Good afternoon I am LuAnne Brown RN, CEO of Buffalo Prenatal Perinatal Network and Chair of the Association of Perinatal Networks. I also spent 30 years at Women and Children's Hospital of Buffalo in various Nursing Administration positions including Chief Nursing Officer and my background is in OB nursing. I have the experience of working in both the health care system and a Community based organization which provides me a unique perspective. Thank you for allowing me to present on this panel as it relates to legislation needed regarding child and maternal health, as well as addressing high maternal morbidity and mortality rates. I am representing the Association of Perinatal Networks of NY (APN), which is an umbrella organization of the 16 perinatal networks and the Maternal Infant community health collaboratives (MICHC) funded by the Dept of health. The Perinatal Networks and other MICHC programs are organizations embedded in communities across the state who interact with the most vulnerable women and families every day and advance perinatal health. The perinatal networks have been focusing on the maternal child population for over 25 years and many are part of the NYS Maternal Infant Child Health Collaborative, which utilizes Community Health Workers to develop relationships with these populations. CHW's serve as the link between the medical care and community services. The positive role CHWs play on health promotion are included in a 2015 Commonwealth Fund report, which states that CHWs improve maternal and child health by encouraging women to

follow recommended care, supporting child vaccinations, and promoting recommended health screenings and better nutrition. The Massachusetts Department of Public Health also researched CHWs and stated that “CHWs help contain costs by preventing unnecessary urgent and ER visits and hospitalizations. We all know this equates to decreased costs for everyone. The report continues stating “CHWs also improve quality of care and health outcomes by improving patients access to and use of preventative services, chronic disease self-management support, maternal child home visiting, and perinatal support. The CDC PEAR report has also published a report showing the efficacy of CHWs which is evidence based. CHW programs have been estimated to show an ROI ranging from $2.28 to $4.80 for every dollar spent because of reduced costs of child protection, K-12 special education and grade retention and criminal justice expenses. The focus of CHW maternal programs to ensure women reach full term pregnancy through prenatal care attendance also ensures enormous savings in a reduction in Intensive Care Nursery stays. CHWs tend to be from within the community and share lived experiences as clients in addition to having an established relationship with community members. They are also very knowledgeable in the resources available in the community and assist women in accessing these services. Research shows that CHWs are successful in reducing child and maternal mortality because of their emphasis on preventative care and the trust they engender with their clients. The Affordable Care Act has

also /promoted the use of CHWs within home visiting programs. One recommendation from Governor Cuomo's Women's Agenda to reduce maternal mortality, was to expand and enhance CHW services. Due to this recommendation, cuts from the previous 2 years were restored so programs could return to their baseline staffing. The APN has been supportive of this agenda as well as the NYS First 1000 days initiative and the Maternal Depression project. Many of you may be newly familiar or have been familiar with the term social determinants of health. Social determinants are conditions in which people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality of life outcomes and risks. They include things like access to education, health care, availability of community services, and transportation options. While the phrase has become the latest buzzword, the Perinatal Networks have been working on these issues for their entire history. Interestingly, in the rest of the world 20% of resources are dedicated to medical services and 80% to social supports while in the US this is reversed. We are of the belief that we need to realign our priorities and focus on those aspects that can help prevent medical complications and are much more cost effective. As mentioned, CHWs are the perfect provider to implement these changes as evidenced by research and even more importantly, first person accounts. Listening sessions coordinated by the NYS DOH in 2018 gathered women from around the State to gather their thoughts on their birth experience and one woman stated "I

wouldn't have made it through without my CHW". Also mentioned in these sessions was the implicit bias many women experienced during their birth experience. This bias has shown to be a factor in the high maternal and morbidity rates and CHWs can play a key role in advocating for their clients and bringing these biases to light with providers. We feel a CHW model should be a universal option for women.

Based on this information APN would make several recommendations:

(1) Many of these programs were subject to the State 20% withhold beginning in April 2020 even though our programs were not involved in Medicaid, DSH, etc. The withhold impacted services we had already provided. The withholds will very shortly be hitting the one year mark and we still haven't heard of any relief. This is during a time when our clients are most vulnerable and our staff has increased their commitment and became very creative to continue and increase services.

We are requesting that the COVID 19 funds being clawed back from Managed care and MLTC be earmarked for our agencies rather than swept from the budget'

2.Legislate rigorous research on CHW outcomes to validate efficacy of their role as is evidenced in other home visiting programs

3.Introduce legislation that allows reimbursement of CHW services. Other states have implemented this type of legislation including Indiana, Idaho, Minnesota, Oregon, and

Pennsylvania. While global funding may not be feasible, directed investment in localities with high maternal and morbidity rates may be a reasonable compromise. This could be targeted to zip codes with hotspots or overall high rates of poverty, maternal mortality and morbidity, preterm birth and /or infant mortality.

4.We recommend that CHWs be integrated into health homes and Medicaid managed care plans care models and care teams. Commercial insurance health plans should pay for outcomes based programs that the CHWs provide