

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

April 9, 2019

Meeting Summary

Location: Maryland Health Care Commission, Room 100, 4160 Patterson Ave., Baltimore, MD. 2125, Remote Access Available.

Purpose of the meeting: Present and discuss literature review results, legislative changes from the 2019 legislative session, and updates from the Medicaid program.

Attendance (In person/phone):

Chair: Ben Steffen

Vice Chair: Noel Brathwaite

Vice Chair: Dr. Lee Woods

Hosanna Asfaw-Means (phone)

Dr. Carla Bailey

Maisha Douyon Cover

Rebecca Dineen

LaWanda Edwards

Marianne Hiles (phone)

Kristin Hiner (phone)

Lee Hurt

Sandy Kick

Mark Luckner

Dr. David Mann

Dr. Russell Moy (phone)

Dr. Lillian Norris-Holmes

Dr. Sheila Owens-Collins

Jay Parekh

Dr. Meghana Rao

Megan Renfrew

Renee Roberts

Kristin Silcox (phone)

Donna Strobino

Shanna Wideman

Andrea Williams-Muhammad
(phone)

Ben Wormser

Lara Wilson (phone)

Andy Zumbrum

UMD Contractors:

Dr. Sandra Crouse Quinn

Dr. Elaine Anderson

Dr. Jessica Gleason

Dr. Dushanka Kleinman

Dr. Marian Moser Jones

Dr. Edmond Shenassa

Deborah Quint Shelef

Agenda Item #1: Welcome, Roll Call, and Past Meeting Minutes:

Ben Steffen, Executive Director at the Maryland Health Care Commission (MHCC) and chair of the workgroup, welcomed all attendees and facilitated introductions. He reminded all in attendance that this will be an intensive process to issue a report with recommendations to the General Assembly in time for the 2020 Legislative session.

Dr. Lee Woods and Noel Brathwaite, the co-chairs of the workgroup, also provided welcoming remarks. Mr. Braithwaite noted that a report containing comprehensive infant mortality data will be provided by Dr. David Mann soon.

Meeting Summary

Mr. Steffen reminded those in attendance of the broad responsibilities under the legislation, including the need to look at programs in other countries, states, and localities that have worked to reduce infant mortality, making recommendations on the use of pregnancy navigators and community health workers to assist pregnant woman and reduce infant mortality, and to also recommend whether there is a need to establish a permanent council to address these issues. In order to accomplish this, an interagency agreement was established.

Agenda Item #2: University of Maryland SPH Introduction

Dr. Sandra Quinn introduced the group from the Department of Family Science at the University of Maryland's School of Public Health (UMD SPH). This team of contractors is working to address some of the requirements of the Study on Infant Mortality in African American Infants and Infants in Rural Communities including: reviewing risk factors, reviewing effective programs, conducting qualitative interviews, and compiling an inventory of programs in Maryland. They also will work with the state staff conducting specific data analytics projects. Over the summer, they will prepare draft reports, working with the MHCC and the work group.

A workgroup member asked whether draft surveys are available and who created them. In response, Dr. Quinn described the survey development process involving internal partners and faculty with expertise in program evaluation. These surveys are currently under review with the Institutional Review Board (IRB), but could be modified if needed.

Agenda Item #3: "Effective Programs" Literature Review Results and Discussion

Dr. Marian Moser Jones (University of Maryland) gave a presentation of the preliminary results of her team's literature review on effective programs (slides available online). The review included a full-text review of 45 articles addressing a variety of interventions. Only studies that had been evaluated in peer-reviewed literature were included in the review. The review was focused on programs within the United States, as the context is different from that in other countries, many of which have universal home visiting programs. In the US, the focus has traditionally been on prenatal care, with home visiting programs only for those at high risk of poor outcomes.

The review started with established federal programs – primarily WIC and Healthy Start – which have mixed evidence on improving outcomes in Black women and insufficient evidence on outcomes among rural programs.

Other programs with promising results were grouped into five categories:

- 1). **Home-Visiting Community Health Worker (CHW) interventions.** CHWs are not nurses or social workers. Evidence suggests CHW home visiting programs may be cost effective model of intervention. Studies have shown lower rates of preterm birth (PTB) and low birth weight (LBW), the two leading causes of infant mortality, in programs with CHW home visiting. CHW home visiting interventions appear to be as effective as interventions with nurses and social workers, and CHWs often function as part of an integrated team.

2). **Centering Pregnancy Programs.** Centering Pregnancy is a program model that already provides group prenatal care at nine sites in Maryland. The intervention is limited to low-risk women, and includes group visits with Certified Nurse Midwives or OBGYNs, as well as self-assessment and education. Studies have shown reduced PTB among Black participants, and also reduction in PTB in rural areas of Georgia. However, this intervention requires a large investment and does not address the needs of women with high risk pregnancies.

3). **Behavioral Interventions.** A subset of programs targeted behavioral interventions (including issues like depression, intimate partner violence (IPV), and smoking cessation) for both African American and rural women. One drawback is the need for trained mental health professionals to supervise paraprofessionals. Another drawback is that interventions that only provided education increased knowledge but did not lead to significant behavior changes.

4). **Community-based Interventions.** The majority of community-based interventions were focused on providing education, connecting individuals to resources, and increasing knowledge of different topics. One example was the Safe Sleep program that encourages having babies sleep on their backs. Another is the Sisters United program that engages women from African American sororities to act as volunteer/mentors to other women. In rural areas, the program, Becoming a Mom/Comenzando Bien, was implemented by the March of Dimes in rural Texas and has worked well.

5.) **mHealth and Telemedicine Programs.** Newer mHealth and telemedicine programs included some promising approaches, particular in rural areas. Telemedicine would involve pregnant women engaging in video chats with medical specialists. mHealth involves combinations of messages and videos sent via email or text to new mothers.

Workgroup Discussion of Presentation

Members of the work group introduced additional areas of possible inquiry; including looking at what combinations of programs work together. Dr. Moser-Jones agreed that looking at combinations of programs would be useful, but that is not how the literature (or the literature review) is structured--most academic literature focuses on testing individual interventions. Mr. Steffen indicated his interest in looking at “compound” interventions and complementary initiatives. The Quality literature may have some frameworks that could help determine effectiveness for multiple interventions.

Additional programs were mentioned including a Texas program that focused on maternal and infant mortality; a program in Ohio that highlighted the benefits of administering 17-hydroxy progesterone shots to reduce PTB; and a study in Memphis focusing narrowly on teen moms and establishing peer networks. Initiatives featuring nurse-family partnerships in Garrett and Prince George’s County were also discussed. Workgroup members promised to send information on these programs to Ms. Renfrew.

Group members also introduced general themes that were not specific to existing programs but important to consider in general. Among them was the importance of regionalization, as it is

Meeting Summary

important that babies are born into facilities that can care for them. Another was the need to consider high-risk factors for mothers including mental health issues, intellectual disabilities, and possible histories of abuse. The workgroup also discussed whether it would be useful to look at the use of prenatal home visits to help reduce PTB, as most home visiting programs focus on post-birth outcomes.

As a practical consideration for the final report, Mr. Brathwaite requests a table of when the interventions were implemented (year) and the sample size.

In conclusion, the workgroup introduced two big picture goals: first, to identify the gaps in the system as a whole, and second, to find ways to link resources to individuals. On the first point, rather than thinking about specific programs, it may be better to think of the gaps in existing services and devote resources to filling those gaps. Second, connecting individuals to existing resources can be a challenge. It may be helpful to have a single source that shows all existing services and how to refer individuals to each service.

Agenda Item #4: “Risk Factors” Literature Review Results and Discussion

Dr. Edmond Shenassa (University of Maryland) presented this literature review (materials on the MHCC website). He began by emphasizing that the work is preliminary and undergoing revisions. The presentation began by highlighting the dramatic decreases in infant mortality overall, but how these declines may mask racial disparities between Black and White infants. First reported in 1968/69, disparities in infant mortality remain profound and persistent today.

He presented background on the literature review. First, all peer-reviewed literature was considered; however, studies that controlled for race or that looked at race as a risk factor were excluded. Second, he used the eco-social perspective as a frame. It is important to recognize that the construct of race comes from heavy historic context. Race is a complicated subject, and a historically weighted variable with biological implications.

Dr. Shenassa started by discussing the individual risk factors, including the known causes of infant mortality that are featured in the most research: PTB, LBW, sleep positions, and accidents. Other studies looked at maternal health status (like BMI, age, parity, depressive symptoms), maternal health behaviors (like smoking, prenatal care, pregnancy intentions), or maternal demographics (education, income, marital status, etc.). Compared with White Americans, African Americans present with more risks, often at more advanced stages, which begs the question, “Why do Black women present with more risk than White women?”

Beyond individual-level determinants of infant mortality, the literature highlights the importance of structural factors that determine access to health promoting resources within communities. These structural determinants of health drive racial-ethnic *disparities* in infant mortality and not individual-level risk factors. He used the example of maternal and child health outcomes across Baltimore neighborhoods to illustrate. This raises the larger question, “Why should race operate differently for two people in the same county?” Answers include income inequality, as studies have shown that increasing income inequality corresponds to increases in disparities. Another issue could be racial bias in research.

Meeting Summary

Many studies used a risk factor approach. For researchers, it is important to consider the sensitivity and specificity by which risks can be identified. It is also important to consider the prevalence of risk factors in the population. Low-risk individuals were associated with nearly as much infant mortality than the much smaller population of high risk individuals. For instance, roughly 40% of women who give birth before 37 weeks have had no individual risk factors. This is one reason why social epidemiologists are moving away from the risk factor approach.

He discussed limitations of this report. As a scoping review, it provides a broad picture of work during a particular period but do not consider earlier seminal works. Additional limitations include the lack of literature assessing interactions across levels of influence, and a lack of studies focused on residents of rural communities. His team will add in an assessment of quality of included studies.

To conclude, he returned to a central issue: determining why infants die does not address why more Black infants die than White infants. Structural determinants of health appear to be driving racial/ethnic disparities in infant mortality and non-individual level risk factors. It is most efficient for programs to be available to the entire community because the vastly higher number of low risk individuals produce more infant mortality than the much smaller population of high risk individuals.

Questions/Comments:

The workgroup members raised several issues to consider. When considering poor birth outcomes among African American women from high income families with high educational levels, it will be important to look at the role of comorbidities, particularly biologic responses to stressors. It is also important to consider congenital anomalies, a top cause of infant mortality. Other issues include the role of adverse childhood experiences among mothers, and miscarriages, including among women receiving prenatal care.

The importance of acknowledging mothers' losses was raised. Any discussion of infant mortality needs to acknowledge women who have experienced this loss and how to connect them to the services they need.

Mr. Steffen asked workgroup to think about the conclusion that any intervention should target all women, given the extent of structural issues. Ms. Renfrew urged the workgroup to direct further questions to her.

Agenda Item #5: Update on Infant and Maternal Mortality Related Bills from the 2019 Maryland Legislative Session

As the meeting ran long, the planned discussion of legislation updates was skipped, but a slide deck was provided and is available online for review. Ms. Renfrew offered to provide copies of bills to anyone interested.

Agenda Item #6: Medicaid Updates: 1115 Waiver Amendment and Application for Maternal Opioid Misuse (MOM) Model

Meeting Summary

Sandy Kick, a staff member in the Maryland Medicaid Office of Innovation, Research, and Development provided updates related to the Medicaid Program. The Centers for Medicare and Medicaid Services (CMS) approved a 5-year renewal of Maryland's 1115 Demonstration which allows for the operation of the Health Choice program, which includes 9 managed care organizations (MCOs). This included an amendment to the 1115 agreement to allow the State to implement the national diabetes prevention program to be conducted state-wide, effective July 1, 2019. A demonstration of this project was just completed, focusing lifestyle change programs for adults with prediabetes or at high risk for Type 2 diabetes. Lifestyle coaches (lay health workers) will offer programs at churches, clinics, etc. This test effectively lowered rates of conversion to diabetes. This plan will be offered in-person and virtually. Early results from the pilot of the virtual program showed high satisfaction and results.

Effective April 1st, a new initiative introduces a limited pilot of dental services for adults, aged 18-64 who are dually eligible in Medicare and Medicaid.

Two community health programs have also been pilot tested. The first is focused on home-visiting. The second is based on providing housing support. Based on stakeholder requests, the program will be doubled in size. A third round of case management services will also be implemented to assist with getting into housing and staying in housing.

Finally, a family planning program was discussed including pregnancy coverage for a full 12 months of family planning following a 2 month postpartum period, for those living at less than 200% of the Federal Poverty Level.

Medicaid staff are also currently working on two large federal grants related to the **Maternal Opioid Misuse Model (MOM)**. State Medicaid programs can apply for funding through CMMI as multi-prong strategy to address opioid crisis. This grant would also allow states to develop and implement innovative payment models to address fragmented care for women postpartum (health, social determinants, etc.). The goal is to improve quality of care and reduce expenses, increase access to treatment, and create sustainable coverage and payment strategies. If successful, the grants would be for 5 years and would rely on MCOs as care delivery partners. The grant application will be submitted in May, and the State will receive a response in November.

Agenda Item #7: Public Comment

Not discussed.

Agenda Item #8: Next Steps and Review of Key Deadlines

A reminder that the next large workgroup meeting will be June 4, from 1:00-3:00 pm. It will include a discussion on a permanent council and risks factors. More frequent meetings will begin in July. Subgroup meetings are currently on hold but may be brought back.

Action Items and next steps:

Meeting Summary

- Draft notes from January meeting are posted on the MHCC website– please review (including attendance) and get feedback by Friday 4/12/19. [Final January meeting minutes have been posted online]
- Any additional comments regarding the draft literature reviews can be directed to Ms. Renfrew.
- Mr. Steffen asked for thoughts about how programs could be combined to eliminate gaps and improve outcomes, as well as thoughts on risk factor discussion.