

Permeant Council on Reducing Disparities in Infant Mortality

Introduction

Chapter 83 of the 2018 State Laws of Maryland requires MHCC to “make legislative recommendations regarding the establishment of a permanent council for lowering rates of disparity with respect to infant mortality”. Workgroup members agreed that it could be useful to have an organizational entity that could center public focus, action, and attention on the issue of disparities in infant mortality, to provide a plan, structure, and accountability for continuing change.

Discussion of Organizational Placement of Permanent Council

Workgroup members felt that it was important to have a centralized entity that could focus public and stakeholder attention on disparities in infant mortality. High level focused attention can be an important motivator to make change happen. However, the Permanent council should not pull resources from existing infant and maternal mortality work, but rather help coordinate existing resources and fill gaps. It is important not to duplicate work and effort.

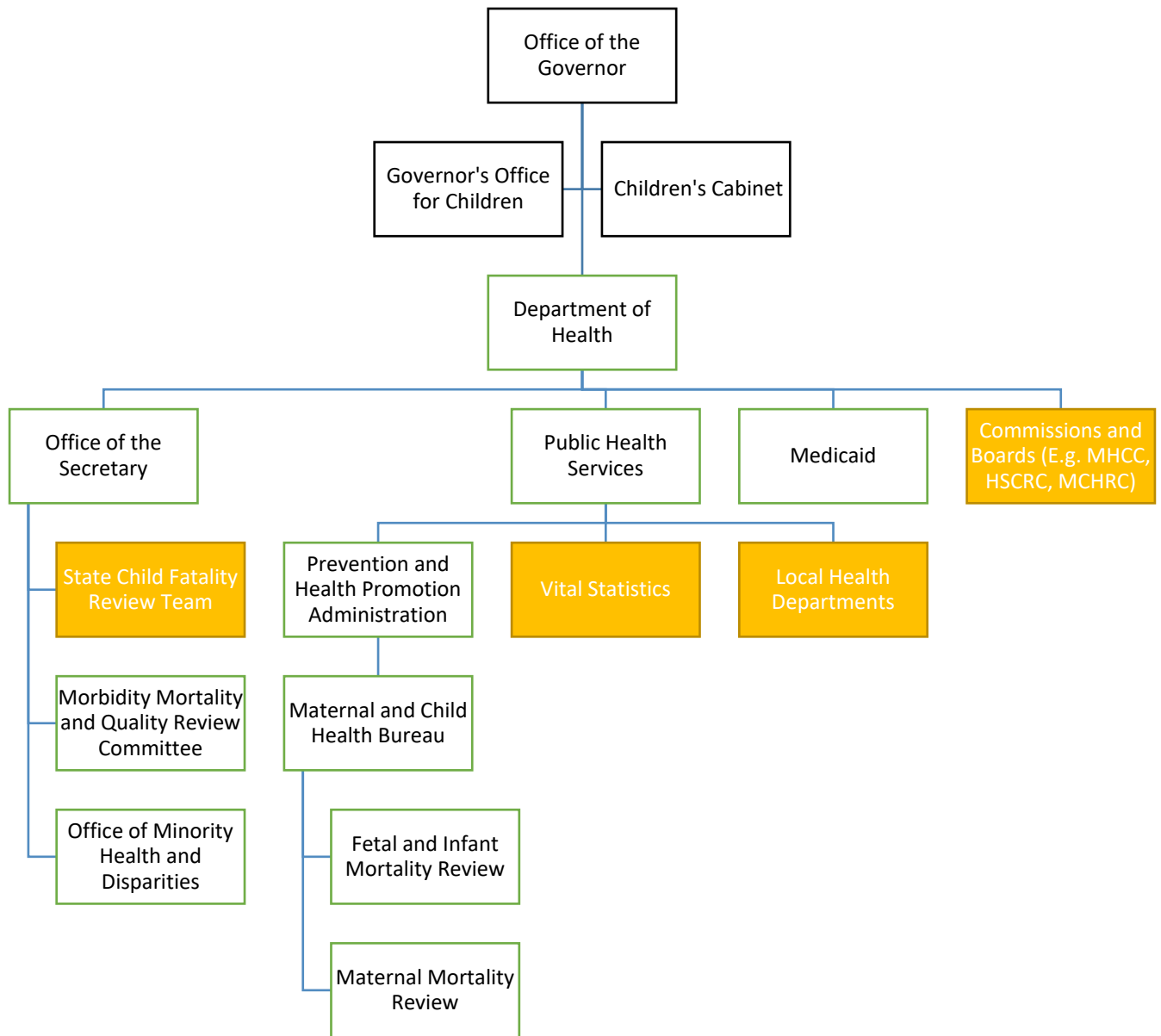
For these reasons, it is important to locate this function in a place in the organization where it can best coordinate resources and bring high level attention to the issue of disparities in infant mortality without impacting ongoing work. New funding and staff resources are likely needed for this effort, but choices about organizational placement are also important.

A number of entities already exist within the State (and local) government that have some relationship to infant mortality and infant health (see next page). These organizations include the Children’s Cabinet; the Governor’s Office for Children and several entities in the Department of Health, including the Office of Minority Health and Health Disparities and the Maternal and Child Health Bureau, which oversees the Fetal and Infant Mortality Review Teams (FIMR) and Maternal Mortality Review (MMR). The FIMR and MMR are current hubs for bringing experts together on issues related to poor birth outcomes and already have existing funding streams.

FIMR Teams are operated at the local level. While some of these teams have public reports (ex. Baltimore City has an annual public report), others do not.

The State MMR process is highly professionalized and designed to protect the privacy of individual family members. Since 2018, the MMR has been required to have bi-annual stakeholder meetings to create a process for patients, families, and other stakeholders to provide input. The State MMR has an annual public report.

Exhibit: Organizational Placement of State Entities Relevant to Infant Mortality



The Governor’s Office for Children

The Governor’s Office for Children identifies inefficiencies, duplications, and gaps in services and resources for programs and services affecting children in their families. The Office then analyzes departmental plans and budget requests; reviews federal, State, local and private funds used by and available to the State; and identifies items in the Governor's budget that affect programs and services for children and their families. In addition, the Office issues impact

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statements and makes planning and expenditure recommendations to the Governor and department heads. The Office also advises the [General Assembly](#) on the needs of youth and their families (Code Human Services Article, secs. 8-101 through 8-1004).

Eight goals for child well-being have been set for the Office by the [Children's Cabinet](#). They are defined as:

- 1) Babies Born Healthy;
- 2) Healthy Children;
- 3) Children Enter School Ready to Learn;
- 4) Children Successful in School;
- 5) Children Completing School;
- 6) Children Safe in their Families and Communities;
- 7) Stable and Economically Independent Families; and
- 8) Communities that Support Family Life.

In April 2015, the Governor assigned four initiatives to the Office. The Governor's charge was to reduce the impact of parental incarceration on children, families, and communities; improve outcomes for disconnected youth; reduce childhood hunger; and reduce youth homelessness.

Appointed by the Governor, the Executive Director chairs the Children's Cabinet and the Advisory Council to the Children's Cabinet, and serves on the Behavioral Health Advisory Council; the State Child Fatality Review Team; the State Early Childhood Advisory Council; the Children's Environmental Health and Protection Advisory Council; the Interagency Disabilities Board; the Governor's Family Violence Council; the Task Force to Study the Restraint, Searches, and Needs of Children in the Juvenile Justice System; and the Maryland Commission on Suicide Prevention.

This office contains a program called [SECOND-GENERATION STRATEGIES, YOUTH HOMELESSNESS, & RACIAL EQUITY](#) which helps plan and implement local programs that prevent youths from dropping out of school, committing crimes, and engaging in other activities which bring them into the juvenile justice system. Such prevention and diversion programs should serve youth in their communities with alternatives to incarceration and institutionalization, help youth gain self-sufficiency, accept personal responsibility for their actions, and be ready for adulthood at age 21.

[The Children's Cabinet](#)

The Children's Cabinet has 7 ex-officio members (David R. Brinkley, Secretary of Budget & Management; Carol A. Beatty, Secretary of Disabilities; Courtney G. McFadden, designee of Secretary of Health; Lourdes R. Padilla, Secretary of Human Services; Sam J. Abed, Secretary of Juvenile Services; Karen B. Salmon, Ph.D., State Superintendent of Schools) and is chaired by the executive director of the Governor's Office for Children. The Cabinet has an advisory committee of 11 members and 5 ex-officio members. The Advisory Council recommends to the Children's Cabinet ways for the State to meet the policy and program goals of its own

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programs for children and families, and how those programs can be coordinated with programs operated by local governments, local management boards, and private agencies. The Advisory Council also recommends how to create more capacity to serve youths in their communities; reduce reliance on institutions as a primary intervention for at-risk youth offenders; promote positive outcomes for youth; fund best practices to deter juvenile crime and delinquency; and reduce the disproportionate confinement of minorities (Chapter 445, Acts of 2006; Code Human Services Article, secs. 8-201 through 8-202).

Department of Health

This cabinet-level department provides public health services, Medicaid, and other health services in Maryland. The Department is led by the Secretary of Health

Office of the Secretary, Health

The Secretary of Health serves on the Children's Cabinet; the State Child Fatality Review Team and the State Early Childhood Advisory Council, and other entities. Reporting to the Secretary of Health, three deputy secretaries each have a specific area of responsibility: [Behavioral Health](#), [Developmental Disabilities](#), and [Public Health Services](#) (Code Health-General Article, sec. 2-103). The Office of Secretary also oversees five offices, including the Office of Minority Health and Health Disparities and the Maryland Primary Care Program Office. The Office is aided by the State Child Fatality Review Team; the Morbidity, Mortality, and Quality Review Committee.

State Child Fatality Review Board

The Team seeks to prevent child deaths by analyzing their causes and incidence; devising plans for change within those government agencies represented on the Team; and recommending changes in law, policy, and practice. Among other duties, the Team (in cooperation with local teams) develops protocol for child fatality investigations, including procedures for local departments of health, law enforcement, medical examiners, and social services (Code Health-General Article, secs. 5-701 through 5-709). For more information: [Child Fatality Review Team](#)

Morbidity, Mortality, and Quality Review Committee

Confidential and anonymous case reviews of morbidity and mortality associated with pregnancy, childbirth, infancy, and early childhood are conducted by the Committee. From such reviews, the Committee develops and implements interventions to improve the system of care for pregnancy, childbirth, infancy, and early childhood (Code Health-General Article, sec. 18-107).

Office of Minority Health and Health Disparities

With public and private organizations and institutions, the Office works to secure funding, administer grants, establish programs, and conduct research to reduce and eliminate racial or ethnic health care disparities in Maryland. The Office's mission is to address the social determinants of health and eliminate health disparities by leveraging the Department's resources, providing health equity consultation, impacting external communications, guiding policy decisions and influencing strategic direction on behalf of the Secretary of Health.

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Key programs include—

- Minority Outreach and Technical Assistance (MOTA), which uses Cigarette Restitution Funding to address tobacco, cancer community health coalition, cardiovascular disease, infant mortality, diabetes, obesity, cancers, and asthma in minority communities. MOTA grantees have also held Community Caucuses to bring stakeholders together to focus on community needs.
- Educating Minorities of Benefits Received after Consumer Enrollment (EMBRACE), which seeks to increase rates of health insurance, increase use of primary care services, and reduce rates of emergency department visits and hospital readmissions.
- St. Mary's Asthma Initiative, which uses community health workers and nurses to provide home-based education and support for children with asthma.
- Health disparities data analysis and reporting
- Awareness, outreach, and workforce development activities, including a newsletter, social media, an annual conference, an internship program, and technical assistance on cultural competency, health equity, health literacy, and workforce diversity.

[MHHD Overview Document](#) (brief doc that includes mission, vision, and office program highlights)

[2018 Annual Report](#)

MHHD Statutory Duties and Role: Md. HEALTH-GENERAL Code Ann. § 20-1004, § 20-1005, § 20-1006

Public Health Services

Lead by the Deputy Secretary for Public Health, Public Health Services oversees local health departments and directs three administrations: [Laboratories](#); [Prevention and Health Promotion](#); and [Vital Statistics](#). It also is responsible for the [Office of Chief Medical Examiner](#), the [Office of Health Care Quality](#), the [Office of Population Health Improvement](#), the [Office of Preparedness and Response](#), the [Office of Provider Engagement and Controlled Dangerous Substance Regulation](#), and the [State Anatomy Board](#). Public Health Services is aided by the Health and Human Services Referral Board.

Prevention and Health Promotion Administration

This administration is responsible for infectious disease, environmental health, and family health. The Administration has five bureaus: Environmental Health; Infectious Disease Epidemiology and Outbreak Response; Infectious Disease Prevention and Care Services; Maternal and Child Health; and Primary Care and Community Health.

Maternal and Child Health Bureau

The Maternal and Child Health Bureau works to improve the health of women of childbearing age and their babies. Under the Bureau are four offices; Family Planning and Home Visiting; Genetics

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and People with Special Health Care Needs; Surveillance and Quality Initiatives; and Maryland Women, Infants, and Children Food Program (WIC). The Bureau is responsible for implementing federally funded home visiting and family planning programs. The Bureau plays a key role in the Fetal Infant Mortality Reviews and Maternal Mortality Reviews, as well as other activities related to reducing infant mortality and serving pregnant women and infants.

Fetal and Infant Mortality Review Program

The goal of the [Fetal and Infant Mortality Review \(FIMR\) Program](#) is to prevent infant mortality and morbidity through the review of [fetal and infant deaths](#) in Maryland. The Maryland Department of Health's [Maternal and Child Health Bureau](#) is the lead agency for Maryland's FIMR Program. There are 18 FIMR projects in the state which represent all 24 Maryland jurisdictions. There are 16 jurisdiction level programs (Allegany, Anne Arundel, Baltimore City, Baltimore County, Calvert, Carroll, Cecil, Charles, Frederick, Garrett, Harford, Howard, Montgomery, Prince George's, St. Mary's, Washington) and two regional FIMR programs: the Lower Eastern Shore Regional FIMR (Somerset, Wicomico, and Worcester County); and the Midshore Perinatal Advisory Committee (Caroline, Dorchester, Kent, Queen Anne's, and Talbot).

Maternal Mortality Review

The Maryland Department of Health (MDH), Maternal and Child Health Bureau (MCHB) collaborates with the Department's [Vital Statistics Administration](#) to obtain vital records information for case reviews. MCHB also collaborates with [MedChi, The Maryland State Medical Society](#) to administer the Maternal Mortality Review Program. MedChi assists in obtaining medical records, abstracting cases, and hosting the Maternal Mortality Review Committee, a committee of clinical and public health experts from across the State. Since 2001, case reviews have been conducted to investigate all pregnancy-associated deaths in Maryland and identify opportunities for reduced maternal mortality. The State publishes an annual report as a result of MMR activities ([2018 Report](#)).

Beginning in 2018, the MMR includes bi-annual meetings of stakeholders. This stakeholder group reviews findings and recommendations in the annual report; examines issues resulting in disparities in maternal deaths; Review the status of implementation of previous recommendations; and identifies new recommendations with a focus on initiatives to address issues resulting in disparities in maternal deaths.

Local Health Departments

Local health departments ensure that basic public health services are provided in all parts of Maryland. Under direction of a local health officer, each local health department provides these services and administers and enforces State and local health laws and regulations in its jurisdiction. Programs meet the public health needs of the community and provide services not offered by the private sector. The local health officer is appointed jointly by the Secretary of Health and the local governing body (Code Health-General Article, secs. 3-101 through 3-405).

LOCAL MANAGEMENT BOARDS

Since 1990, each county in Maryland has been required to establish a local management board to plan, implement, and monitor child and family services. Each board determines what services are needed within the parameters of the eight Goals for Child Well-being of the [Children's Cabinet](#). Each board enters into a community partnership agreement with the

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Governor's Office for Children, which assists with training and technical assistance to develop resources, implement programs, and become fiscally accountable.

Reflecting the interagency nature of services for children and families, each board's membership must include representatives from the local health department, core service (mental health) agency, and department of social services; the local office of the [Department of Juvenile Services](#); and the county public school system. Other members representing public and private community organizations also may serve on a board (Code Human Services Article, secs. 8-301 through 8-305).

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Recommended Approach- Outline for legislative draft

Purpose

The purpose of the permanent council would be to recommend actions to mobilize and coordinate resources within the State of Maryland to create sustainable reductions in disparities in infant mortality across the State and hold State entities accountable for that change.

Duties

The permanent council shall conduct the following duties:

1. Monitor State operated and State-funded programs related to infant mortality;
2. Monitor data on infant mortality and infant health.
3. Convene meetings of community members and stakeholders
4. Create recommendations for interventions to reduce racial, ethnic, geographic, and other disparities in infant mortality in the State of Maryland;
 - a. Consider social determinates of health in creating recommendations.
 - b. Consider opportunities for administrative simplification and streamlining of programs and processes in the State to focus more resources on families and less on administration/program overlap.
5. Monitor the implementation and impact of such recommendations on reducing disparities in infant mortality;
6. Report annually to the Governor and the legislature on recommendations, implementation progress of past recommendations, and the impact of those recommendations.

In the first year, the recommendations shall include recommendations related to addressing bias in the health care system and addressing trauma in the patient population.

Membership

The council would engage--

- community leaders,
- Mothers and families
- State Agencies
 - A representative from the Office of Minority Health and Health Disparities
 - A representative from the Maternal and Child Health Bureau
 - A representative from Vital Statistics
- “On the ground” workers (e.g. lactation consultants, home visitors, doulas, and/or community health workers)
- OBs and nurse midwives

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- Faith-based organizations
- non-profits
 - A representative from the Maryland Patient Safety Center
- community organizations
- youth
- Organizations that may benefit from savings generated by actions of the council (Managed Care Organizations, insurance companies, hospitals)
- Human resources professionals.
- Experts in key social determinates of health (housing, transportation, economic development and workforce, and food access) should be included.

The make-up of the permanent council should be balanced between community workers and leaders and high level professionals and the facilitation of the group should encourage participation and value input from all parties, to avoid “over-medicalization” of the group, which can have the impact of excluding non-professional input.

Considerations for appointment. –

In deciding which individuals to appoint or nominate the Secretary shall, to the extent practicable, consider:

- i) the geographic and demographic diversity of the State;
- ii) diversity in [XXXX]; and
- iii) [INSERT ADDITIONAL CRITERIA].

Term & Removal

- (1) The term of a member of the Council is 2 years.
- (2) A member who is appointed after a term has begun serves only for the rest of the term and until a successor is appointed and qualifies.
- (3) A member may not serve more than 2 terms.”

Leadership

Elected Leadership: “(1) once every 2 years, the members shall:

- (i) Elect a chair for a term of 2 years; and
- (ii) Select an executive board that consists of 5 members

Compensation & Reimbursement

A member of the Council:

- (1) May not receive compensation as a member of the Council; but
- (2) Is entitled to reimbursement for expenses under the Standard State Travel Regulations, as provided in the State budget.

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Meetings

- b) Bi-annual Meetings: The Council shall meet at least two times each year
- c) Open Meetings: The Council shall open all meetings to the public.
- d) Quorum- A majority of the membership of the council is a quorum.
- e) Substitutes-- If a member of the council is unable to attend a meeting of the council, the member may designate another individual to attend the meeting as their designee.

Staff

The Secretary shall designate the staff necessary to support the council.

Optional authority to hire consultants—“The Advisory Council may employ consultants subject to the State budget.”

Funding

Report

Beginning [INSERT DATE], and year thereafter, the Council shall submit a report of its activities to the Governor and the General Assembly in accordance with § 2-1246 of this article.”

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Other models that could be useful in planning and drafting for the permanent council

The State Advisory Council on Health and Wellness could serve as a model for legislative text (http://mgaleg.maryland.gov/2017RS/chapters_noln/Ch_40_sb0038E.pdf). The Maryland Health Benefit Exchange has a standing advisory committee that could be a model for how to involve stakeholders (https://www.marylandhbe.com/wp-content/uploads/2014/03/SAC-Bylaws_12.19.2014.pdf). There is a social determinates of health task force in Baltimore City that could also be a useful model (<https://www.umaryland.edu/sdh-taskforce/> ; http://mgaleg.maryland.gov/2018RS/Chapters_noln/CH_708_sb0444e.pdf).

Discussion questions:

1. Should infant and maternal mortality be combined for purposes of address disparities?
2. Should “disparities” be limited to race and geography, or should other disparities (ex. income, education level, and other factors) be part of this council’s task?
3. Should the council be advisory or should it have the authority to implement programs (e.g. offer training, do outreach)?
4. How does the council fit into the structure of the State and have power to make sustained change happen? What structures and processes need to be in place to allow that to happen?
5. Council size v. breadth of membership—what members are necessary for the council v. who should the council be encourage to engage?
6. How is the council funded?