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HEALTHY COMMUNITIES

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Stagnant or Increasing Infant Mortality:

The MCH Director's Role in Responding

RODNEY WISE: Good morning. I'd like to thank AMCHP and the SEEM Collaborative for this opportunity to present the information on infant mortality in Louisiana. This will be a brief review of our work in Louisiana. Most of this information was provided by our MCH EPI unit, which was initially headed by Dr. Juan Acuna, and now headed by Dr. Lankiltica. Background. Louisiana has traditionally ranked very poor among the states in infant mortality. We have seen an increasing trend in infant mortality over the last five to seven years. Births in our states are primarily to whites and African-Americans, and there is a very significant racial disparity in outcomes, much like the rest of the country. We have a very high rate of premature deliveries in our state, second only to Mississippi and Alabama. And we have many of the contributors to infant mortality that you would expect. Poverty, lack of education, stresses associated with that, STI's, and poor access and utilization of care.

Resident births. In 2004 we had almost 65,000 births in our state. Some 36,000 were to whites and a little over 26,000 to African-Americans, at almost 41% of our births. Less than 3% of our births were to Hispanics. I'd like to look at

Medicaid covered births as a marker for the economic status of the MCH population. Of all births in 2004, 62.6%, almost 63% of our births were covered by Medicaid. Of African-American births, 84% were covered by Medicaid. I think this actually under-represents though the economic status of our state, because those on the lowest end of the economic level deliver at state hospitals and do not even complete a Medicaid application. Our trend. In the early-'90s, mid-'90s, we had a decreasing trend. But as I said over the last five to seven years, we have had an increasing trend in infant mortality.

Reporting has also been an issue in our state. We found that we've had under-reporting of deaths, especially in vital records under 500 grams. We found birth certificates for these infants, but no corresponding death records. When adjusted, like here in 2000, as you can see in the green line, we actually did not have a decrease in infant mortality, but either a stagnant or increasing level. In other years, like 2002, under-reporting has been relatively low. We're continuing to monitor this.

Racial disparity is significant in our state. We have about 41% of our births to African-Americans. This number, along with the associated disparity contributes significantly to our state's high rates. While we have seen a decreasing trend in the disparity ratio, as you see at the bottom there, it's not due to great improvements in the African-American population, but worsening in the infant mortality rates among the white population.

We had been performing perinatal periods of risk in our state for about 10 years. These analyses have helped us in a couple of ways. Help us understand the components of deaths, as you see here and would probably expect, the maternal health and prematurity component is a large one. We also have a significant problem in the infant health cells. Our neonatal care cells actually performed pretty well. Secondly, we take this data to the regional level. In this assists our FEMA teams and our FEMA community action teams in direction of their activities. PPOR really helps us direct programs to areas of greatest need.

'Cause we certainly have limited resources. Leading causes of all deaths in 2002 to four is here. Prematurity fetal weight is the leading cause, and it contributes the greatest to the black/white disparity ratio, as you can see in the third column. Congenital malformations is our second leading cause, but pretty equal in both races. SIDS is our third, with also some disparity in our African American population. Very though birth weight infants and levels of hospital care was another issue that we've looked at. We have a State perinatal commission, and it does have a State perinatal plan. However, the plan did not link Level 3 neonatal and Level 3 maternity units. The unintended consequence was that a significant number of births occurred in a Level 2 facility with the resultant transfer of the infant to the Level 3 neonatal unit. We looked at these, if you look at the first column there is deaths rates in the Level 3 facilities, with the second in the Level 1 and 2. As you can see, it's much higher at all time groups in the Level 1 and 2 facilities.

We're taking this information, had a revision of our State perinatal plan that is now linking neonatal and maternal levels of care. MCH data, we're very fortunate in Louisiana, we have a large dedicated MCH EPI group. They have a good number of linkages, as you see here. We've also begun discussion looking at other linkages, with our addictive disorders, mental health, education systems, and perhaps even our juvenile justice systems. The coordinated effort between the MCH EPI and our program staff is continuing. Our MCH EPI head, Dr. Lancaltika, is also one of the leads in our statewide FEMA organization. At each of our monthly maternity group meetings, we have EPI representation. And all new programs are with EPI at the table from the beginning for evaluation component. And we're doing a great deal of regional dissemination. Our FEMAs want information, they want it at the regional level, and our EPI people are helping us provide that.

Recent data analyses that have been performed are kind of listed here. I'm just going to point out a couple of them. First one is STDs. Traditionally our state has ranked very high, usually in the top five, for rates of gonorrhea, chlamydia, and syphilis. An analysis was done looking at STDs during pregnancies and as you would expect, those pregnancies performed poor with more pre-term births. A recent analysis was done of WIC enrollment in birth weight. And this found that WIC enrollees did have a higher birth weight than non-enrollees. And our PRAMS. We've had PRAMS for a good number of years. Our regions are now

requesting PRAMS data at the regional level. It's a little bit difficult with small numbers, but we're trying to help them. PRAMS was interrupted briefly during, after the hurricanes, but it's now back up and running.

Our public health interventions are listed here. I will mention a couple of them.

The first is our fetal and infant mortality reduction initiative. This is a statewide initiative that began earlier this decade. But it's regionally or locally directed.

Really two components, one is our FEMA network. We have or are organizing FEMA teams in all nine regions of our state. And also nurse family partnerships are occurring in all regions.

The other is the next to the last one there. In 1995, our needs assessment found substance abuse and mental health issues leading priorities in all regions. We've subsequently contracted and purchased state licensure for the Four Piece Plus Tool, with our partners and we'll be kicking that program off this month on a pilot basis. Lessons learned, critical need for data and its analysis, but also interpretation and dissemination of this data. Partnerships, partnerships, partnerships. Our FEMA community action teams were instrumental after the hurricanes. Prepare for the unexpected. Be flexible. We've certainly learned that. And constantly look for new opportunities. Conclusions are pretty much what you would expect in other states. Our biggest challenge right now is a resultant of the 2005 hurricanes. The MCH infrastructure in southern Louisiana was destroyed and most of it surprisingly is still not rebuilt. We need medical personnel,

buildings, and funding. And we have a need for, a critical need for a bilingual healthcare system. After the storm, some 200,000 African Americans evacuated out of the city. It's now estimated that we have 130,000 Hispanics that have moved in. And our healthcare system is not bilingual. Thank you.