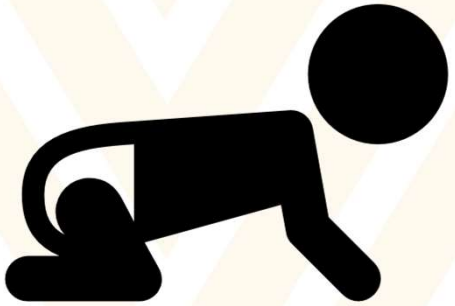
Inequities in Infant & Maternal Health West Virginia

A Set of Recommendations

Lauri Andress, MPH, J.D., Ph.D.
May 2020



“I suppose it is tempting, if the only tool you have is a hammer, to treat everything as if it were a nail.”

Abraham H. Maslow (1966). The Psychology of Science. p. 15. ISBN 9780976040231.

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Authenticity

Reflexive Auto-ethnography and Positionality

As health clinicians, researchers we must address not just the 'what' of our research questions and design; but also the 'how' of what we do, i.e., how our identities intersect with the research.

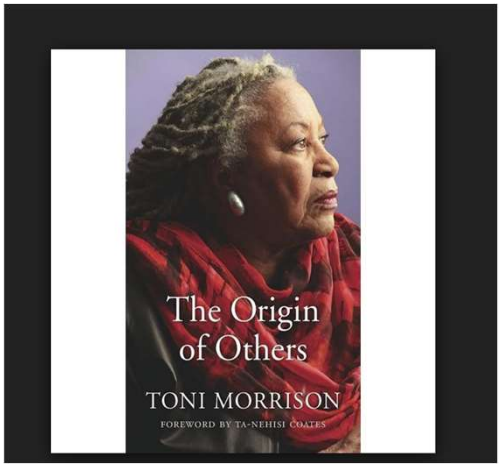
How do experiences of social-cultural identities and training express themselves within our efforts and impact our capacity to see and confront inequities?

Muhammad, M., et al. (2015). "Reflections on Researcher Identity and Power: The Impact of Positionality on Community Based Participatory Research (CBPR) Processes and Outcomes." Critical Sociology 41(7-8): 1045-1063.

Before

September 2017
Interaction WV Director Office of Maternal, Child and Family Health

October 2017
The Origin of Others by Toni Morrison



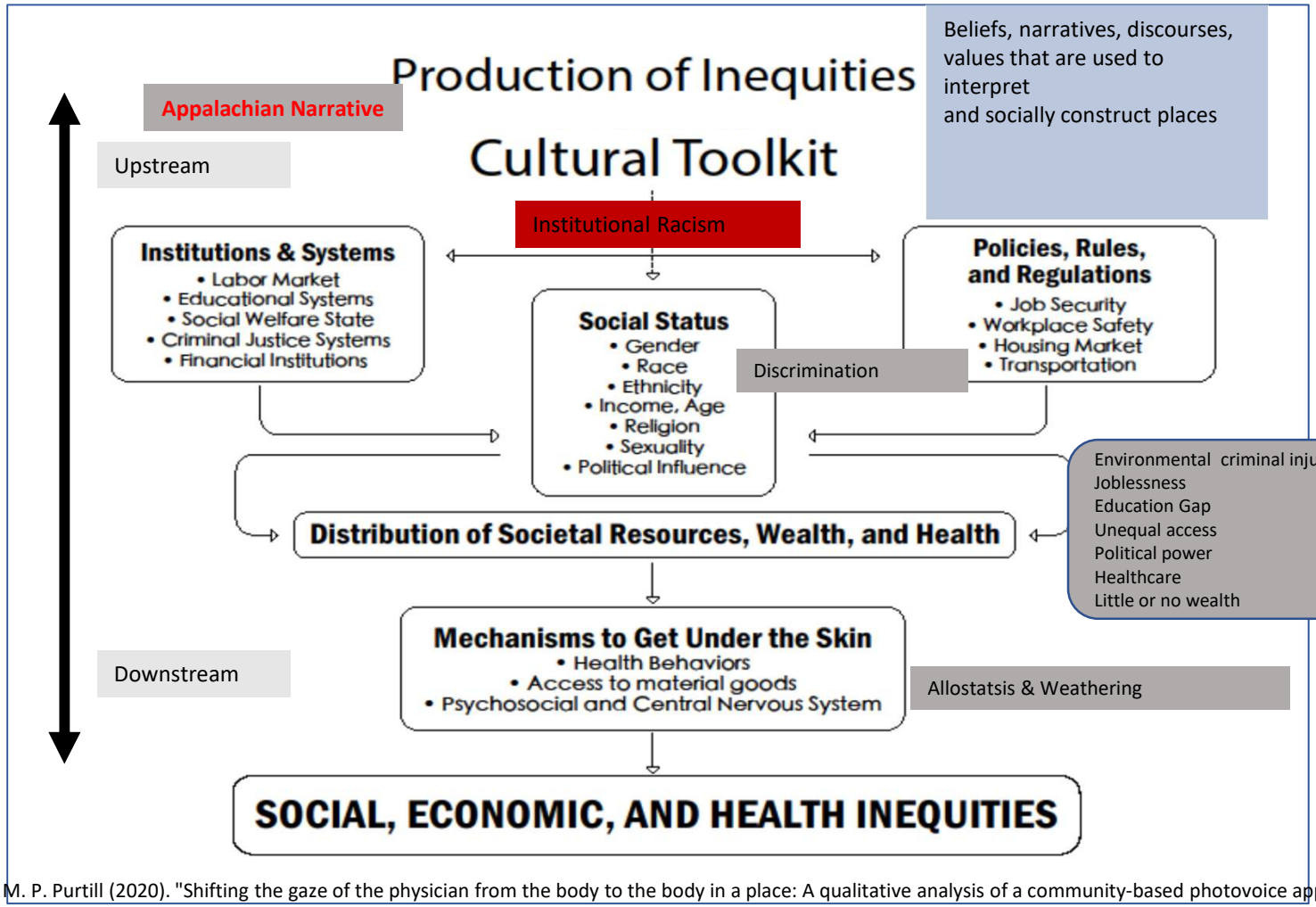
December 2017
Begin to draft *Appalachian Narrative*

February 2018 WVU Law School Presentation
https://www.youtube.com/watch?v=bZHuNsFxmUk&fbclid=IwAR0s4PWx4U8phYMalW8uf5j0h2-tt-LeSPwVYAoHk8EaYew3jHkj8Rjo4ig

December 1, 2018
Charleston Gazette-Mail
WVU professor's research reveals disparity in infant mortality rates
By Rebecca Carballo Staff writer
https://www.wvgazettemail.com/news/health/wvu-professors-research-reveals-disparity-in-infant-mortality-rates/article_4c2a0356-edca-5607-9981-0a4e736d93a3.html#comments

July 17, 2018
Presentation Joan C Edwards School of Medicine, Marshall University

June 2019
Funded by Joan C Edwards School of Medicine, Marshall University



Andress, L. and M. P. Purtill (2020). "Shifting the gaze of the physician from the body to the body in a place: A qualitative analysis of a community-based photovoice approach to teaching place-health concepts to medical students." PLoS One 15(2): e0228640.

POLL

Where Do you Do Most of Your Work?

- Downstream
  - Clinical or behavioral changes
- Midstream
  - Distribution of determinants of health
- Upstream
  - Changing the cultural toolkit
- Not sure

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West Virginia Demographics

Race and Ethnicity

- White: 93.0%
- Black: 3.8%
- Asian: 0.7%
- Two or more races: 1.9%
- Other: 0.5%
- Hispanic or Latino: 1.4%

Income

- Per capita income: $26,179
- Mean household income: $61,707
- Median household income: $44,097

Educational attainment (population 25 years and older)

- Less than high school: 12.2%
- High school or equivalent: 39.7%
- Some college: 19.2%
- Associate's degree: 7.5%
- Bachelor's degree: 12.8%
- Graduate or professional degree: 8.5%

Source: U.S. Census Bureau, 2018 American Community Survey, 1 year estimates

CREATING A CULTURE OF HEALTH IN APPALACHIA

DISPARITIES AND BRIGHT SPOTS

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Appalachia

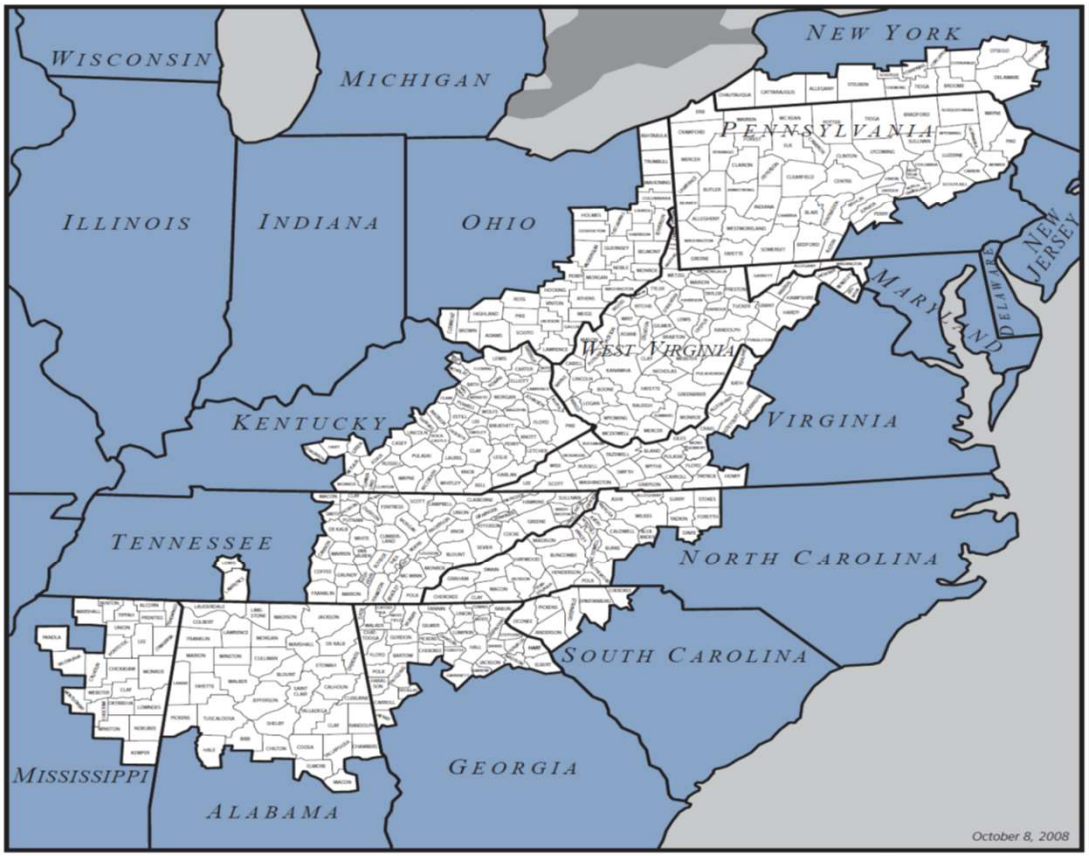
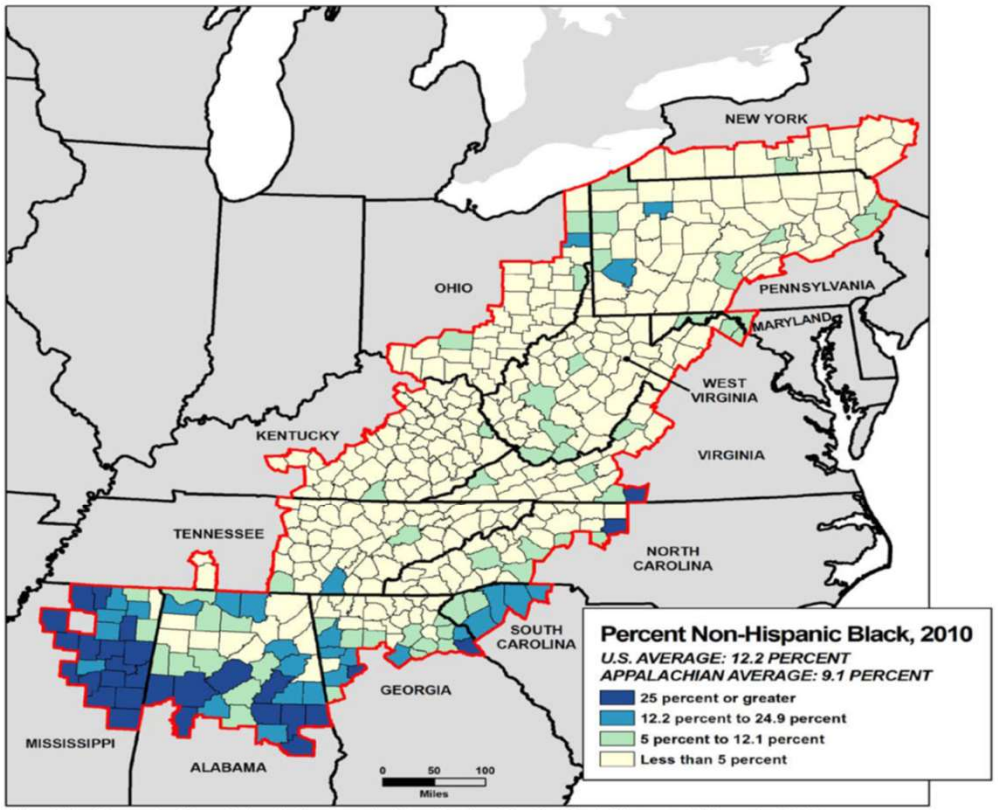

WISCONSIN
MICHIGAN
NEW YORK
PENNSYLVANIA
ILLINOIS
INDIANA
OHIO
NEW JERSEY
MARYLAND
DELAWARE
WEST VIRGINIA
KENTUCKY
VIRGINIA
TENNESSEE
NORTH CAROLINA
SOUTH CAROLINA
GEORGIA
MISSISSIPPI
ALABAMA
October 8, 2008

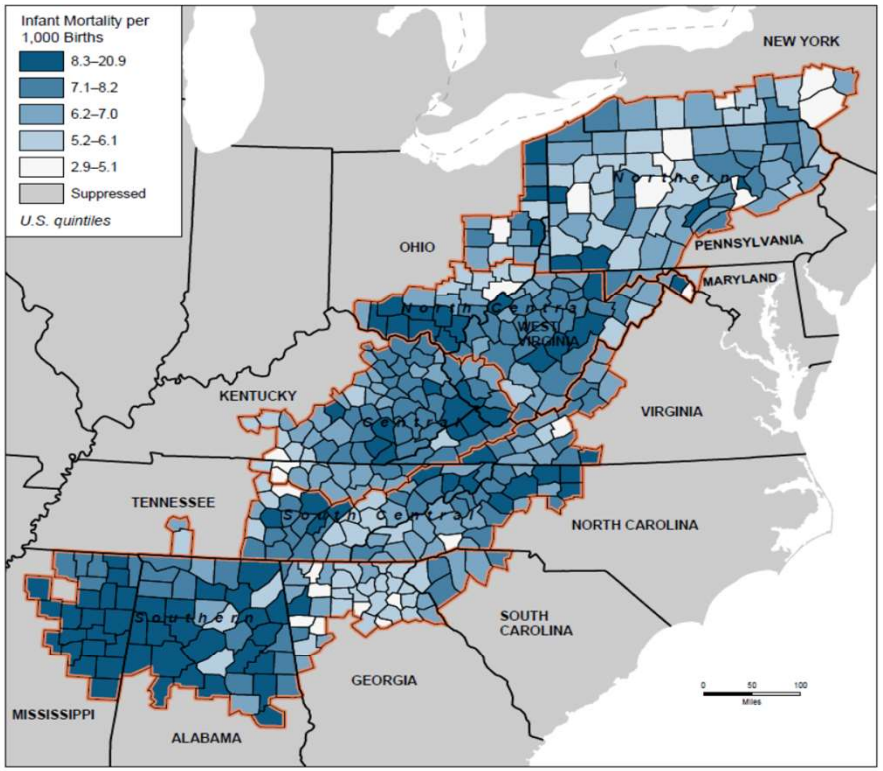
Figure 3.2: Percent of Population in the Appalachian Region That Is Black Alone, not Hispanic, 2010



Map Title: Percent of Population in the Appalachian Region That Is Black Alone, not Hispanic, 2010
Data Source: U.S. Census Bureau, 2010 Decennial Census.

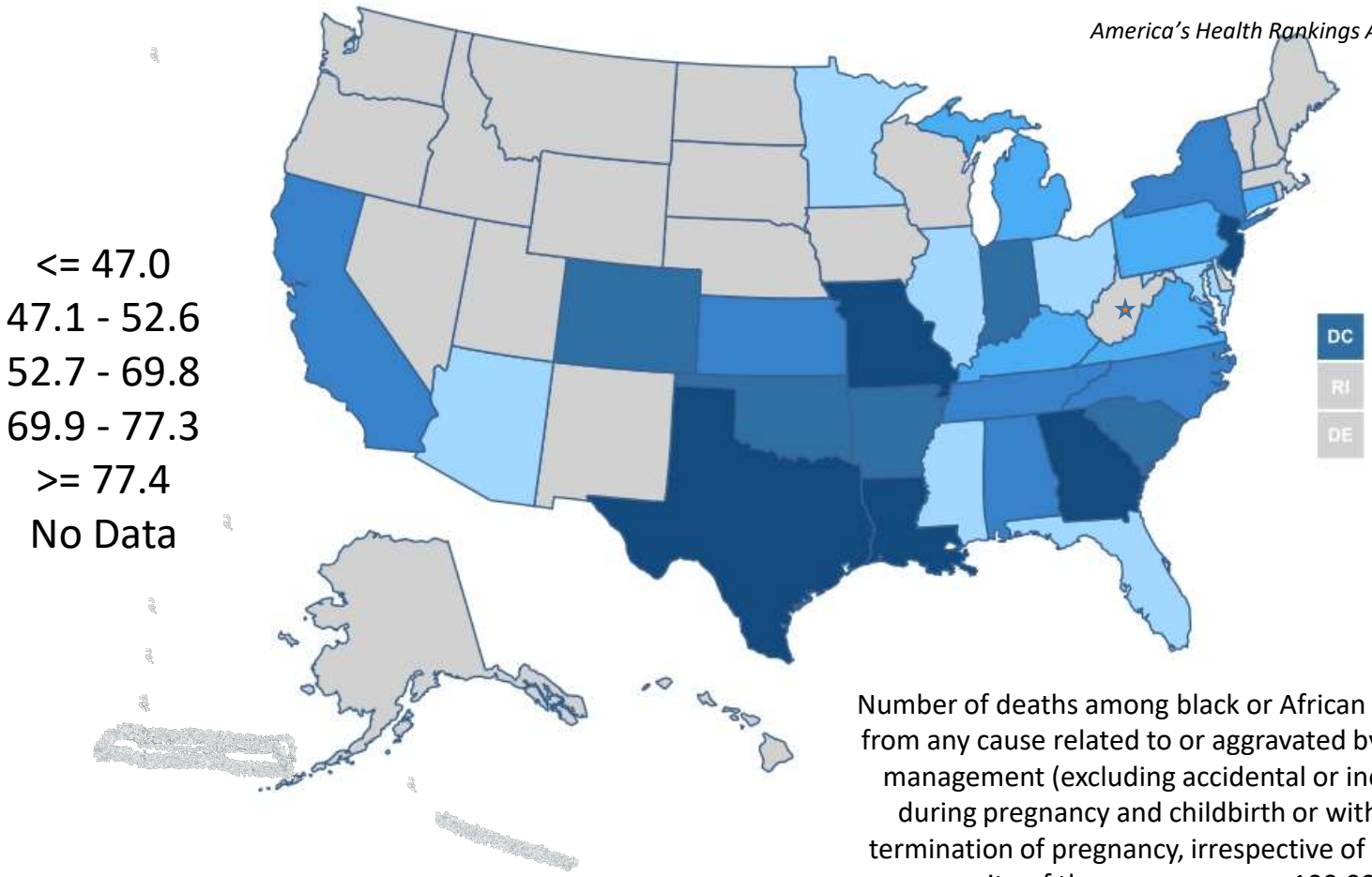
Although non-Hispanic African Americans remain the largest single minority group in Appalachia, their share of the region's total population is still lower than it is in the United States as a whole. Within the region, the largest proportions are in southern Appalachia, which has nearly all of the 57 counties where blacks' share of the population matches or exceeds the national average. At the other end of the spectrum, persons who are "black alone, not Hispanic" account for less than 5 percent of the residents in three-fourths of Appalachian counties.

Figure 77: Map of Infant Mortality Rates in the Appalachian Region, 2008–2014



Data source: National Center for Health Statistics. Compressed Mortality File, 1999–2014 (machine-readable data file and documentation, CD ROM Series 20, No. 2T) as compiled from data provided by the 57 vital statistics jurisdictions through the Vital Statistics Cooperative Program. Hyattsville, Maryland. 2015. http://www.cdc.gov/nchs/data_access/cmf.htm

America's Health Rankings Annual Report 2019



Number of deaths among black or African American women from any cause related to or aggravated by pregnancy or its management (excluding accidental or incidental causes) during pregnancy and childbirth or within one year of termination of pregnancy, irrespective of the duration and site of the pregnancy, per 100,000 births

Source:
•CDC WONDER Online Database, Mortality files

health.ri.gov/publications/issuebriefs/2020PreconceptionPregnancyAndPostpartumHealth.pdf

Apps | Academic Calendar... | AMC Gulf Pointe 30... | Change Your HS Pa... | Andress, Lauri - Out... | Bookmarks | Chase Online - Log... | EndNote | Other bookmarks

MCH-IssueBrief_PPP_2020-2 1 / 4

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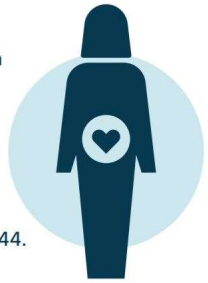
PRECONCEPTION, PREGNANCY, AND POSTPARTUM HEALTH
Rhode Island Issue Brief

What is Preconception, Pregnancy, and Postpartum Health?



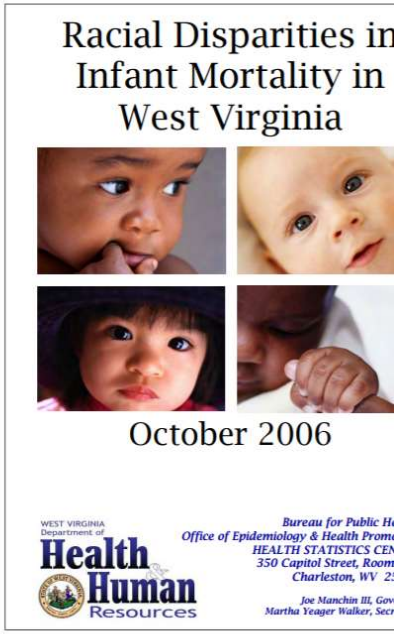
Preconception, pregnancy, and postpartum health refers to the health of people before, during, and after pregnancy. This also includes the supports and resources needed to become pregnant, if and when someone wants to, and to ensure parents and children thrive with safe and healthy outcomes. Child-bearing age is defined as age 15-44. However, demographic trends show that the age range has been widening in recent years.

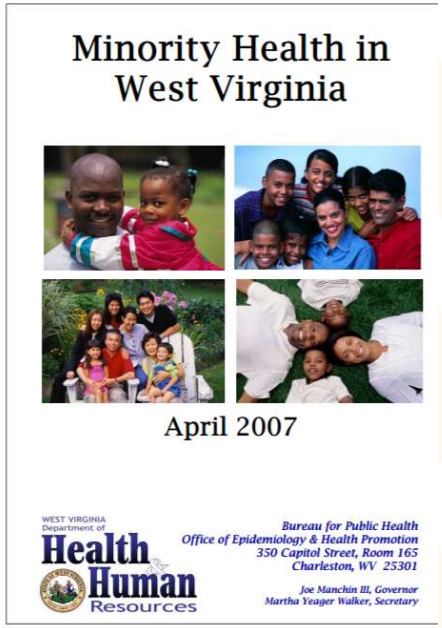
The Rhode Island Department of Health (RIDOH) strives to ensure that all people who are considering pregnancy, who are pregnant, or who were recently pregnant, receive timely, high-quality, culturally sensitive healthcare.

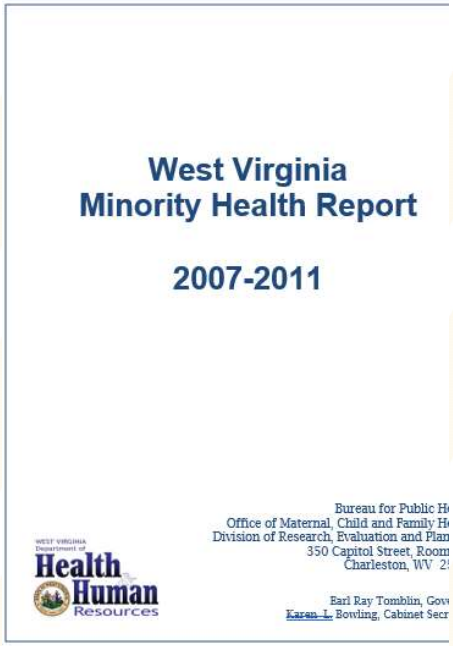
About the Data

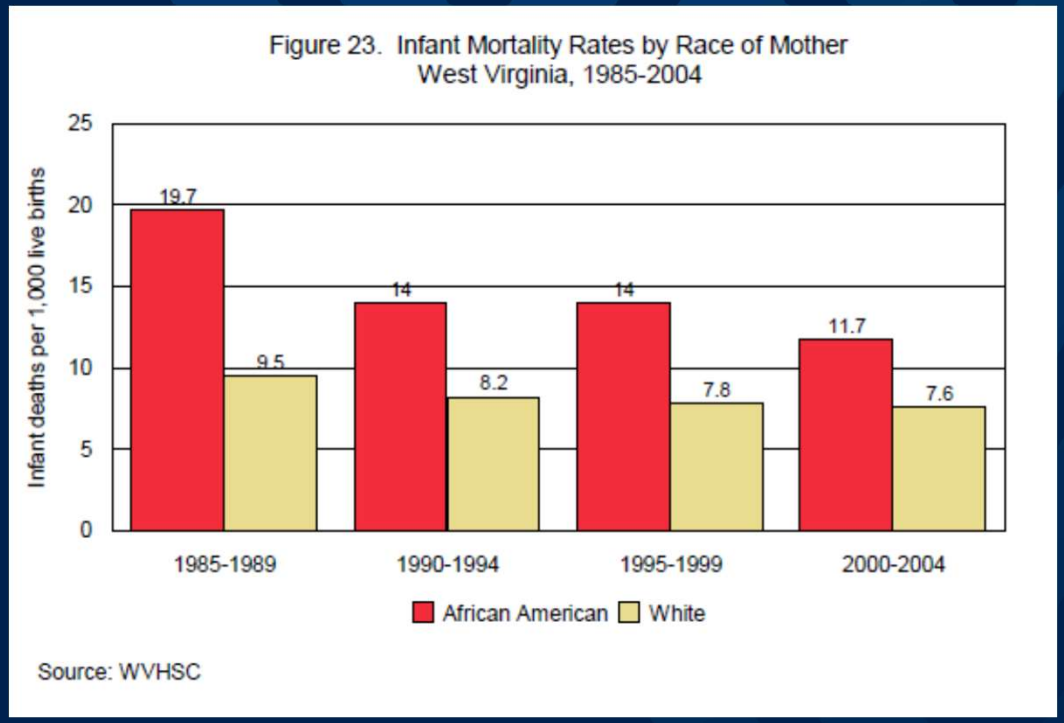
RIDOH seeks to recognize the breadth of gender identities among individuals who may become pregnant. This includes individuals who are trans, non-binary, and intersex. However, there are limitations in the data on pregnant individuals. This is because current, population-level data report pregnant people as female/women.

Throughout this brief, data are presented as they were originally collected and reported for gender, age, race, and ethnicity. RIDOH recognizes that these categories may not reflect how people and communities define themselves. We acknowledge these limits and strive to use language that is welcoming and inclusive of every Rhode Islander whenever possible.[1]


Racial Disparities in
Infant Mortality in
West Virginia
October 2006
Health
Human
Resources


Minority Health in
West Virginia
April 2007
Health
Human
Resources
Bureau for Public Health
Office of Epidemiology & Health Promotion
350 Capitol Street, Room 165
Charleston, WV 25301


West Virginia
Minority Health Report
2007-2011
Health
Human
Resources



Racial Disparities in Infant Mortality in West Virginia 2006

Minority Health in West Virginia April 2007

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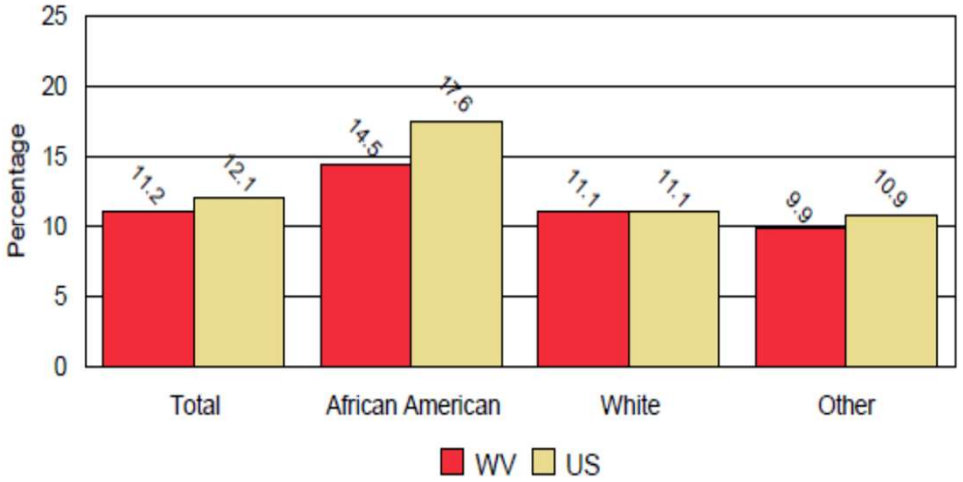
Figure 12. Percentage of Premature* Births
By Maternal Race
West Virginia and United States, 1999-2003



*Gestational age <37 weeks
Source: WVHSC

2011 West Virginia and United States Infant Mortality by Race of Infant

(Number and Rate per 1,000 Live Births)

Race of Infant	West Virginia		United States*	
	Number	Rate	Number	Rate
All Races	141	6.8	23,907	6.0
White	128	6.5	15,451	5.1
Black	12	16.8	7,221	11.4
Other	1	2.9	1,235	4.0

*Source: http://www.cdc.gov/nchs/data/nvsr/nvsr61/nvsr61_06.pdf

Approximately one out of six (17.0%) infant deaths in 2011 were due to SIDS (sudden infant death syndrome). Approximately one in four (23.4%) was the result of congenital malformations, while 40.4% were due to certain conditions originating in the perinatal period, including disorders relating to short gestation and unspecified low birthweight (12.1%).

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Infant Mortality Deaths in West Virginia 2018 Analysis

Analyzed by Carol Gilbert, CityMatCH www.citymatch.org Presented 7/17/2018

United States Department of Health and Human Services (US DHHS), Centers of Disease Control and Prevention (CDC), National Center for Health Statistics (NCHS), Division of Vital Statistics (DVS). Linked Birth / Infant Death Records 2007-2015, as compiled from data provided by the 57 vital statistics jurisdictions through the Vital Statistics Cooperative Program, on CDC WONDER On-line Database. Accessed athttp://wonder.cdc.gov/lbd-current.html on Feb 16, 2018 2:56:15 PM

Infant Mortality Deaths in West Virginia 2018

BLACKS ACCOUNT FOR 3.7 PERCENT OF BIRTHS BUT 5.8% OF DEATHS AND 8.6 PERCENT OF EXCESS (PREVENTABLE) DEATHS ---

THE BLACK IMR IS HIGHER THAN THE IMR OF ANY OTHER RISK GROUP

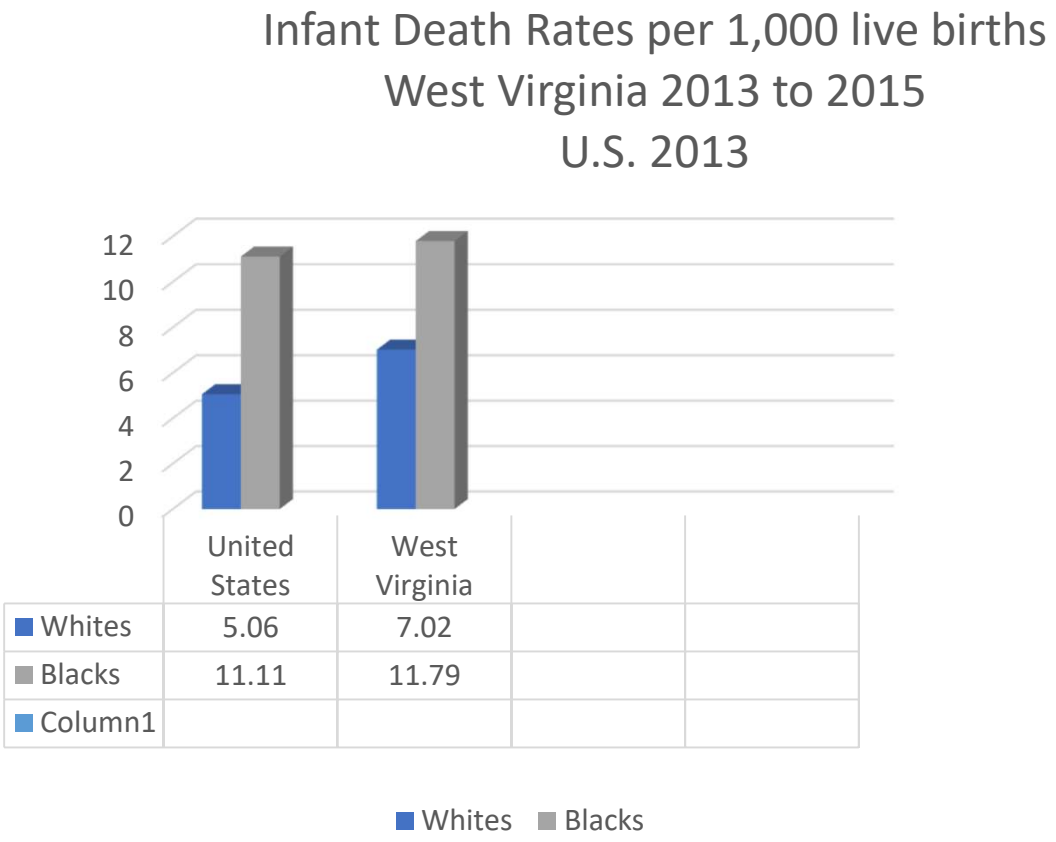
- HIGH SCHOOL EDUCATION
- TEEN
- UNMARRIED WOMEN AND
- LATE OR NO PRENATAL CARE

United States 2013

White infant death rate
5.06/1000

Black infant death rate
11.11/1000

- **West Virginia 2013-2015**
- Black infant death rate was 11.79
- White infant death rate was 7.02
- Ratio between these two rates is 1.7
-
- The chance that a black infant will die in the first year of life is 1.7% times greater than the chances that a white infant will die



Dilemma

How Do you Work on an Invisible Problem?

Recommendations

Build Capacity, develop common language and narrative

- Community –based Online Learning Group

Overhaul the WV Fetal Infant & Maternal Death Review Panel

- Chapter 61 of the criminal code -Article 12A Fatality and Mortality Review Panel
- Create Community –based Action Team on Infant Mortality Disparities
- Maternal Interviews

National Center for Fatality Review and Prevention (NCFRP)

The National Center for the Review and Prevention of Child Deaths is funded by the Health Resources and Services Administration of the Maternal and Child Health Bureau (MCHB) as a resource and data center for state and local Child Death Review (CDR) and Fetal and Infant Mortality (FIMR) programs around the country.

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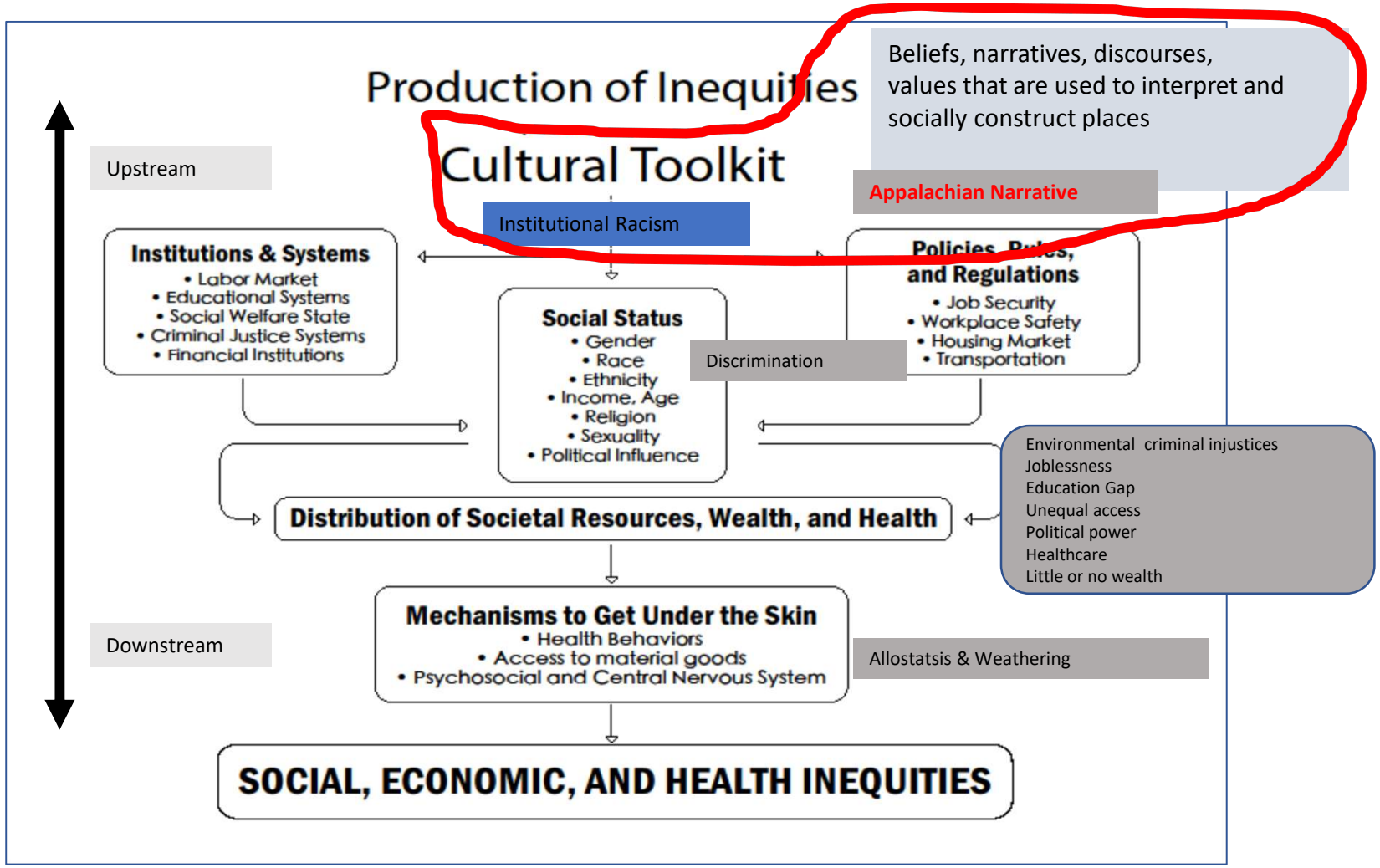
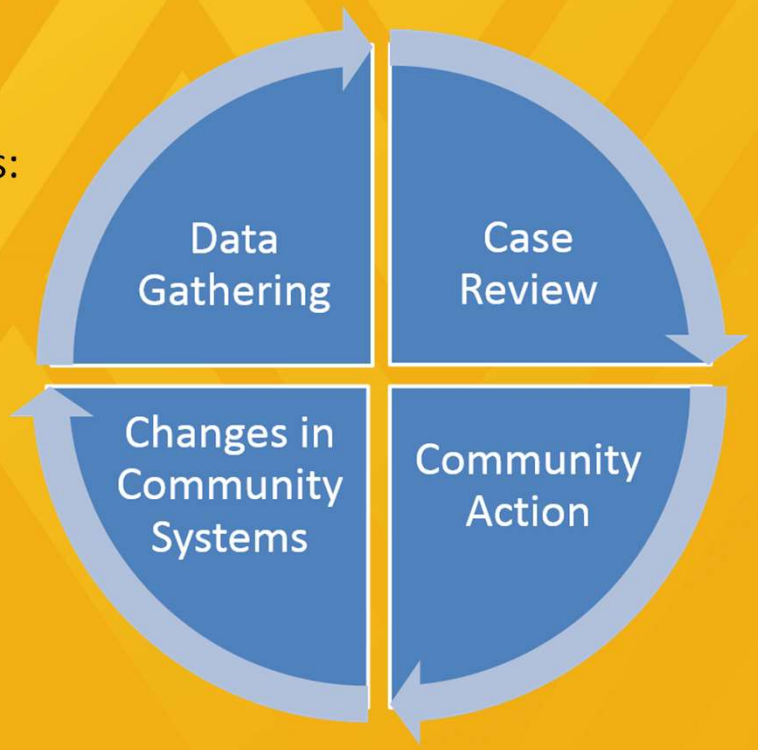
Photo by Liv Bruce on Unsplash


Production of Inequities
Cultural Toolkit
Beliefs, narratives, discourses, values that are used to interpret and socially construct places
Upstream
Appalachian Narrative
Institutional Racism
Institutions & Systems
• Labor Market
• Educational Systems
• Social Welfare State
• Criminal Justice Systems
• Financial Institutions
Social Status
• Gender
• Race
• Ethnicity
• Income, Age
• Religion
• Sexuality
• Political Influence
Discrimination
and Regulations
• Job Security
• Workplace Safety
• Housing Market
• Transportation
Environmental criminal injustices
Joblessness
Education Gap
Unequal access
Political power
Healthcare
Little or no wealth
Distribution of Societal Resources, Wealth, and Health
Mechanisms to Get Under the Skin
• Health Behaviors
• Access to material goods
• Psychosocial and Central Nervous System
Allostatsis & Weathering
Downstream
SOCIAL, ECONOMIC, AND HEALTH INEQUITIES

Fetal & Infant Mortality Review (FIMR) is:

A **multidisciplinary, community** team that examines a fetal or infant death case that is:

- Comprehensive
- De-identified
- Confidential
- Giving voice to mothers' experiences
- Engenders Dialogue



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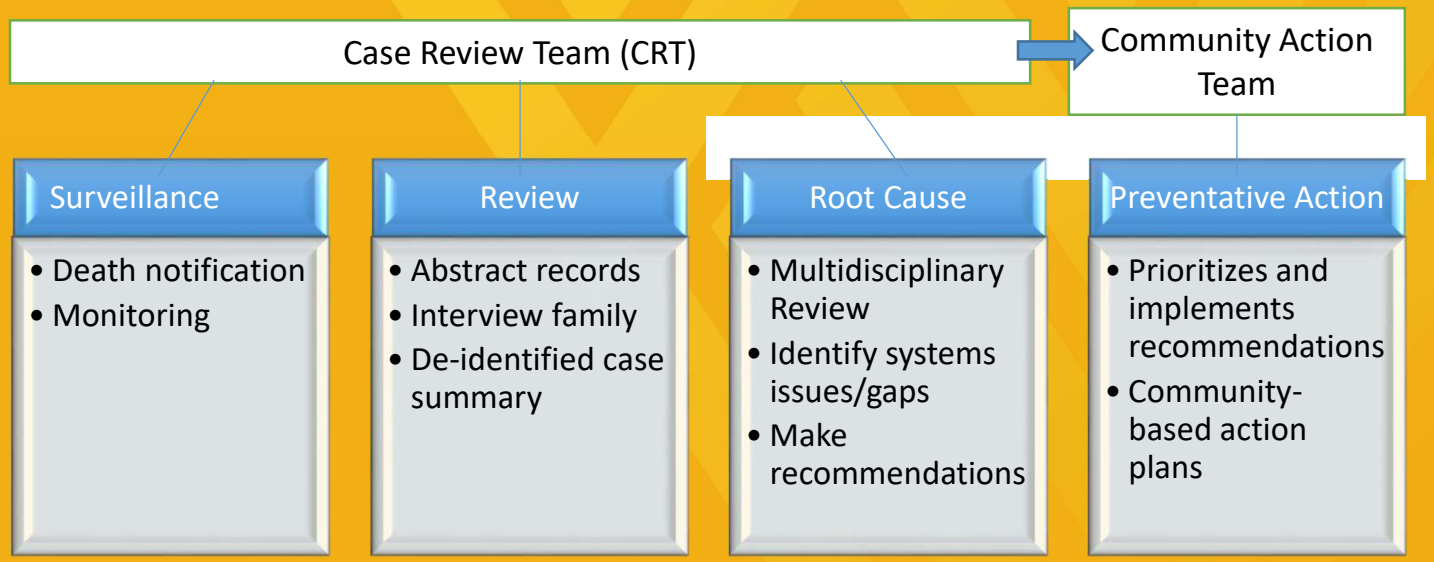
FIMR Interviews plus Community Panel– Why?

- Four corners of the death record cannot tell us everything we need to know about a mother's experiences.
- Pregnancy is about more than the 9 months that a woman is pregnant.
- The Community is where narratives and discourse determine how phenomena are framed, considered,
- The community is where stakeholders have a real stake
- Health care facilities
- Where we work
- Where we go to school
- Where we play

The FIMR process



FIMR Focuses on Systems

Each FIMR Case Review provides an opportunity to improve communication among medical, public health and human service providers and to develop strategies to improve services and resources for women, infants, and families

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Fatality & Mortality Review Team
West Virginia

April 2013

Senate Bill 108 passed establishing Chapter 61 of the criminal code - Article 12A

February 2015

Rule 29 : Established procedures for the formation of the Fatality and Mortality Review Team FMRT

Created under the WV Bureau for Public Health.

A multidisciplinary team created to oversee and coordinate the examination, review and assessment of:

- (1) The deaths of all persons in West Virginia who die as a result of unintentional prescription or pharmaceutical drug overdoses;
- (2) The deaths of children under the age of eighteen years;
- (3) The deaths resulting from suspected domestic violence; and
- (4) **The deaths of all infants and all women who die during pregnancy, at the time of birth or within one year of the birth of a child.**

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February 2015 Rule 29 West Virginia State Code

Established procedures for the formation of the Fatality and Mortality Review Team FMRT

Rules prohibit family contact which goes against the national recommendations

FILED
2013 APR -1 P 3:11
OFFICE WEST VIRGINIA
SECRETARY OF STATE

TITLE 64
LEGISLATIVE RULE
BUREAU FOR PUBLIC HEALTH

SERIES 29
FATALITY AND MORTALITY REVIEW TEAM

§64-29-1. General.

1.1. Scope - This rule establishes standard procedures for the formation and conduct of the Fatality and Mortality Review Team. The Fatality and Mortality Review Team (FMRT) is a multidisciplinary team created to oversee and coordinate the examination, review and assessment of special cases of death where other than natural causes are suspected. This rule should be read in conjunction with W. Va. Code §61-12A-1, et seq. The W. Va. Code is available in public libraries and on the Legislature's web page, http://www.legis.state.wv.us/ .

1.2. Authority - W. Va. Code §16-1-4 and §61-12A-2(c).

1.3. Filing Date -

1.4. Effective Date -

§64-29-2. Application and Enforcement.

2.1. Application - This rule applies to the Fatality and Mortality Review Team and also to four fatality and mortality Advisory Panels set forth WV Code §61-12A-1, et seq. and described in this rule.

2.2. Enforcement - This rule is enforced by the Commissioner and by the Chief Medical Examiner in the Bureau for Public Health.

§64-29-3. Definitions.

3.1. Bureau – The Bureau for Public Health in the Department of Health and Human Resources.

3.2. Child - A person less than eighteen (18) years of age.

3.3. Child Fatality Review Panel (CFRP) - A multidisciplinary group of professionals including representatives from public health, medicine, law and law enforcement, and child welfare that reviews the circumstances surrounding the deaths of children.

3.4. Commissioner – The Commissioner of the Bureau for Public Health or his or her designee.

3.5. Department - The West Virginia Department of Health and Human Resources.

3.6. Domestic violence fatality - An unnatural death precipitated by events surrounding a relationship among individuals who are family or household members as defined in W. Va. Code §48-27-204.

3.7. Domestic Violence Fatality Review Panel (DVFRP) - A multidisciplinary group of professionals including but not limited to representatives from public health, mental health, medicine, law and law

13.2.c. The Chief Medical Examiner in the Bureau for Public Health or his or her designee;

13.2.d. The Director of the Office of Vital Statistics in the Bureau for Public Health or his or her designee;

13.2.e. Representation from each of the three medical schools in the state;

13.2.f. The Director of Obstetrics, the Director of the Neonatal Intensive Care Unit and the Director of Pediatrics at each of the tertiary care hospitals in the state;

13.2.g. On representative from the West Virginia State Medical Association;

13.2.h. One representative from the West Virginia Nurses Association;

13.2.i. One representative from the West Virginia Society of Osteopathic Medicine;

13.2.j. One representative from the West Virginia Academy of Family Physicians;

13.2.k. One representative from the West Virginia Chapter of the American College of Nurse Midwives;

13.2.l. One representative from the West Virginia Chapter of the American College of Obstetrics and Gynecology;

13.2.m. One representative from the West Virginia Chapter of the American Academy of Pediatrics;

13.2.n. The Chairperson of the Child Fatality Review Panel; and

13.2.o. Any additional person that the chairperson of the IMMRP, or the Chairperson of the FMRT, determines is needed on a particular case under consideration by the panel.

13.3. The current membership of the IMMRP shall remain effective and authorized to carry out the duties described in this rule and the authorizing statute. In the future the FMRT shall appoint members to serve on the IMMRP and shall also appoint persons to fill vacancies on the Infant and Maternal Mortality Review Panel.

13.4. Each member shall serve for a term of five years.

13.5. Members of the Infant and Maternal Mortality Review Panel shall, unless sooner removed, continue to serve until their respective terms expire and until their successors have been appointed and have qualified.

13.6. An appointment of a physician, whether for a full term or to fill a vacancy, is to be made by the FMRT from among three nominees selected by the West Virginia State Medical Association or the organization to be represented on the panel. When an appointment is for a full term, the nomination is to be submitted to the FMRT not later than eight months prior to the date on which the appointment is to become effective. In the case of an appointment to fill a vacancy, the nominations are to be submitted to the FMRT within thirty days after the request for the nomination has been made by the FMRT to the chairperson or president of the organization. When an association fails to submit to the FMRT

nominations for the appointment in accordance with the requirements of this section, the FMRT may make the appointment without nominations.

13.7. Each member of the Infant and Maternal Mortality Review Panel shall serve without additional compensation and may not be reimbursed for any expenses incurred in the discharge of his or her duties under the provisions of this article.

13.8. The Office Director of the Office of Maternal Child and Family Health in the Bureau shall serve as the chairperson of the Infant and Maternal Mortality Review Panel, or his or her designee. The IMMRP shall review death certificates of infants and women sent monthly by the office of vital statistics.

13.9. Each member of the Infant and Maternal Mortality Review Panel shall examine the records of his or her agency to determine if the infant or woman received services at his or her agency, and if necessary, may contact other agencies to complete the review.

13.10. Panel members shall present to the rest of the Infant and Maternal Mortality Review Panel the information obtained from the record reviews, but shall retain the documents in each agency's files.

13.11. All documents regarding a particular case that are reviewed by the Infant and Maternal Mortality Review Panel shall be destroyed by the Panel after the publication of the FMRT annual report in which that case data is included.

13.12. The Infant and Maternal Mortality Review Panel members, in the exercise of their duties as defined in this subsection, may not:

13.12.a. Call witnesses or take testimony from individuals involved in the investigation of an infant or maternal fatality;

13.12.b. Contact a family member of the deceased infant or mother, except if a member of the panel is involved in the investigation of the death and must contact a family member in the course of performing his or her duties outside of the panel; or

13.12.c. Enforce any public health standard or criminal law or otherwise participate in any legal proceeding, except if a member of the panel is involved in the investigation of the death or resulting prosecution and must participate in a legal proceeding in the course of performing in his or her duties outside of his or her affiliation with the panel.

§64-29-14. Recommended Protocols for Panel Reviews.

14.1. The following are recommended protocols to aid in the review of unintentional pharmaceutical drug overdose, child, domestic violence and infant and maternal deaths by all four of the Fatality and Mortality Review Advisory Panels.

14.1.a. All Review Panel members shall sign a sworn statement promising to maintain the confidentiality of information, records, discussions and opinions disclosed during reviews.

14.1.b. The Review Panel may call for an immediate review of medical records requested from physicians and hospitals treating the person whose death is under review to try and determine causes and possible preventative measures related to the death.

Recommendations

- Add **Community Action Team** to the Review Panel like other state level Fetal Infant Mortality Review Panels (FIMRs).
- Add **family interviews** where infants have died as other FIMR's already do this.
- Build capacity, common language and narrative
- Will use the information from the review processes to inform communities on factors that contribute to disparities in infant and child outcomes, and, most importantly, to create tools and best practices to help communities translate those finding into action.
- Design or identify a method to engage in conversations necessary to address inequities created by adverse circumstances (e.g., poverty, racism, historical trauma, socioeconomic biases, etc.).
- Design activities that engage the community and stakeholders authentically (e.g., evening meetings, residents actively involved, etc.).
- Initiate study to explore relationship between adverse events over the life course of women in WV ages 18-45.

What are differences in (adverse) experiences over the life course between Black and White mothers in West Virginia?

Berkeley 21.4/1,000 live births

Cabell 21.1 /1,000 live births

Kanawah 8.8/1,000 live births

Do American-born Black mothers in Berkeley or Cabell county (where the Black IMR is high) and low income, American-born Black mothers in Kanawha county (where the Black IMR is low) experience different kinds of structural, institutional, policy-based or systems problems?

Hypotheses

POLL

Where Do you Do Most of Your Work?

- Downstream
  - Clinical or behavioral changes
- Midstream
  - Distribution of determinants of health
- Upstream
  - Changing the cultural toolkit
- Not sure

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Thank you……