

## ADVERSE BIRTH OUTCOMES DISPARITIES RECOMMENDATIONS

The Governor’s Interagency Council on Health Disparities has identified three recommendations for the Legislature and state agencies to reduce disparities in adverse birth outcomes:

- **Support community-driven approaches**
- **Enhance the First Steps program**
- **Promote equity in state government**

More detailed information on these recommendations begins on page 5.

### Persisting Disparities

In 2011, 387 infants died in their first year of life in Washington State. These deaths were not shared across the population uniformly. Infants whose mothers were American Indian/Alaska Native were more than three times likely to die than infants born to Asian mothers and more than two times likely to die than infants born to White mothers. Infants of Black mothers also had higher infant mortality<sup>i</sup> than those born to Asians or Whites. Infants of Pacific Islander and Hispanic mothers had elevated rates compared to those of Asians.<sup>1</sup> In general, disparities persist even after controlling for factors such as income, education, and socio-economic status. While the infant mortality rate has been declining in Washington during the last decade, the rate among American Indians/Alaska Natives has been increasing.<sup>2</sup>

Leading causes of infant death in Washington are birth defects, Sudden Infant Death Syndrome (SIDS), and preterm birth.<sup>3</sup> Babies born with very low birthweight<sup>ii</sup> are usually very premature. From 2009-2011, very low birthweight babies accounted for 1% of births yet made up 42% of all infant deaths in the state. Disparities in low birthweight and very low birthweight rates exist for all racial/ethnic groups, with rates being twice as high for African Americans as for Whites.<sup>4</sup> Risk factors that contribute to the many causes of infant mortality include social isolation, poverty, smoking and other substance use during pregnancy, and maternal stress, among others. Preconception care, early and continuous prenatal care, and family planning are important strategies for preventing adverse birth outcomes. Disparities in receiving first trimester prenatal care<sup>iii</sup> exist for American Indian/Alaska Native, Black, Pacific Islander and Hispanic women.<sup>5</sup>

### A Statewide Priority

Infant mortality is a marker of a society’s overall health, serving as an indicator of underlying issues like poor access to and quality of healthcare services and health inequity. As such, it is an important indicator in Results Washington<sup>6</sup> and decreasing disparities in low birthweight is one specific objective.

#### Results Washington Indicator:

Decrease the percentage of infants born with low birthweight among Blacks from 9.6% in 2011 to 9.3% in 2016 and among American Indian and Alaska Native populations from 8.7% in 2011 to 8.5% in 2016.

<sup>i</sup> Infant mortality is the death of a child under one year of age.

<sup>ii</sup> Very low birthweight is less than 3 pounds, 5 ounces. Low birthweight is less than 5 pounds, 8 ounces.

<sup>iii</sup> Prenatal care is comprehensive health care provided during pregnancy.

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There are many ongoing statewide activities aimed at promoting healthy birth outcomes. Just a few examples include:

- **Safe Deliveries Roadmap.** Led by the Washington State Hospital Association, this public-private partnership aims to improve healthcare quality during pre-pregnancy, pregnancy, labor management, and postpartum.
- **Infant Mortality CoIIN.** National effort to reduce infant mortality and improve birth outcomes across the nation. The Washington CoIIN Collaboration is supporting the Safe Deliveries Roadmap, exploring the influence of substance use and abuse on various causes of infant mortality, and identifying gaps, barriers, and potential strategies.
- **Healthier Washington.** Initiative based on the Washington State Health Care Innovation Plan. Related performance measures include unintended pregnancies and prevalence of cesarean-section for women delivering their first baby (singleton) at term and head-down.
- **Bree Collaborative.** Public-private initiative to improve healthcare quality, outcomes, and cost effectiveness. Related goals include eliminating all elective deliveries before the 39<sup>th</sup> week of pregnancy (when not medically necessary), decreasing elective inductions of labor between 39 and up to 41 weeks, and decreasing variation among Washington hospitals in the cesarean-section rate for women who have never had a cesarean-section.
- **Tribal Maternal-Infant Health Strategic Plan.** Created by the American Indian Health Commission, the Tribal Maternal-Infant Health Strategic Plan sets goals, objectives, and strategies to bring American Indians to parity with the total population in Washington State for maternal and infant health. It also suggests model programs and promising practices to carry out the strategies.
- **Apple Health Performance Improvement Plan.** Apple Health’s external quality review organization, Qualis Health is in the process of developing a performance improvement plan for the Apple Health Managed Care Plans to reduce low birthweight in the African American and American Indian/Alaska Native populations.

In recognition of the significant and persisting disparities in adverse birth outcomes that exist in the state and out of a desire to align its work with Results Washington, the Governor’s Interagency Council on Health Disparities selected adverse birth outcomes as a priority health topic. In selecting it as a priority, the Council expects to add value to ongoing state efforts to reduce infant mortality by focusing on recommendations for state actions to promote equitable birth outcomes and reduce disparities. The Council strongly believes that investment in maternal health, before a woman becomes pregnant, and infant health up to age one, will help put all Washington children on a path to lifelong health and success.

**Adverse Birth Outcomes Disparities Advisory Committee**

On February 12, 2015, the Council convened an advisory committee to assist with developing recommendations to eliminate disparities in infant mortality, low birthweight, and other adverse birth outcomes. The committee met six times from February through April 2015. Committee members represented community-based organizations and coalitions, health care providers, state and local governmental organizations, and other nonprofit organizations. Table 1 includes a list of committee members.

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The committee reviewed statewide data, including perinatal periods of risk analyses, and received briefings on current activities at the national, state, and local levels to reduce infant mortality and promote healthy birth outcomes. The committee also reviewed and discussed findings from the scientific literature on potentially effective strategies. The committee discussed how evaluation of programs at the community level, particularly in communities of color, is rarely conducted. Therefore, the evidence-base to support community-based prevention activities is lacking—not because the programs are not effective, but because they have not been well researched.

Through its deliberations, the committee identified and discussed the merits of nearly 80 strategies in areas such as the social determinants of health, institutional racism, data, social support, nutrition and hunger, women’s health, family planning, innovative care models, the healthcare delivery system, healthcare workforce, parenting skills, infant health, and others.

The committee then conducted a series of prioritization activities to narrow the list to three final recommendations using the following criteria:

- Focus on reducing disparities
- Be actionable, measurable, focused, feasible, and strategic
- Build on practice-based evidence
- Address any federal or state barriers if they exist

| <b>Table 1: Adverse Birth Outcomes Disparities Advisory Committee Members</b>  |   |
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| <b>Name</b>  | <b>Organization/Affiliation</b>                       |
| Sofia Aragon   | Commission on Asian Pacific American Affairs          |
| Vazaskia Caldwell  | Governor’s Interagency Council on Health Disparities  |
| Sheila Capestany   | Open Arms Perinatal Services                          |
| Maria Carlos   | Public Health—Seattle King County                     |
| Kathy Chapman  | Department of Health                                  |
| Nora Coronado  | Commission on Hispanic Affairs                        |
| Emma Medicine White Crow (Chair)   | Governor’s Interagency Council on Health Disparities  |
| Sharon Eloranta  | Qualis Health   |
| Neve Gerke   | Midwives Association of Washington State              |
| Lori Hernandez   | Department of Early Learning                          |
| Gina Legaz   | March of Dimes  |
| Devon Love   | Center for MultiCultural Health                       |
| Shelley Means  | Native American Women’s Dialogue on Infant Mortality  |
| Leah Tanner  | Global Alliance to Prevent Prematurity and Stillbirth |
| Heather Weiher   | Health Care Authority                                 |
| <b>Consultants, Alternate Members, and Other Contributors:</b><br>Meghan Donohue, Qualis Health; Stephanie Dunkel, Department of Health;<br>Lea Johnson, Tacoma Pierce County Public Health; Ann Mumford, Black Infant Health Program;<br>Eva Wong, Public Health—Seattle & King County; Casey Zimmer, Health Care Authority |   |

## Recommendations

### Recommendation 1—Support Community-Driven Approaches

The Department of Health should conduct a preliminary analysis to identify local communities in the state at high risk for adverse birth outcomes, such as infant mortality, fetal deaths, low birthweight, birth defects and premature birth. The Legislature should provide funding for the Department of Health to complete the analysis and create a comprehensive program to support local communities at high risk as identified through the Department's analysis or based on a community's own data and information. Support should include funding for project implementation in the community, technical assistance, and evaluation. Support should be prioritized for innovative, culturally-connected projects that are led by community-based organizations that are trusted among the communities they serve.

#### ***How do community-driven programs reduce disparities in adverse birth outcomes?***

- Inequities in birth outcomes are long-standing.<sup>7</sup> In order to reduce disparities, funding and other resources need to be targeted for communities at greatest risk.
- Social support for at-risk pregnant women, when delivered by a health care worker or community health worker, and continued through the prenatal and postnatal period decreases infant mortality and improves other important maternal and child health outcomes.<sup>8</sup>
- Anecdotally, community-based programs that provide education, resources, linkages, and support to pregnant women and to families postpartum have potential to promote equity in birth outcomes.
- More research is needed to evaluate the effectiveness of community-based programs,<sup>9</sup> particularly those aimed at reducing adverse birth outcomes among diverse communities.

### Recommendation 2—Enhance the First Steps program

The Legislature should increase funding for the First Steps program in order to increase the number of allowable Maternity Support Services (MSS) units<sup>iv</sup>, allocate units to only be used during the postpartum period, enhance the reimbursement rate for childbirth education, and reinstate additional payments for providers to address performance measures for family planning and tobacco cessation. The Health Care Authority should seek input from MSS providers, community groups that work to improve equity in birth outcomes, and other maternal and infant health experts in determining the appropriate number of allowable MSS units and reimbursement rate.

#### ***How will enhancing the First Steps program reduce disparities in adverse birth outcomes?***

- Prior to March 1, 2011, all pregnant women were eligible to receive 60 MSS units during pregnancy and 60 days postpartum. Since March 1, 2011, the allowable number of units is based on a woman's risk factors that may lead to poor birth outcomes, with the maximum allowable units being 30.
- Anecdotal information from MSS providers indicates that current unit allotments based on risk are not sufficient and many women are going without needed services. MSS providers also highlight an important need for additional postpartum units.
- The number of women receiving MSS services and the number of visits received has decreased from 2004 through 2013. In 2004, 71% of Medicaid women with deliveries received MSS, compared to 55% of

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<sup>iv</sup> All pregnant women enrolled in Medicaid are eligible to receive MSS and level of service is based on risk. Services are provided based on the number of allowable units and a unit is equal to 15 minutes. MSS is provided by an interdisciplinary team consisting of at least a community health nurse, a registered dietician, a behavioral health specialist, and at the discretion of the provider, a community health worker.

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similar women in 2013. The average number of MSS visits has decreased from 7.9 in 2004 to 5.6 in 2013.<sup>10</sup>

- In Washington State, expenditures for MSS peaked in 2005 at \$25.5 million, plus \$3.6 million for Infant Case Management and \$0.5 million for other services including Child Birth Education. By 2014, expenditures for MSS had decreased to \$7.1 million and \$1.2 million for Infant Case Management.<sup>11</sup>
- Disparities in adverse birth outcomes and other related indicators continue to exist for women receiving Medicaid compared to women who do not receive Medicaid. For example, the infant mortality rate for women receiving Medicaid-funded maternity care is higher than that of infants whose mothers did not receive Medicaid-funded maternity care. In addition, women receiving Medicaid have lower rates of first trimester prenatal care and higher rates of late/no prenatal care than women who do not receive Medicaid.<sup>12</sup>
- A study evaluating the effect of Washington State's expansion of prenatal services, found significant improvement in low birthweight rates for single adults, African American adults, and adults and teenagers with medically high-risk conditions.<sup>13</sup> In another study, an evaluation of the First Steps program from 1999-2002, showed the program was associated with a significant reduction in low birthweight, particularly among Hispanic women.<sup>14</sup>

### **Recommendation 3—Promote equity in state government**

The Governor's Interagency Council on Health Disparities should compile a list of quality cultural humility<sup>v</sup> trainings and make this list available to all state agencies. The Council strongly encourages state agencies to require that all employees receive cultural humility training and that all employees who work with Tribes or American Indian/Alaska Native populations receive the Government-to-Government training offered by the Governor's Office of Indian Affairs. The Council should also compile a list of tools and resources (including equity impact assessment tools) that agencies can use to assess equity impacts before policy, program, and budget decisions are made. The Council strongly encourages state agencies to incorporate the systematic use of such tools into agency decision making. The Legislature should provide additional funding to the State Board of Health to increase capacity for Health Impact Reviews, which are objective analyses of legislative and budgetary proposals to determine if there are impacts on health and health disparities.

#### ***How will equity in state government reduce disparities in adverse birth outcomes?***

- There is strong evidence that maternal perceived discrimination in a variety of situations (at school, getting a job, at work, getting housing, getting medical care, and from the police or in the courts) is linked to increased rates of preterm birth, low birthweight and very low birthweight babies.<sup>15</sup>
- There is evidence that maternal stress due to discrimination causes inflammatory and infection responses in the body that lead to adverse birth outcomes.<sup>16</sup>
- Emerging practices to reduce racial disparities in birth outcomes take into account social, political, and ecological factors that influence the health of mothers and families and recognize the intergenerational effects of stress and poverty as a result of prejudice on the health of mothers and children.<sup>17</sup>

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<sup>v</sup> Cultural humility incorporates a lifelong commitment to self-evaluation and self-critique, to redressing the power imbalances, and to developing mutually beneficial partnerships with communities on behalf of individuals and defined populations. Citation: Tervalon and Murray-Garcia (1998). Cultural humility versus cultural competence: A Critical Distinction in Defining Physician Training Outcomes in Multicultural Education. *Journal of Health Care for the Poor and Underserved*;9(2):117-125

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- In order for the state to play a role in effectively redressing the persistent disparities in adverse birth outcomes, equity needs to be proactively considered and addressed in state policies, programs, and decisions that affect health and the social determinants of health, such as education, economic development, housing, transportation, and the environment.

## Additional Considerations

The large number of potential strategies identified by the group and the difficulty the group had in narrowing the list to a few recommendations speak to how there is still so much that could and should be done to achieve equity in birth outcomes. While the committee was able to agree on three final recommendations, the committee wanted to highlight other important strategies that have potential to reduce inequities in birth outcomes.

- **Long-Acting Reversible Contraceptives (LARC).** Unintended, unwanted, and mistimed pregnancies are associated with a significant increased risk of pre-term birth and low birthweight.<sup>18</sup> LARC methods are more than 99% effective<sup>19</sup> at preventing pregnancy, are safe for most women and teens,<sup>20</sup> and are underutilized.<sup>21</sup> The committee suggests exploring ways to reduce barriers to LARC use and encouraging healthcare providers to discuss LARC along with other contraceptive choices.
- **Universal Home Visiting.** Home visitation programs have been shown to significantly increase the use of prenatal care and improve child and infant health outcomes and depending on the specific program model, some have seen positive effects on preterm birth and low birthweight.<sup>22</sup> The committee suggests exploring options for all women to have access to an initial prenatal home visit with appropriate levels of follow up based on need.
- **Paid Family Leave.** Mothers who are able to use the Family Medical Leave Act to take time off for pregnancy in the US tend to be wealthier and experience improved birth outcomes as a result of their ability to take leave.<sup>23</sup> Internationally, long duration paid parental leave has been shown to significantly decrease infant mortality.<sup>24</sup> The committee recommends exploring options for funding paid family leave in Washington State.
- **Doula Care.** There is strong evidence that doula care improves labor outcomes by reducing caesarian deliveries, length of labor, and pain medication use.<sup>25</sup> There is also strong evidence that doula care increases rates of breastfeeding.<sup>26</sup> The committee recommends exploring Medicaid reimbursement for care provided by doulas.
- **Educational and Economic Opportunity.** There is a substantial body of evidence linking education and income to various health outcomes,<sup>27</sup> including birth outcomes. The committee recommends exploring options to enhance early learning programs in communities of color, including integrating coping skills and resilience. The committee also recommends exploring educational and economic opportunities for women of color through actions such as promoting affordable housing and a living wage.

## References

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- <sup>5</sup> Washington State Department of Health (June 2014). Prenatal Care: MCH Data Report. DOH 160-015.
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