the Maryland Commission on Infant Mortality Prevention – 1993 Annual Report

CONTENTS

BACKGROUND ............................................. page 1
HIGHLIGHTS ............................................. page 2
SUMMARY ................................................. page 8
RECOMMENDATIONS ................................. page 9
THE COMMISSION ................................. page 10

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Dear Governor Schaefer and Special Secretary Grasmick:

The Maryland Commission on Infant Mortality Prevention is pleased to present its 1993 Annual Report. Among our accomplishments, we developed draft legislation which would require state-owned and state-funded substance abuse treatment programs to establish priority slots for pregnant and postpartum women. This legislation was successfully submitted by legislative members of the Commission and became law in May 1993.

To improve pregnant women’s access to prenatal care, especially those at highest risk for poor birth outcomes, the Commission played an instrumental role in establishing the first ever pilot regionalized high-risk clinic on the Eastern Shore. In addition, the Commission has continued working with the private sector in an effort to raise awareness of infant mortality prevention among working women.

We would like to thank all of the distinguished members of the Commission for their hard work and dedication. It has been a true honor to work with each of them and witness their dedication in improving the health prospects of Maryland’s infants. As we continue to build on our strong foundation to prevent infant deaths in Maryland, we urge the citizens of Maryland to continue to support our efforts. We all have a stake in the healthy births of today’s infants—they are our future.

Sincerely,

Samuel C. Schwab, Chairman

Carol Ann Baglin, Executive Director
BACKGROUND

Infant mortality is a major problem with socioeconomic implications. Infant mortality occurs when an infant dies within the first year of life. The leading cause of infant mortality is associated with low birthweight (5.5 lbs. or less at birth) which can often be prevented with early and continuous prenatal care. Despite the existence of a highly sophisticated medical system, the United States ranked 20th out of 23 developed countries in UNICEF's 1990 study. However, there has been a declining trend in infant deaths. From 1985 to 1990, infant mortality dropped 13.2 percent on the national level based on figures from Maryland's 1990 Vital Statistics Report. The number of deaths among African-Americans continues to increase nationally while the deaths among white infants decreased (Washington Post, 1993).

Maryland has followed the national trend of recent decreases in infant mortality with a 19.4 percent decline in infants deaths from 1985 through 1990 according to Maryland's 1990 Vital Statistics Report. In 1990, Maryland ranked thirty-one out of all fifty states for its infant mortality rate based on a 1990 March of Dimes study (Evening Sun, 1993). African-American infant mortality rate remains more than twice as high as the rate for White infants.

In 1991, the Maryland General Assembly created the Maryland Commission on Infant Mortality Prevention to analyze the State's infant mortality problem and develop a prevention plan. The twenty-member Commission includes members of the General Assembly, the State Superintendent of Schools, the Secretary of Human Resources, the Chief of Maternal Health and Family Planning, representatives from state government and the business community, and experts in the field of infant and maternal health. The twenty member Commission has established the Perinatal Data Surveillance, Access to Care, Public Awareness & Community Education and the Infant Mortality Review committees to analyze individual factors contributing to infant mortality. In its second year of existence, the Maryland Commission on Infant Mortality Prevention has begun to address key issues identified from its first year assessment of Maryland's infant mortality problem as part of a comprehensive statewide prevention plan.

Briefly, state law charges the Maryland Commission on Infant Mortality Prevention to:

- establish a region-based perinatal system of maternal and infant health by developing a strategic infant mortality prevention plan and community-based programs, monitoring existing prevention programs, recommending legislative initiatives, and advising local governments and health providers on the condition of infant mortality in their region.

- build relationships with private health care providers, legislators, grassroots groups, businesses and other concerned groups in order to assure them that all pregnant women and teenagers receive necessary prenatal care.
launch a statewide multimedia campaign to educate the public about the problem of low birthweight babies, the importance of prenatal care and other factors which lead to infant mortality.

recommend that community incentive grants for infant mortality prevention be awarded to innovative community programs that have demonstrated a high level of commitment to prevention.

**HIGHLIGHTS**

- The Commission, University of Maryland, School of Medicine and the Maryland Department of Health and Mental Hygiene established the first ever regionalized high-risk obstetric clinic on the Eastern Shore with the goal of providing high-risk pregnant women with the primary portion of their prenatal care on the Eastern Shore.

- State Senate Barbara Hoffman and Delegate Marsha Perry successfully sponsored legislation on behalf of the Commission which mandates that state-owned and state-funded substance abuse treatment centers establish treatment priority slots for pregnant and postpartum women. Treatment centers must prove that they have such priority slots in their grant applications to the State. The Governor signed this legislation into law in May 1993.

- The Commission has continued working to improve Maryland’s Vital Records system to ensure that accurate and complete data is available in a timely fashion for data analysis. The Commission made several recommendations to the Maryland Department of Health & Mental Hygiene which included hiring a manager with extensive experience in vital records and data collection for Maryland’s Vital Records. As a result, a Research Statistician has been hired to manage the Vital Records system.

- The Commission has also recommended that improvement of 1993 vital statistics be a top priority and it has continued to support the introduction of the electronic birth certificate as an effective means of producing timely and accurate birth data.

- The Commission has supported the Field Representative program at the Maryland Department of Health & Mental Hygiene which provides staff to work with hospitals and doctors to explain their respective responsibilities for filling out birth certificates and submitting them to the Office of Vital Records. This program will work to ensure that hospitals and physicians are complying with Maryland’s birth registration law which will ultimately provide timely and accurate birth data.

- The Baltimore Community Foundation awarded the Commission a grant to implement the Business & Industry Initiative with the goal of educating employee benefits officers about infant
mortality and prevention strategies. Goals for the Business & Industry Initiative involve surveying Maryland businesses to determine if their benefits packages and company policies promote healthy pregnancy outcomes and educating businesses about how to promote prenatal health through a newsletter series, fact sheets, and presentations before business groups.

- The Commission successfully lobbied Maryland Medicaid to formally request participation in the feasibility study for the Multi-State Medicaid Reciprocity program which would create an interstate compact whereby agreeing states would honor Medicaid cards of migrant farm workers regardless of which state initially registered the worker. This program would ensure that pregnant migrant workers have access to medical care as they move from state to state.

- In 1992, the Commission identified the Brooklyn Park-Curtis Bay community as a high infant morality area in the State which enabled the Anne Arundel County Health Department to receive a $30,000 grant from CIGNA to implement a pilot project for "Healthy Generations," a home visiting and community outreach program for at-risk pregnant women and infants. The program has been effective in identifying pregnant women and linking them to prenatal care and connecting at-risk infants to preventative care.

- During 1993, the Maryland Commission on Infant Mortality Prevention focused on central issues that have the potential to significantly improve the quality of maternal and infant care available in Maryland. These issues include regionalization of high-risk obstetrical care, substance abuse treatment for pregnant women, and continued efforts to raise awareness about infant mortality and the importance of prenatal care among target populations in Maryland.

Regionalization of High-Risk Obstetrical Care

In 1992, the Maryland Commission on Infant Mortality Prevention recommended that the State support the proposed pilot regionalized high-risk obstetric clinic on the Mid-Eastern Shore (Talbot, Caroline, Queen Anne, Kent and Dorchester counties) as part of a larger goal to ultimately expand regionalization statewide. Regionalization involves "development within a geographical area, of a coordinated, cooperative system of maternal and perinatal health care in which by mutual agreement between hospitals and physicians and based upon population needs, the complexity of maternal and perinatal health care each hospital is capable of providing is identified so as to accomplish the following objectives:

1. quality care to all pregnant women and newborns,
2. maximal utilization of highly trained perinatal personnel and intensive care facilities, and
3. assurances of reasonable cost effectiveness" (March of Dimes, 1976).

Regionalization has been proven to significantly improve birth outcomes by establishing a system of identifying a patient's risk for a healthy birth outcomes and linking a patient with
health care providers and facilities capable of providing the appropriate level of care. It facilitates continuing education for community health care professionals on how to better manage moderate to high-risk patient care. Patients benefit with regionalized care because they are able to receive the appropriate level of care in their communities which improves the likelihood that the patient will seek care and continue it throughout pregnancy. Regionalization also improves maternal and infant transport systems by creating a partnership between local hospitals and physicians and tertiary care centers. In essence, it reduces the fragmentation in the existing health care system.

High-risk Clinic: In July of this year, the Commission along with the University of Maryland, School of Medicine and the Department of Health and Mental Hygiene officially established a weekly regionalized high-risk obstetric clinic on the Mid-Eastern Shore with maternal-fetal medicine specialists (high-risk obstetricians) seeing certain patients and convening High Risk Conferences monthly. This region was chosen as the site of the pilot project because the existing health care system lacked high-risk patient care facilities in the community which resulted in high-risk patients traveling to Baltimore City for the primary portion of their prenatal care. This system was ineffective in providing pregnant women who were at the highest risk for a poor birth outcome with proper medical care.

The goal of the Eastern Shore Regionalized High-Risk clinic is to provide a more effective, coordinated public health system for high-risk pregnant women that includes establishing protocols of prenatal care for common complications during pregnancy, developing a list of risk factors for referral to the regionalized high-risk clinic and referral to a tertiary care center in Baltimore City. The major advantages of the regionalization project are that it creates a strong linkage between the clinic on the Eastern Shore and a tertiary care center in Baltimore City which will result in a more coordinated maternal and neonatal referral network and it will result in pregnant women who are at the highest risk of a poor birth outcome to be able to receive high-risk obstetric care primarily on the Eastern Shore.

Needs Assessment: At the onset of the project, the Commission sponsored a study and evaluation (needs assessment) of the existing medical system on the Mid-Eastern Shore to identify social and medical factors which may be contributing to poor birth outcomes and acting as barriers to pregnant women obtaining prenatal care. Major findings from the study revealed that lack of transportation was the main reason for missed prenatal care appointments. The need for a clear, universal definition of high risk for a poor pregnancy outcome among health care professionals and the need for uniform treatment protocols within the region and the inability for pregnant women who obtain prenatal care through the local health department to receive emergency care during weekend and after clinic hours from health department staff were major medical factors, contributing to inadequate maternal health care on the Eastern Shore.
**Risk Assessment Tool:** To create a true system of regionalized obstetric care, community health care providers needed to identify patients as low, moderate, and high risk with use of a formal risk assessment tool. Then, a list of medical risk factors requiring consultation at the high-risk clinic and at the tertiary center needed to be developed. At this time, an existing list of medical conditions requiring consultation is being expanded and altered. A major advantage of developing both the risk assessment tool and list of risk factors is that high-risk women are immediately identified and referred to the appropriate level of care on the Eastern Shore. Only the highest risk patients would require referral to tertiary care centers in Baltipore City which reduces the amount of fragmentation in the overall health system on the Eastern Shore.

**Outpatient Record System:** To facilitate a coordinated system of patient care, it will be necessary to develop a common outpatient record system for the region so that patient records can be easily accessed by physicians at the high-risk clinic, local health department clinics and at the tertiary care centers. The existing outpatient record system is being used while new computerized record systems are being evaluated.

**Protocols:** Protocols for prenatal care of patients with common complications are being developed and established. It is necessary for a standard level of care to be given to women with certain complications to increase the probability for a positive pregnancy outcome. A system of standardized care will ensure that patients with the same complications receive the same level of care from providers on the Eastern Shore and will give local physicians confidence in treating high-risk patients. New protocols for prenatal care have begun emerging from education conferences with physicians and daily patient care while existing protocols are being expanded.

**Training:** To facilitate continuing education for local health care providers in high-risk patient care, maternal-fetal specialists from the tertiary care center provide on-site patient consultation and continuing education conferences twice a month at the high-risk clinic. At these conferences, local physicians introduce high-risk patients and seek advice on the best method of treatment from the maternal-fetal specialists which establishes ad hoc protocols of prenatal care for common complications and educates local health care providers on high-risk patient care. Neonatologists have also been invited to participate in high-risk patient consultation conferences.

**Data Analysis:** To evaluate the effectiveness of the regionalization project, there will be data analysis to determine if the number of infant deaths, low birthweight births, and maternal death as a result of complications during childbirth have decreased since initiation of the pilot project. Through this pilot project, a model of regionalized high-risk care will emerge which could be replicated in any region of the State with only minor community-specific modifications.
Substance Abuse Treatment for Pregnant Women

During its first year, the Commission studied the problem of substance abuse during pregnancy extensively since infants exposed to drugs in utero are at a greater risk of being low birthweight and having developmental and behavioral problems. Historically, substance abuse treatment programs have been designed for men. Too many programs have been reluctant to admit pregnant women out of fear of potential medical liability for medical complications. To encourage treatment programs to admit pregnant women, Commission members State Senator Barbara Hoffman and State Delegate Marsha Perry sponsored legislation that would require state-funded treatment programs to establish priority slots for pregnant and postpartum women up to one year. Treatment programs would be required to show evidence of priority slots as part of their grant funding application to the Alcohol and Drug Administration. The Governor signed this legislation into law in May.

The major benefits of this law are that it mandates treatment programs to recognize substance abuse during pregnancy as an emergency condition deserving prompt action since there are two lives at stake and it holds treatment programs accountable to providing priority slots. In essence, this law gives pregnant women greater access to treatment, which will ultimately improve the likelihood for a healthier pregnancy outcome and gives postpartum women and their babies a chance at a drug-free life.

Public Awareness and Community Education

Educating Marylanders about infant mortality and the importance of prenatal care is an important part of the Commission’s prevention efforts. The business community can play a pivotal role in educating the community about the importance of prenatal care. In October 1992, the Commission, in partnership with CIGNA Corporation, convened a Corporate Summit for Children in order to address infant mortality among working women. This was the first major meeting between government representatives and business leaders about infant mortality prevention in the State.

As a follow-up to the corporate summit and to strengthen our partnership with the business community, the Commission applied for and received grant funding from the Baltimore Community Foundation to implement the Business & Industry Initiative. The goal of this initiative is to educate human resource professionals about infant mortality and its prevention and to encourage them to adopt company policies and benefits packages that promote healthy pregnancy outcomes through a newsletter series, fact sheets, and presentations before business groups. The Commission hopes to reach 1200 human resource professionals from large and small companies in the State through its partnership with the Chesapeake Human Resources Association. An initial component of this initiative involved surveying human resource professionals to determine if their employers had policies and benefits in place that promoted...
healthy births among employees. Preliminary survey results indicate that many of Maryland businesses do have special programs such as dissemination of prenatal health promotion materials to their employees, prenatal health education seminars, liberal leave for prenatal doctor visits, etc. in place to encourage healthy birth outcomes.

To address the rising incidence of infant deaths among African-American infants, the Commission has developed a brochure designed to educate African-American women about how unhealthy life-style choices and certain medical conditions could place them at higher risk for a low birthweight birth. An important part of this brochure is to provide information on how to get prenatal care, substance abuse treatment, and WIC services. The Commission hopes to have this brochure printed in 1994 and distributed in Baltimore City, Allegany County and the Eastern Shore counties participating in the regionalization project.

**Perinatal Data Surveillance**

The Commission believes Maryland must produce accurate and timely data on infant births, deaths, and prenatal care. A major goal of the Commission, through the Perinatal Data Surveillance Committee, has been to work jointly with the Department of Health and Mental Hygiene's Office of Vital Statistics to improve Maryland's data system. At this point, the Commission continues to work with the Office of Vital Statistics to ensure that data for 1992 and 1993 will be complete, accurate and available for public health planning purposes. Unfortunately, the Maryland's Vital Records system continues to be inadequate. Data are not produced in a timely manner and significant information is missing which severely hampers analysis and definition of the infant mortality problem. Accurate and timely data are necessary for the Commission to realistically define the scope of Maryland's infant mortality problem, develop comprehensive prevention efforts and finally, evaluate the effectiveness of existing prevention efforts in reducing the number of infant deaths.

The Perinatal Data Surveillance Committee has began establishing an important relationship with Office of Vital Statistics from the District of Columbia since there are a number of Maryland residents giving birth in the District and vice versa. It was also important to learn about the structure of other data systems which will ultimately help the Commission propose additional recommendations for improving the State’s system based on successful methods used in other jurisdictions. This meeting also helped the Commission determine if there were a significant number of Maryland residents giving birth and Maryland infants dying in the District and the impact of these events on the accurate and timely collection of Maryland. The Committee concluded that events occurring in the District have little impact on the accurate and timely collection of births and deaths occurring to Maryland residents in the District since these data are forwarded to Maryland’s Office of Vital Statistics within a short time period.
After a review of the electronic birth certificate system, the Commission has supported efforts to introduce this system in Maryland. This review included monitoring the results of the pilot project launched earlier this year by Vital Statistics, investigating the impact of the electronic birth certificate in other states in terms of accuracy of birth information, and possible changes to birth registration law. The Commission has also supported the Field Representative Program because it allows staff from the Office of Vital Statistics to work directly with hospitals and physicians to reeducate them about specific provisions pertaining to them in Maryland's birth registration law and the importance of providing complete and accurate medical information on birth certificates.

The Commission has also been evaluating Maryland's birth registration law to determine if it facilitates accurate reporting of births in Maryland. Factors being reviewed include the requirement for doctors to sign the birth certificate, the need for the mother to sign the birth certificate, and the responsibility of the doctor or medical clerk to fill out the medical information sections. Possible legislation or regulations regarding Maryland's birth registration law are still under consideration.

The Commission continues to support the Healthy Start program in Baltimore City. As an urban center, Baltimore City has one of the highest infant mortality rates in the State which resulted in the Federal government selecting Baltimore as one of fifteen cities nationwide to receive a multimillion dollar grant to design and implement a comprehensive infant mortality prevention program over five years. Baltimore's Healthy Start program has established sites in the eastern and western areas of the city where clients will receive prenatal care, family planning, WIC registration, pediatric care, nutrition education, and male involvement. The Perinatal Data Surveillance Committee recently recommended that staff from the data division of Healthy Start work more closely with the Maryland Office of Vital Statistics to address the need for quarterly data reports for analysis.

**Summary**

The Commission remains committed to reducing infant mortality in Maryland. Infant mortality is a complex issue with social, economic and medical implications which requires comprehensive prevention efforts to ensure that all pregnant women in Maryland have access to prenatal care for a healthy birth outcome.
RECOMMENDATIONS

Primary
1. Maryland should require the Maryland Department of Health and Mental Hygiene's Office of Vital Records to produce complete data on a quarterly basis to ensure the timely release of data for analysis, evaluation and community health planning purposes beginning with 1992 data.

2. Maryland should continue to support and offer technical assistance for the pilot regionalized high-risk clinic on the Mid-Eastern Shore region. Regionalization should be expanded to the entire Eastern Shore in 1994-1995. The necessary record and communication systems must be implemented on a limited basis.

3. There needs to be increased efforts to augment the number of substance abuse treatment slots available to pregnant women with provisions for their dependents.

Secondary
4. Maryland should continue efforts in Medical Assistance reform to extend the coverage for mothers to one year postpartum and to streamline the application process for assistance programs.

5. Alcohol and tobacco significantly and conclusively contribute to the incidence of low birthweight babies and hence, infant mortality. The Commission recommends that these facts be strongly considered in any action the Legislature takes in respect to these products.

6. There should be an investigation into how prenatal, delivery and postpartum care for uninsured women can be publicly funded.

7. The Department of Mental Health and Hygiene, with cooperation and involvement from local health departments should initiate a study of infant mortality and neonatal morbidity to gain information for the design and implementation of effective intervention programs in respect to unique local needs.

8. Maryland should upgrade its death certificate recordation system to national computerized standards to ensure that timely and accurate data is available for assessment of the health needs of the State.

9. Maryland should continue to support the Primary Prevention Initiative (PPI) instituted by the Maryland Department of Human Resources which provides a special $14 monthly nutritional allowance for pregnant recipients who obtain prenatal care and requires recipients of Aid to Families with Dependent Children (AFDC) to receive regular checkups for their infants.
THE COMMISSION

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