial disparities in first trimester prenatal care with 25 percentage points between Black, non Hispanic and White non-Hispanic. We framed the issues from the standpoint of looking at our infant mortality leveling, low birth weight, pre-term birth increasing, our low national ranking and the fact that prenatal care is an opportunity to improve outcomes for mother's and newborns. The rates and the early initiation could be improved and we needed to discuss and the commissioner needed to have a feeling about why prenatal care was so important. So she decided to convene a prenatal care task force and many of you are probably aware of all the task forces that go on in different parts of government. The commissioner came to every meeting, senior staff, deputy and assistant commissioners were at every meeting. If other departments who were supposed to be partners did not send someone they got a phone call from the Chief of Staff. We were asked, Dr. Hicks and I, to put together a proposal of the members to participate in the task force. We went to the usual suspects, ACOG, New Jersey OB/GYN Society, the family physicians and we had two pediatricians actually come forward and say that it was very important for pediatricians to be a part of this group. A1, ACNM and the rest as you can read, they were all volunteers. They were not paid. We had monthly meetings and sub-committees met a minimum of two times a month. We had other partners; we pulled together the Hospital Association, primary care. When you look and it says Department of Human Services, three representatives, we had three representatives from Medicaid, our Health Start program, which is our prenatal program and from the Health Department as I said the deputy and assistant commissioner, Dr. Hicks, the medical director for the division, myself, some of my staff

because we were the ones that staffed the committees. And now I will introduce Robyn in her other role. She was Chair of the task force.

ROBYN D'ORIA: Thank you. We actually had quite a job ahead of us and it was somewhat daunting. We got together in the beginning of the spring at about March into April and she wanted recommendations on her desk by June. So we compromised and came forward with our report in July. So you can see we really had quite the task in front of us. We knew that we needed to review the data on first trimester prenatal care within our state and you saw the earlier slide. And at that point we knew there were lots of things we needed to look at. Racial and ethnic disparities and other contributing factors as well. We looked at best practices and identified successful programs that either in our opinion or were recognized nationally as programs that could increase prenatal care rates as well as reviewing current support for improved pregnancy outcome activities within our state as well. This actually is a picture from one of our first meetings and at our very first meeting we reviewed all of this material. We knew that our goal was to provide recommendations to the commissioner and her staff on ways to improve first trimester prenatal care. So at that first meeting we reviewed the literature and with the help of our MCH epidemiologist and his staff we were give quite a bit of information. We looked at different measures to access prenatal care and we recognized that there were a number of different ways, but for our purposes we looked at early prenatal care, late prenatal care, no prenatal care and also looked at adequacy of prenatal care. We looked at our birth certificates as well as our PRAMS data and tried to get a sense of where we stood as a state. We knew we were at the bottom of the

heap which unfortunately is what brought us together, but the good news was the only way to go was up and that's really what we were hoping for. We took a close look at risk factors associated with late prenatal care, whether they be demographics, psychosocial, situational and geography and all of the information that's inherent with that and I won't belabor the point and go through the list of things we looked at but we truly looked at every nook and cranny as it related with each of these areas. You saw this earlier. We took this as our presenting slide and said this isn't anything we really need or should be proud of in the State of New Jersey. And when you look at this and you look at the disparities between the different race and ethnicities it was quite apparent that we certainly hadn't improved over the last ten plus years and in some cases actually went down. With our overall rate of prenatal care first trimester prenatal care being within the state at 78%. There are a number of maternal characteristics we found that were associated with second trimester or late prenatal care entry and we realized that if you were married, college educated, 30 plus years, U.S. born and a white mother, chances are you did go in to get your prenatal care within that first trimester. But if you fell off of that description you were far and away less likely to get your prenatal care within the first trimester and if we were lucky in the second and if not in our third trimester. We looked at what it looked like for those women as far as outcomes who participated in prenatal care within the first trimester and those who had no or late prenatal care and it was clear that women who didn't partake in prenatal care within that first trimester their outcomes were poorer whether it had to do with preterm and low birth weight. Certainly infant mortality rates were greatly reduced and that your chances of an infant dying

within that first year if you had no care or late care could be as high as 33% more than those women who had first trimester care.

SANDRA SCHWARZ: As a PRAM state we always like to use the data that we have from that and the commissioner was very, very pleased that we had the survey data from PRAMS as something that she could use as a true New Jersey base and it was more in real time than some of the other data that we all know we use. Mothers who are privately insured were more likely to enter prenatal care as Robyn said by the first trimester. Some of these we kind of copied the ones that Robyn had but we wanted to show you from a PRAMS perspective what we were looking at. We felt that insurance coverage is often the best predictor of whether a mother will enter into prenatal care by the first trimester. This graph shows a direct relationship between the continuity of insurance coverage and the initiation of first trimester prenatal care. Across all racial and ethnic groups regardless of birth place, privately insured mothers have first trimester prenatal care rates that exceed the state average. However the interaction of insurance coverage with both race, ethnicity and birth place may result in substantial decreases in first trimester care.

Pregnancy intention is something that we've been looking at as I told you I'm the program manager for reproductive health and paranatal health so we have the family planning side as well as the paranatal side and we've been looking at intendedness of pregnancy and how that affects early entry into prenatal care as well. Other characteristics play a role in how early a mother enters care. Of the mother's receiving

prenatal care, high rates of family care and mothers with no insurance report that they did not get into prenatal care as early as desired. Likewise, mothers who were not aware that they were pregnant usually until 9 ½ weeks also showed prenatal care coverage much later than the state average. One of the things that we found pretty consistently is the problem with the insurance but also from the standpoint of geography, where you are in the state and how many clinics are functioning and the backlog at the clinics, this shows some of the major cities in New Jersey. Atlantic City at the top, Plainfield City at the bottom. New Brunswick is our shining star that had their great prenatal care that actually happened to be one of the places within Robyn's consortia where we had a healthy mother/ health baby coalition, the medical school is located there and there are...there is also an FQHC so there are a variety of providers and once we made an effort with our Black Infant Mortality Reduction project, healthy mothers/healthy babies and several other projects that were going on in that area they did much better than the rest of the state.

This again is about the geographic areas in our world it's as we call it the usual suspects. We have ten cities with the highest need. There are always the ones that we have problems with. Among family care participants New Brunswick is the leader among eight other communities with first trimester care that exceeds the state average.

Leading barriers for women are not being able to get an appointment, not having insurance or the money to pay for care and not having a Medicaid card although we have presumptive eligibility for Medicaid many, many women do not use that system.

While privately insured mothers most often report the lowest frequency of barriers mothers who are new to family care led the pack in barriers related to insurance coverage often because they didn't know how to use the system.

Family planning recipients in New Jersey this is just below 21 years of age. It was pretty telling.

ROBYN D'ORIA: So the first meeting when we all met and these were the statistics and the information that were provided with us many of us sat there kind of with our mouths open. Not that we didn't know a lot of what you saw existed either intuitively or having lived it being in the community and working in our communities but it just was much more powerful when you saw one thing after another and how it would impact the women that we serve. What we realized were there were multiple reasons. There is certainly not one intervention that could be had or one reason why women did not access care, choose to get to care or were able to get early prenatal care. We knew there were lots of opportunities to improve and that there were a number of different types of intervention that may have a better impact than others and where we needed to focus it. We realized that participation among different demographics was very telling where the higher risk the women were, the lower the percentage of early prenatal care. Which again you intuitively knew but this at least helped us to quantify that.

Pregnant...the whole issues of pregnancy awareness and intensesness was one of those things that really had us thinking because we hadn't really thought about that as much and this helped to bring that to light. We knew that early prenatal care certainly

related to insurance before enduring pregnancy and if a woman accesses prenatal care the likelihood of her getting insurance, being successful in getting that insurance and helping to insure her prenatal care so that it would be considered adequate by definition whether you use coddle check or anybody else's determination was there. We knew that new family care enrollment in the initiation of prenatal care could be effected by system delays and again like I said the pregnancy intended and pregnancy awareness were factors that we had to look at. So we sat back and we said what do we need to do? And certainly you saw the size of the committee and it really was an active committee and there were a lot of people. The entire committee numbered over 25 and we knew we couldn't do all this work, especially with a short turnaround time in one big group so we broke up into sub committees and we knew we needed still more information. So additional literature reviews were going to take place. We focused on three areas. And those areas included education, capacity within our state and quality outcomes. Each subcommittee was charged to look at a number of things, but we knew we needed to look at education not only for our community but also at our health care professionals because whether we wanted to admit it or not all health care professionals did not necessarily see the importance of preconceptual health and/or interconceptual health for their female patients. Access to care, access to reproductive health services and also access to practitioners. We've seen a huge decrease in the number of OB's practicing in New Jersey over the years. We do have a medical school. Not one person from the last class of the medical school chose to set up practice as an obstetrician in the state of New Jersey, not one. And there are a lot of reasons for that but all of those things started to come out on the table and we recognized it's something we need to

deal with. Certainly the systems we work within they're all so convoluted and so at times I want to say pathological but they don't always make sense. So we needed to look at the systems we had built and whether we needed to change, them, add to them, delete them and finally evaluation, looking at data and how do we use that information for our programs. Education we knew that we needed to have a recognition of preconceptional care, preconceptional health to be not only for obstetricians but also family practitioners, internists, anyone who came in contact with a woman of childbearing age and even ultimately those younger and to work with our pediatrician's in increasing the knowledge of preconceptional health for our young women. Our primary target is not only women, though. We knew that we needed to include men and other significant people in a woman's life so that they would understand the importance of health and wellness for a woman should end or when they get pregnant. Our capacity sub committee looked at a few things. They looked at access to care issues. In New Jersey we had just five years ago about 67 hospitals that had birthing facilities. Today we're at 57. Just in the past two years we've had somewhere in the neighborhood of four or five hospital closures for birthing facilities. Either hospital closures completely or closing their OB services. That has really impacted on the availability of sites for women to access their care as well as geographically a nice range of where a woman could be depending on where she lives. We also knew we needed to look at Medicaid presumptive eligibility enrollment and why women were necessarily availing themselves of that. We had to look at health care provider issues. I spoke a few seconds ago about OB's not wanting to come to New Jersey and are fleeing New Jersey quickly and ACOG and our NJOG's our other professional committees the New Jersey Medical Society they were all looking at these

issues but as you can see there are quite a few here that directly related to the provider and the ability to have providers available for the women in our state. And finally our quality sub committee our outcome sub committee. We wanted to look at standardizing measures of quality, availability of data and promoting quality improvement within our state as it related to maternal and child health. And not everyone in our state was as familiar with the different measures that we either had access to or could use. The population paranatal risk index is a tool that the MCH epidemiologist within our state had come up with and decided to put together a number of factors that would help to better identify cities and/or areas that were more problematic or had poorer outcomes. As Sandra said the usual suspects certainly all were there but we wanted to make it so that it was much less subjective and it was objective in that. The...by looking at a population risk approach we felt that we would be able to get a better way in which to measure these particular cities. And there were five areas that we actually looked at, low birth weight, infant mortality, paranatal mortality, as well as late prenatal care and birth to teens. And how the epidemiologist actually came up with these scores or numbers. They use a logistic regression to isolate the population component from these different indicators. The five...they actually take those indicators and go through four steps. They do a separate regression equation for each birth outcome and estimate the effect of race, Hispanic origin, foreign birthplace of mom, parity, mom's age, marital status and education for all births state wide. They then take each equation and generate expected probabilities for individual birth outcomes. They average these probabilities and yield municipalities expected rate for each outcome and the five population risk components. And then finally they combine these five risk components

and use principle components factor analysis to obtain weighted and standardized composite scores. And what it looks like and although certainly you can't see all these numbers but what it did was it helped us to better realize where our high risk pockets were. For example, probably everyone here has heard of Newark, New Jersey, not the most shining star when it comes to outcomes and we would expect Newark to be up high on this list. It is but surprisingly it's not the number one. Although it has a huge number of births, 24,000 plus births it was about the sixth when it came to risk. Camden which did come out on top again one that did not surprise us, but despite it only having about 8500 births it still ranked much higher than Newark. By doing this we're better able to allocate resources to those areas that really have the need even more than others. Every community has pockets, we realize that, but we knew if we were going to make a difference and with the limited number of dollars that we have available both state wide and within our communities we needed to focus on those areas with the highest risk. And this tool has been instrumental in helping us do that. So what happened? We did come out and we did make our recommendations. We met it seemed like all the time for those few months but it was quite a dedicated group I have to say and it was kudos to that committee that allowed us to come up with these recommendations. We published a report. It is available online. We have copies with us here if you'd like just to take a peek. But we put the recommendations in writing. So let's talk a little bit about what the recommendations were and then I will share with you some of the things that we have done. Now the report was published in July of 2008. It took probably until the end of that year into the beginning of 2009 to begin to disseminate all of this information. We talked about earlier how involved our

commissioner was. Not only was she involved, we actually sat down one on one with our governor and shared with him exactly what happened with this task force and where we saw the barriers were where the pockets of opportunity were and what we needed to do. It was that level of support, I truly believe that has allowed us to move forward in a relatively quick fashion and you'll see what we've been able to do just in this past year in beginning to get some of these recommendations out. You'll see that many of them are long term. And we need to really start to build an infrastructure to be able to put them out there. But my hope is that we will. The first one under education is to increase public awareness of the importance of preconceptual health. And that seems pretty straightforward. Some of the things or the action steps we have included to do that, we need to provide information to a myriad of people to educators, health care providers, we need to look at the materials that we provide to our public, make sure that they are written in a way that the public can understand and take into an account the issues of literacy. Both health literacy and literacy in general. Looking at social marketing campaigns and ways in which to get this information out. And engaging and encouraging our media partners into doing different things. We also realized as a goal that we wanted to improve community, consumer and professional knowledge of risks and behaviors that impact preconceptual health. And we need to identify and disseminate reproductive life planning tools. And that's something that we're beginning to do not only in our public setting such as FQHC's and community health centers but also within our private providers and engaging those private providers although a challenge has been very rewarding. Because now everyone gets the same material regardless of where you may be. This was our prenatal care awareness campaign that

is ongoing as we speak. The materials have been posted and placed in a variety of places within the state and they're all very culturally sensitive and we were sure...that was important to us because we recognize that would be something we would need to do. And finally goal three here is assure that all females of childbearing age in New Jersey receive preconception care services that will enable them to enter a planned pregnancy in optimal health. We know that we need to target statewide continuing ed. type of education so that preconceptual health is intertwined into health care issues as we go forward. Implementing curricula that includes preconception care not only at the school age level but as we go up through the years we have a number of colleges and universities in New Jersey and we actually have agreements with some of them, actually with almost all of them at least in the central part of the state to bring preconceptual health, materials and educational programs right on campus so we can get young women of childbearing age. But also recognizing that we need to work down from there as well. To identify and provide screening tools has been very important to us and you'll see a couple examples of the screening tools that we've used...that we're currently using to implement as well as disseminating a lot of the information that we found out early in the process. I shared with you not only the literature reviews but the issues of evidenced based projects and projects that we knew had a history of success. We're now sharing that with our partner's state wide so that we're not the only ones with the keeper of that knowledge but certainly they are and hopefully we'll be able to implement some of those things.

SANDRA SCHWARZ: Goal four was to reduce risks indicated by a previous adverse pregnancy outcome through interventions during the inner conception period which can prevent or minimize future health problems. We had used a number of things. We obviously we do femur, we do maternal mortality review, we have a paranatal addictions prevention project, we have post partum depression screening. We do a number of those things but there wasn't a great linkage. One of the things that has come out of the paranatal addictions prevention project and we've worked with the Department of Human Services Medicaid...a paranatal risk assessment to actually look at all of the women as they go through their prenatal care. Originally in the 80's when we went to the health start model where we used the Poprus form and the advanced evaluation and assessment and that kind of went out of favor and it moved along and people weren't using that as much so this has gone under a couple of revisions and this seems to be the one people are most comfortable with. Based on what came out of the prenatal care task force Medicaid was able to pull the major providers of Medicaid services, the insurance providers to the table and they liked the form so it's going to be implemented through the Medicaid system. Private providers are also starting to come online with this. This is what we had started with as part of our paranatal addictions prevention program the four P's plus. We as a state hold a Healthy Start grant and have had one since 1994 so we had been involved with Dr. Chaznov. He has come to New Jersey on a number of occasions. We now have three Healthy Start projects in New Jersey so we've been using the four P's plus for a number of years. We've used some of that data and that has helped us get additional funding for that project but to be able to put it also within this project has also been helpful. Intensive interventions to women

especially things like infant death, fetal loss, birth defects, low birth weight...we recommended a modification to third party payer rules that permits payment for pregnancy, a pre-pregnancy visit. Educate women and couples on the value and availability of pre-pregnancy visits, fund home visitation services in each county to include preconception and interconception focus. We're waiting for the RFP just like all the rest of you. And integrate; formalize interconception health counseling into other services, special child health, case management, early intervention that we would start looking to bring women into services early. We have a femur project in this state. We cover most of most of the state. We fund it with our Title V dollars. This past year and over the course of the last several years, we have 6<sup>th</sup> regional and child health consortium in the state, they have banded together and do the training as a group so there is cross pollination between the different projects, and as Robyn said as we keep losing maternity hospitals those nurses show up somewhere else so we have a good pool of nurses who have been trained. We also wanted to integrate components of the preconceptional health into existing local public health and related programs. One of the things that we have in New Jersey is something called public health priority funding. To receive those fundings and we have 110 local health departments, boards of health and all the rest. We only have 21 counties. They receive that funding based on different requirements within the public health priority funding guidance. The money is distributed among the different counties. One of the factors is improved pregnancy outcome. And it was one of the old, yes the public health nurse needs to do a home visit and that was what was there. We took what had been written into the recommendations of the task force and incorporated those into the actual guidance and regulations for improved

pregnancy outcome. Horizon Health Center is one of our federally qualified health centers. It happens to be in Jersey City. They and they've also expanded to a couple of other places as hospital closed. Our FQHC's have gotten very good at providing ambulatory care services by contract to some of the hospitals. They are also a family planning provider so the commissioner was trying to link those together so that people could see that we are looking at co-location of services, that we're looking at leveraging what dollars we have. Promote equity in pregnancy outcomes. As some of you may know we've had a Black Infant Mortality Reduction project since the '90's. We've made some in-roads but when the disparities in early entry into prenatal care showed up at the task force there were people at the task force that were just as surprised at that. We have made some differences in our infant mortality numbers but we're not bringing enough women on board fast enough. And we've wanted to educate providers on how to reduce the disparities. Promote consistency and equity in the quality of care provided to all women. We want to encourage and support model programs and projects, integrated service delivery. Identify and promote the use of effective prenatal education and health literacy tools. Identify and disseminate best practices in model programs including things like health start which is our Medicaid expansion project which promote cultural and linguistic competencies. Family planning waiver was one of our biggest recommendations. The commissioner did not understand why in New Jersey 26 other states had a family planning waiver and we didn't. As Robyn said one of the biggest supporters for this was when Governor Corzine was in office the governor stepped forward as one of our biggest supporters and said make it happen. We decided to look at increasing access for women over 18 years of age. We submitted a preliminary draft

application to CMS and this slide is old as of two weeks ago. CMS recommended that we send women and men as part of our application.

SANDRA SCHWARZ: Then finally we went to assuring a system of data collection and evaluation that would really be able to better capture what we were doing and where we needed to go and with that we did a number of things but most importantly I think was to make people aware and for those projects that may or may not have had evaluation components to it earlier we made sure that was there. We wanted to maximize our public health surveillance and other types of related research and using our public health surveillance to track the delivery of preconception health services which we really didn't have before something that was looking more specifically to preconception health. We used our PRAMS and we're using that even more frequently and calling upon our MCH epidemiologist department to assist us with doing that. And then finally we looked at our capacity subcommittee. And what are the things that we need to do as it relates to capacity. You'll notice that some of these goals under recommendations do overlap somewhat. And that was somewhat of a frustrating part of the committee because we knew that where do we put it. But we tried to place the recommendations where we felt it was the most needed although recognizing that it would be needed overall. We knew that we needed to continue our work with ACOG and NJOG's and look at the issues surrounding malpractice, tort reform as well as the current OB malpractice standards as they are in New Jersey today. Looking at providing incentives for care. There is a reason why physicians don't want to come to work in New Jersey. Malpractice is a big one and that is something that we're having a tough time dealing with but if there is a

way we could possibly decrease those malpractice costs or assist with loan or loan redemption programs that might help. But also looking outside of just obstetricians looking at our midwives and other types of health care practitioners that may or may not be able to ease the burden on the obstetricians within the state itself. A recommendation was also to insure cultural competence and sensitivity in delivery and health care of women. We found that many of the places and reports from women themselves really found that this was not the case, although we thought we were doing a great job that wasn't in fact true. And we've worked with the State of New Jersey where now all the medical schools in New Jersey have to provide instruction in cultural competency in their curriculum. And in order for licensure renewal, all physicians must show a six hour course in cultural competency. And that's for medical schools, osteopathic schools, as well as podiatry schools within this state.

Our second goal was to promote women's health issues by improving the coordination of efforts of state governmental agencies. And I think this is one of our successes in that we really opened up a line of communication between the Department of Health and the Department of Human Services and the Department of Children and Families. Because all of us have programs that somewhat interact with one another or if they don't they certainly could and by doing so would have a better effect on the people that we serve. There currently is an interagency council that's dealing specifically with children's issues and we are now in the process of doing one that is more specific to perinatal and women's issues. Unfortunately for us or fortunately time will tell there has been a change of administration within the State of New Jersey. A new governor was elected

and a new commissioner of health. So that fast track that we were on has been stalled somewhat. But hopefully we'll continue to move on.

One of the shining stars that occurred within this past year is an initiative that came out of the Department of Human Services and the Department of Health and Senior Services and that's the insured for sure initiative. This was a family care initiative that is a pilot program now at 9 New Jersey hospitals. And in this pilot no newborns will leave the hospital without health insurance. It is under this pilot that both the commissioner of both services actually went, did a press conference and have visited hospitals. The hospitals submit data to the Department of Health and Senior Services right there at the hospital before mom is discharged. They confirm that the child is either covered by their parent's insurance or if uninsured a one page document or application is completed and is immediately submitted online prior to discharge so that family is insured. This just shows a picture of our commissioner's which is right up on the top here. Our commissioner Department of Human Services, and our former Commissioner of Health and they went and visited one of the largest hospitals in the state where the pilot is being done now. They have over 6000 births and they were really quite impressed by the quick adoption of the hospital and the support that the hospital had of the program. Another goal is to insure availability of ongoing early prenatal care services to women in areas affected by hospital closures and or reduction of services. I mentioned earlier we've had quite a number of them and that really has put a little bit of a crimp in the care that is provided in those areas. Unfortunately where those hospitals closed are also areas of high need and high population risk index scores that you saw earlier so we

have our work cut out for us. We know that we need to better serve the people in the communities so that a system has been put in place where there is a confidential warning system that identifies any hospital, federally qualified health center or family planning agency who in a community is at risk financially or otherwise of closing. They speak with the Department of Health and Senior Services and contingency plans can be put in place prior to the actual closure. So in part there are no real surprises but also there is some continuity of care for the women and children in that area. Another recommendation is that when a hospital closes and or it's impacting that there's a promotion of different types of programs that may help to insure that a woman at the very least has access to her medical history and or care during a pregnancy, an active pregnancy so that should she show up at a neighbor hospitals door they have something to help take care of her. With that, a prenatal care card has been developed and is being adopted by hospitals within this state. And this is just a very...it's just a handy dandy...it's about the size of this Sharpie box, it's in a little plastic container and on it has all just some basic historical information, there's some educational material, signs and symptoms of pre-term labor or obstetrical emergency, it's in English and Spanish on this one card and over here just documents key types of tests and procedures that are done on the woman or for the woman during the pregnancy so should she show up at a neighbor hospital there's...I mean we've had issues, where's the prenatal record? Who knows? The hospital's closed, it's gone. So some providers don't even know how to access a prenatal care record. At least if she has that card we're able to begin caring for her in a more comprehensive manner and in fact may be able to not duplicate testing, etc. Other types of things the department has put into place

is an expedited review of any licensing applications where there maybe modifications to a facility and/or if there is a change for the licensure and also developing criteria for use of a hospital stabilization fund which can assist facilities in assuming additional patients. We recognize that if a hospital closes, a services closes either problem can cause massive disruption in neighboring institutions and we certainly don't want that to happen. We want to best streamline and if there are some dollars set aside that can help those facilities that can make a big difference.

SANDRA SCHWARZ: As Robyn said one of the things that we had to look at was care. We had an occasion where we closed voluntarily; hospitals came forward and closed in one of the major metropolitan areas of the state. The only provider left was a religious facility which did not provide the full range of reproductive health care. So all the other providers, the FQHC in the area was at capacity and supported opening a prenatal clinic in the family planning site. So the commissioner moved forward with that, gave them seed money to get them up and running so that they could hire the proper staff. We were fortunate as Robyn said, the commissioner was there. We were fortunate that one of our and I don't like to use the word old. One of our old friends who had run one of our major clinics in Newark was available, Dr. Rhonda Nichols and she stepped in, had done prenatal care in the past, she was a great asset and within about six weeks we had a prenatal clinic up and running in downtown Patterson. Oh, and one other thing, the person in the middle of the picture happens to be the state senator from that area who was very involved and very pleased that the commissioner stepped forward and did this project. And since she's on the budget committee we're very happy too.

Presumptive eligibility is run different in every county of the 21 counties in the state of New Jersey or was at the time of the task force report. We've changed Medicaid directors twice since the report came out. We now have a new governor, I'm not sure who the new Medicaid director is going to be, but one of the first things that was done after the report was filed was that they went to an online application. That seems to be helping. Women seem to be a little bit more in touch with that but we've also had incidences where families don't have computers. So some of our projects have started moving forward with especially our Healthy Start project that we have in East Orange actually has computers in the waiting room that they assist the clients in their enrollment on site so that they can do what they need to do. Medicaid eligibility determination has been a little bit of a problem because of the county boards of Social Services but there has been more of an understanding that that's part of what we need to fix in this project.

ROBYN D'ORIA: So then finally our last committee was quality and data. The first two goals in this particular committee was to increase awareness among health professionals and the public of first trimester prenatal care as a measure of quality of maternal health care. And then increasing awareness among health professionals and the public regarding the disparities. And you can see obviously this overlaps quite a bit with our education goals. We also wanted to increase awareness among health care professionals and the public regarding disparities of fetal and infant mortality rates. And to do that we want to more readily publicize documents that we have that report for first trimester prenatal care as a standard (Inaudible) measure in the quality of health care services. But we also want to do this not only within the public and the health care

professionals but involve and collaborate with other agencies that we haven't traditionally thought about. Health, Human Services, Children and Families they all seem like quite common and what you would expect to be partners of ours but we are also looking at and working with the division of...Department of Banking and Insurance to develop internet based approaches to make first trimester prenatal care performance measures widely accessible, collaborate with them as well and New Jersey Medicaid to develop a report that identifies at a minimum the rate of first trimester entry into prenatal care and using (Inaudible) indicators and making that public. And then looking at these indicators and relating them to healthy people 2010 and ultimately healthy people 2020 and our New Jersey Center for Health Statistics. We also want to look at promoting quality improvement programs to improve first trimester prenatal care rates and infant mortality rates and to utilize our population risk index not only to identify but to target cities like I mentioned earlier. And we have done that through the use of allocating additional dollars not only for this fiscal year 2010 but as we move forward to 2011. And sharing best practices that we always hope that were doing anyway but to do it in a more active manner amongst our providers, but also working closely with the professional associations that I identified earlier as another mechanism to get this information out.

SANDRA SCHWARZ: One of the recommendations that was hard fought at the prenatal care task force we were told you are not getting any more money. We were told we had to be budget neutral. One of the sub committees came forward and said we need to redirect the funding that you already receive. Obviously if the Black Infant Mortality

Reduction project has done things for Black infant mortality, from an infant mortality stand point but we're not getting women into care sooner, we need to look at those funds and that was a nice million dollars, a combination of state and federal funds and we have an infant mortality reduction initiative that we've had since 1985 that's been in...that we use the health mother/health baby coalition model that had been in place since 1985. It was hard fought. There were people at the table who were very upset but it was decided that we were going to take that 3 million dollars; we put it together as an RFP with the best practice model. We did not identify what the best practice model had to be. That was up to the individual agencies. We got phenomenal applications. The applications were so good and with Dr. Hicks's help we were able to arm twist our assistant commissioner and we got a little bit extra funding. We were able to fund nine of the applications. And when you look at the list of all the agency of all of the cities in the population risked we were able to fund projects in 20 of the top 30 of the population risk identified cities. That made a real difference so we had state-wide representation; hopefully we're going to continue. It's a new administration. Those projects began January 1 of this year. It was a tough process. It was...people who hadn't spoken together are speaking together. We have FQHC's working with family planning agencies, working with consortia, we have one model where the FQHC got the award and the consortia is doing the home visiting model because they're already a recipient of healthy families and nurse family partnership grants so they're able to leverage those dollars so there has been a total buy in from a lot of the agencies we've funded through the years that they're stepping back to the plate and they're looking at things in a different way and that has been one of the most amazing things with this project.

Robyn D'Oria: Really as we summarize what we're doing what Sandra just described I think is the icing on the cake, at least for me being part of this project, it was painful to go through, however the new relationships that have been formed within the state can only improve the care and the ability to provide continuous ongoing support for the women and children in our state. We now know who all the stakeholders are. Whereas before I don't know that we all worked in silos, frankly. And I've been in Maternal Child Health for 30 years and I have never seen the amount of partnership, collaboration, facilitation of services between agencies that I see today. And coming from a more hospital perspective and into the public health arena less than ten years ago, there was never a time that these agencies really spoke to each other. Hospitals felt they were doing everything for the woman and in fact were taking care of their community. It's a surprise to them to think that they aren't able to do that but in fact those community agencies are much more important to them now. And I really think that is one of the biggest benefits that this project has provided to us. The number of programs that we've done just within this past year has really been quite astonishing. And to help set up these collaborations and help to establish these relationships so that they will be ongoing. They certainly need to be nurtured. It's not something that will happen overnight and nobody is best friends necessarily, but at least there is a dialogue between these stakeholders and I think that's important. One of the first things that happened was National Prematurity Awareness day back in the fall of that first...in 2009 and even in 2008 we actually worked together with our New Jersey March of Dimes chapter, our commissioner of health was there as well as providers and other stake

holders at this state-wide kick off for Prematurity Awareness Day. We have now a paranatal collaborative which is being co-sponsored by the Department of Health and Senior Service and the New Jersey Hospital Association and we even have the chair of that committee with us in the back of the room today. This particular collaborative has truly been amazing and I sit around the table and I shake my head. Hospitals are actually sharing policies between each other without even a question. Now for some of you that might be normal practice but I can remember a day where you never shared your pit policy with the people next door because maybe that would put you at a disadvantage. Well that's not the case anymore in the state of New Jersey. People there is an ongoing dialogue with...we're using the Internet, we're going through the New Jersey hospital association and we're looking at different projects. Our first project is what you've heard all these past few days looking at elective inductions prior to 39 weeks and the escalating C-section rates. Ours are no different than any other state in the United States. They're going...they're skyrocketing. But by working through this together, hopefully we will make a difference.

SANDRA SCHWARZ: This is you. See she didn't read her own code.

ROBYN D'ORIO: Sorry. State-wide roll out. When we first did the report and it was done in that July of '08 we also had a press conference in '08. We did this at again one of our major birthing hospitals within the state, the press was invited, there were a number of agencies represented at that table, not only the hospital but all of the community was there, our federally qualified health center, physicians, nurses, etc. Our commissioner

also went on a tour of the state. She went everywhere. And you'll see her in all of these pictures it's like finding her wherever it is. She went to the universities, the colleges, we have quite a few. In this case this is the college of New Jersey. Just talking about prenatal care awareness and what it means and why young women should be care...unfortunately in the audience that day there were only young women there weren't young men. So as we move forward, I'm hoping that our audience will be a little bit broader. She went to individual activities in the cities. As Sandra mentioned we did have up until January health mothers/health baby coalitions in many of our high risk cities. She actually went to the health fairs in the cities to meet the women to hear from them what some of the issues were and she participated at the events. Here she's holding the laundry basket which was the give-away for one of our raffles that day. But she spoke with the women and I think that's what's important. The key here is everybody is at the table and we all are working together. In this particular case she visited another one of the federally qualified health centers and which is a midwife run health center to talk with them in Newark. Probably...do you want to summarize? Come on up. Like I said earlier there really has not been the communication amongst practitioners. There has not been a focus on maternal child health. Having been in maternal child health for my career I've never seen the interest or the dialogue between these people. Certainly not at the state level as well as even in some of the agencies and that's what's made a difference. I think that's why we've gone as far as we have in the past year and a half as we've started to implement, I'm extraordinarily excited for the new projects that are being started now this year and hopefully will continue for the next few years so that we can really finally implement programs that we know have proven,

positive outcomes that will help to improve the health and well being of the people, the women and children certainly in our state.

SANDRA SCHWARZ: And I cannot tell you how important it was for the commissioner and the governor to be as involved as they were. The commissioner was amazing. Those of you in state government it's a double edged sword. You are very popular and you write a lot of speaking points and a lot of speeches but it was so rewarding that we actually were able to do things. There were several meetings as Robyn said with the governor, there...at one point when the family planning waiver was to move forward the governor at the last minute called a meeting of the family planning providers at his residence and in a week's notice get everybody there and he wanted to hear what they had to say about the family planning waiver and how we should move forward and who we should talk to. It was truly amazing. There has been buy in as Robyn said. Both of us are on the perinatal collaborative with the hospital association. There are amazing things happening that two or three years ago I just couldn't believe that we could do this. It has been one of the most positive experiences in state government in a very long time. Now our challenge is though like we said we have a new governor, I'm not quite sure where he's at with some of his perspective on maternal child health and we also have a brand new commissioner who happens to be a physician, not one in maternal child health and we're not really sure where her priorities lay and what the future will bring. The good news is the rest of the infrastructure is still there between Dr. Hicks, Sandra, our assistant commissioner and our deputy commissioner who was there for part of the process that we outlined for you. So we're hoping we will be able to move

forward, but honestly given the infrastructure that we've started to set into place over the past two years from the inception of the task force, I think we'll be fine. We'll just need to educate our newcomers and bring them around to where we'd like to see them to be. So thank you very much. We appreciate your time.

(Applause)