

Infant Mortality in African American Infants and Infants in Rural Areas Study: Advisory Work Group

September 17, 2018 Meeting Summary

[Version Date: 12/3/2018]

Location

Maryland Health Care Commission
Room 100, 4160 Patterson Ave.
Baltimore, MD 21215

Virtual Meeting Access was available
(web/phone).

Workgroup web page: Meeting dates, times, locations, and meeting materials

https://mhcc.maryland.gov/mhcc/pages/home/workgroups/workgroups_african_american_rural.aspx

Work Group Members in Attendance

Steering Committee Members

Chair: Ben Steffen, Executive Director,
Maryland Health Care Commission

Vice Chair: Noel Brathwaite, Director,
Office of Minority Health and Health
Disparities, Maryland Department of Health

Vice Chair: Dr. Lee Woods, Medical
Director, Maternal and Child Health Bureau,
MDH

Lee Hurt, Director, Vital Statistics, MDH

Dr. David Mann, Epidemiologist, Office of
Minority Health and Health Disparities,
MDH

Lawrence Reid, Director, Office of Maternal
and Child Health Epidemiology, MDH

Megan Renfrew, Government Affairs and
Special Projects, Maryland Health Care
Commission

Other Work Group Members

Dr. Robert Atlas, Chair, Department of
Obstetrics and Gynecology, Mercy Medical
Center, Vice-chair of Maryland ACOG,
representing MHA.

Carla Bailey, PhD, RN, Director, Perinatal
Programs, MIEMSS

Lisa Burgess, Chief Medical Officer,
Maryland Medicaid

Sade Diggs, Office of Rural Health, MDH
(Delegate for Temi Oshiyoye)

Rebecca Dineen, Dep. Commissioner,
Baltimore City Health Department

Marianne Hiles, Maryland Nurses
Association, Frederick Memorial Hospital

Anne Jones, Acting Program Manager for
Hospitals, Office of Health Care Quality

Sandy Kick, Maryland Medicaid

Mark Luckner, Executive Director,
Maryland Community Health Resources
Commission

Dr. Russell Moy, Health Officer, Harford County

Dr. Lillian Norris-Holmes, Ed.D., Ed.S., M.S., Board Member, Advocates for Children and Youth

Dr. Meghana Rao, OB/GYN at an FQHC, MD ACOG

Shanna Wideman, Chief, Child, Adolescent and Young Adult Substance Use Services, Behavioral Health Administration

Lara Wilson, Executive Director, Maryland Rural Health Association

Other Meeting Attendees

Robyn Elliott, Policy Partners

Neal Karkhanis, Maryland Hospital Association

Pam Kasemeyer, Schwartz, Metz & Wise, P.A.

Nathan McCurdy, Department of Legislative Services

Ben Wormser, John Hopkins Fellow

Welcome

Mr. Steffen, the work group chair, welcomed everyone to the first meeting of this work group and introduced the vice-chairs. All members of the work group in attendance (including virtual attendees) introduced themselves.

Dr. Brathwaite spoke about the importance of infant mortality and addressing disparities. He challenged the group to make a significant difference in disparities in the next 5 years.

Dr. Woods welcomed everyone. She noted that we have made a lot of progress since the 1980's and 1990's, but progress has stalled in the past few years. In addition, the disparities we discussed in the 80's and 90's continue and are unacceptable. House Bill 266 is a good nudge to get us to focus on these issues

Workgroup Charge and Work Plan

Member list: Megan asked all group members to review the member list and provide feedback. [Member List as of 9/17/2018](#)

Review of Charge and Charter: Megan Renfrew walked through a [presentation](#) describing the work group charge, charter, and process. The work group is a result of [Chapter 83 of the Maryland Code, 2018](#). Megan reviewed the statute's charge for the work group and shared the [Workgroup Charter](#) that describes the governance and process that will be used for the work group. The charter describes the role of the state steering committee and three subgroups of the larger workgroup.

Group members were asked to provide feedback on the charter and to sign up for subgroups.

Data Review

- [Presentation: Overview of Maryland Infant Mortality Data](#)
- [US Comparison Data](#)

Lawrence Reid presented data on infant mortality in Maryland, including national comparisons and breakdowns by race and geographic area. Maryland's infant mortality rate overall is higher than the national average, but rates for African American and Hispanic infants are lower than the national average. Maryland has one of the 10 lowest infant mortality rates for African Americans among the states, which is significant progress since 2007.

Infant mortality rates are down in urban areas in Maryland, but have recently been climbing in rural areas. Dr. Reid noted that that this increase does not appear in white rural populations and is driven by increased infant mortality among black populations. By infant age, neonatal deaths are more frequent than post neonatal deaths. A work group member suggested that we use race adjusted geographic rates, as different jurisdictions have different levels of diversity in their population, and this can impact their rates.

While infant mortality rates are about the same in rural and urban areas, the number of infant deaths is much higher in urban areas (due to population density). The jurisdictions with the highest infant mortality rates include both urban and rural jurisdictions--the rate is computed by 1000 live births and some of these counties fewer than 1000 live births, so interpreting these rates in counties with small populations is risky. Some counties would drop from the analysis due to small counts if we had a shorter than 10 year time frame.

In addition to county level analysis, Dr. Reid presented analysis at the census tract level, which allowed for more stratification of types of geographic areas. The relevance of this analysis is one that the data analysis subgroup can discuss in more detail. Maryland and Federal government definitions of rural are different. This is important when we compare our performance with national figures (such as census tract level data). For example, HRSA includes prison populations. Kent and Garrett are the only rural counties in Maryland by the Federal definitions of rural for HHS/Census. U.S. Dept. of Ag's definitions are different from the Census. Federal definitions are much narrower. For example, Somerset is defined as a rural county by Maryland government, but considered part of the Salisbury Metropolitan Statistical Area (MSA), a rural area by the federal government. It is important to think about what we want to do if we use census tract data-- the point isn't about reclassifying counties-- it is about identifying people and understanding them and targeting interventions. Is "rural" strongly related to other factors that impact outcomes? Where should the rural/urban divide be in census tract analysis?

Dr. Reid also presented on his perinatal periods of risk analysis. This analysis compares black non-Hispanic mother outcomes to a reference group of what non-Hispanic mothers to determine the "excess" fetal infant deaths (where the rate exceeds the reference group). Almost half of these excess deaths are attributable to the mother's health, which points to opportunities for early intervention.

Dr. David Mann summarized the presentation by making three main points:

1. Black infant mortality is worse than white regardless of rural/urban. Black non-rural has improved, but black rural may have gotten worse.
2. Race-adjusted infant mortality would show that the rural rate is worse than urban.
3. White rural and non-rural rates are the same.

Dr. Mann concluded by arguing the workgroup's main focus should be on rural and non-rural black outcomes.

The workgroup discussed a number of items in the data, including questions which the data analysis subgroup may want to review in more detail.

1. What percentage of the Maryland population falls in each geographic subgroup for the census tract level trends (ex. rural)?

The census tract data may show that some very small areas have very bad rates.

2. Can we look at change in population over time? Is the urban population getting larger or the rural population? Does population shift from rural to urban impact the rates?

The national trend is movement of population to urban areas, but we'd need to look more closely. The point of a population rate is to allow for a number that is comparable regardless of actual population. However, if the characteristic of the population is shifting (not just the count), then that may impact the rates (for example, economic status). A workgroup member pointed to the rapid growth in Southern Maryland's population. Another member noted that reverse migration of people into rural areas due to the loss of economic opportunities has occurred in Hagerstown and could be a confounding factor. An urban workgroup member noted that just because urban areas are better now, that could change.

Access to providers was discussed, including OBs, Family Medicine doctors who provide OB services, etc. Issues of patients may go out of state migration to get care (W.VA, PA, and VA). The importance of pre-conception care was emphasized and a workgroup member argued that this care often is inadequate. Some members felt the State could develop programs to educate GYNs to treat every visit as preconception care. The prevalence of obesity was noted as a complicating factor in many pregnancies.

The workgroup discussed access to obstetric services. Mr. Steffen noted that no Maryland hospitals had closed. Dr. Wood responded that several rural hospitals ended obstetrics programs in the last decade. The workgroup discussed the impact of distance to hospital plays in defining access. The workgroup discussed developing a transportation access measure. Several members pointed out that miles is not a great proxy for access since some urban populations with short distances have trouble getting to care due to congestion and lack of access to public or private transportation.

A work group member mentioned medical liability issues in the context of OB access and workforce. Dr. Wood reminded members that in rural areas family medicine physicians often deliver babies. Megan Renfrew stated that some solutions to workforce issues may be beyond the scope of this workgroup. She noted that a community health workers implementation workgroup is now underway.

Open Discussion

Megan asked group members to discuss what issues they bring to this work.

The 2011 Infant Mortality Study made it clear that we needed more resource in both urban and rural areas. That study took a life-span approach to women's health. We need to be able to use the data we have to explain to people who are not in this work every day that we need resources for home visitors, prenatal care, etc.

It is important to look beyond access to also look at quality, and as part of quality look at biases-- is the quality of care such that people trust the care they are getting?

Are behavioral health services integrated and available easily to families? Are services co-located with prenatal care?

Could we have a grid with subpopulations that we plan to focus on with and interventions that we are aware of, and suggest practical and affordable interventions that we could suggest?

It is important to build the capacity of providers that serve this population. How can we better educate these providers about the resources that are available?

There was a discussion about social determinants of health and non-medical interventions, like access to food--how do we make it easier to get families what they need? Do they need to get to a separate appointment for WIC and would it be possible to make it easier?

At the national level there is a discussion about maternal health HRSAs--even in Baltimore city, some providers have long waits for some populations.

Would one-pagers for physician education on referrals be helpful? Or, would an app be better? It is important to be able to find information for specific populations (ex. undocumented, uninsured)--what resources exist? At least one county has a prenatal clinic for the uninsured that uses a NP for the prenatal care. Could head start programs be a useful linkage, since parents with young children may have more children?

How can we better use schools and school superintendents to support this effort? Engaging with school health folks is key to preconception health. How do we talk to teens about the importance of getting good care and being in the best state of health to have kids in the school health curriculums?

Maryland has systems that don't function well (ex. prenatal risk assessment)--how do we make them electronic and make them more robust? Baltimore City is piloting electronic prenatal risk

assessment. There is a lot discussion of social determinants of health databases for resources and referrals.

Garrett and Hartford County are in a Medicaid waiver pilot--Home visiting pilot in 1115. We should take advantage of the relationships that we've built with the front line home visitors. They know the issues that the families face and have worked to connect families to somatic and behavioral health care services. This could be a good opportunity for focus groups.

Are the quality indicators in this area useful? The quality indicators often treat one prenatal visit as prenatal care and it isn't meaningful. Some quality indicators look for more visits. Preconception care may be more important than prenatal care.

Do we have data on connection between infant mortality and teen pregnancy? Yes. In some geographic locations it plays a bigger role than others.

Summary of the discussion:

1. Build on existing programs and resources, but look at resource constraints.
2. Build better integration with medical and behavioral services
3. Develop better use of data--assessment systems are not yet fully functional.
4. We heard about education as a way to reach teens and families.
5. We heard about connection to communities.

Key Analytical Steps for the project:

1. Who are we trying to reach? Who is at risk?
2. Who do we reach them and get them engaged? What sort of system/programs does this require?
3. Once we've engaged them--what determinants are we trying to impact (ex. smoking, diabetes, etc.) and how do we do that?
4. How do we monitor the data to be sure that we are making progress?

Innovation can happen at any point in this process--this is a frame of reference that applies to all subcommittee work.

In order for any this to improve, there has to be money and resources. Does the state have the will to put forth this effort?

Stress has a real impact (crime, vacant housing, etc.) on maternal health and infant mortality. Behavioral health issues are important, as are substance abuse problems (opioid epidemic). Mental health is so intertwined in both infant and maternal health outcomes. The state has to have programs so that providers have somewhere to send people. There are not a places to refer pregnant people who have an SUD and need help.

Mr. Luckner talked about the Community Health Resource Commission's Grants and relevant filing dates for applications.

Baltimore is engaged in a project to compare itself to other cities. It is useful to know per capita investment (public, private, insurance) across jurisdictions. The differences may be extraordinary.

Cost analysis (which is different), is required by the statute and will need to fall under data analysis as well.

<u>Next Steps</u>	<u>Status</u>	<u>Responsible Party</u>
Draft meeting summary	<i>Complete</i>	Megan Renfrew
Schedule Meetings for work group and subgroups	<i>Complete through December</i>	Megan Renfrew
Provide any edits or other feedback on membership list and charter		Work group members
Sign up for subgroups		Work group members (others are welcome)