

## 2008 Maryland Maternal and Child Health Block Grant Maryland Priority Needs Summary and Rationale

Below are Maryland's 8 priority needs identified, as required, as part of the state's 2005 Needs Assessment process. Please note that while the priorities are numbered, the assigned numbers do not reflect their importance. Consideration was given to multiple factors in selecting Maryland's MCH priority needs. These included findings from a review of data trends and analyses; focus group comments; local health department surveys and meetings; the use of a Title V instrument titled CAST -- 5 that was used to conduct a capacity assessment; and input from Title V Program staff and other MCH service agency staff in DHMH.

### 1. To eliminate racial and ethnic disparities in maternal and child health.



Over the past two decades following the publication of national and state reports (e.g., the 1987 Maryland Governor's Commission on Black and Minority Health), awareness has been raised about racial and ethnic disparities in health. Both the Maryland Department of Health and Mental Hygiene and the Title V Program are committed to eliminating health disparities. DHMH was also recently mandated by the state Legislature to create an Office of Minority Health and Health Disparities. Racial and ethnic disparities that were identified as a priority area during the last comprehensive needs assessment remain as a priority for the 2005 needs assessment.

Maryland data consistently reveal substantial racial and ethnic disparities on numerous key indicators of health and access to health care including infant and child mortality. The research literature is increasingly recognizing that social factors, including poverty and discrimination, contribute significantly to these disparities. Maryland has begun to look at the role of stress and racism in poor birth outcomes for African American babies. The role of public health in addressing social issues that have normally been viewed as falling outside of our rubric will be considered over the next five years as Maryland attempts to address persistent, yet ameliorable disparities within its maternal and child health population. Technical assistance will be provided to local health departments and other MCH serving agencies within DHMH to address this priority.

The selected state performance measure is the percentage of jurisdictions with written plans to address racial/ethnic disparities in MCH. A related national outcome measure is the ratio of Black infant deaths to white infant deaths. A concerted effort will be undertaken to determine the causative factors of key disparities, including maternal and infant mortality, and asthma morbidity.

### 2. To promote healthy pregnancies and healthy pregnancy outcomes.

As part of its mission statement, Maryland's Title V Program envisions a future in which all pregnancies are planned, all women reach an optimal level of health and well-being prior to pregnancy, no woman dies or is harmed as a result of being pregnant, and all babies are born healthy. Results of the 2005 Needs Assessment indicate that much work remains to be done if this future is to be realized for all mothers and babies. The majority of babies in our state are born healthy to healthy mothers who experience healthy pregnancies. However, Maryland continues to have one of the nation's highest rates of infant mortality and low birth weight. The health disparities identified in priority #1 partially contribute to this finding.

Two state performance measures have been selected to address this priority: (1) Percentage of pregnancies intended, and (2) Percentage of women using alcohol during pregnancy. This priority is directly linked to the infant mortality outcome measure as well as performance measures # 8, 15, 17 and 18.

### **3. To promote optimal family functioning.**

Throughout the five year needs assessment, we heard about the need to support and strengthen families to assure that children remain healthy and thrive. This need for support is cross-cutting and required for all Maryland families, especially socio-economically disadvantaged families. However, the Title V Program also recognizes that families of children with special health care needs are especially vulnerable and in need of services that enhance their ability to care for their children and address their need for supportive services such as respite and child care.

Many Maryland families were anecdotally described as "in crisis or in peril." We heard that families are disconnected; parents are stressed and overwhelmed with the process of parenting as well as accomplishing the tasks of daily living; parents are placing demands on their children to be "successful;" children are being abused and neglected; and parental substance use is a growing problem. Family support can take many forms, including parenting classes, affordable quality child care, mental health counseling programs, and substance abuse treatment programs. Over the next five years, the Title V Program will promote optimal family functioning by partnering with other MCH serving agencies, families, and communities to develop and implement policies and programs that promote optimal family functioning for all families.

### **4. To promote healthy children.**

Similar to the 2000 needs assessment findings, both qualitative and quantitative data continued to reveal unacceptable levels of morbidity and mortality among children in the early and middle childhood periods. Areas of continuing concern included asthma, overweight and obesity, dental caries, mental health related problems, and child abuse and neglect. This priority was selected to ensure continued focus on improving the health of children in the early and middle years. For example, asthma currently affects more than 100,000 Maryland children and it is the leading cause of hospitalization for children in the elementary and middle school years as well as the leading reason for school absenteeism. Asthma is a controllable disease when properly managed. The use of hospital emergency departments for routine asthma management can be an indicator of poor asthma management. The Maryland Asthma Control Program which is administratively housed in the Center for Maternal and Child Health is implementing a statewide plan to reduce mortality and morbidity from asthma by promoting educational and other strategies to improve asthma management. The emergency department use rate due to asthma will be used as one the state performance measures for this priority.

This priority was also chosen because of the relationship between health, school readiness and school performance. The Center for Maternal and Child Health is the recipient of an MCHB funded Early Childhood Comprehensive Systems Grant. This funding is being used to develop a plan for promoting school readiness by improving the health of young children in Maryland through early childhood systems building and collaboration. The second state performance measure for this priority is the percentage of students entering school ready to learn.

### **5. To promote healthy adolescents and young adults.**

Adolescence, however it's defined (ages 10 -- 19 or 12-19 or 13-24), is a time of tremendous change and growth. This transitional developmental period between childhood and adulthood offers many physical, mental and emotional challenges. Risk taking is the norm during this period. Many adolescents make the transition to adulthood with few problems; others do not fare as well. Focus groups with parents and service providers consistently identified the need to promote healthy, positive youth development by

offering adolescents "a sense of future." The health care system was not viewed as "adolescent friendly" and seen as ill equipped to address growing mental health, psycho-social and emotional problems of teens. Hence, adolescent health promotion was chosen as a priority to highlight the unique needs and issues that affect this often overlooked segment of the MCH population within the public health system.

Data on the health and mental health of Maryland adolescents, beyond traditional vital statistics measures, is limited. The Title V Program has chosen the high school graduation rate as the state performance measure and the adolescent/young adult mortality rate as an outcome measure for this priority. Other national Title V measures linked to this priority include rates of teen births, suicide, juvenile arrests and high school drop-outs.

## **6. To promote healthy nutrition and physical activity across the lifespan.**

Adult and childhood overweight/obesity is increasing at alarming rates in the U.S. and we suspect in Maryland. Data on the prevalence and incidence of childhood overweight is currently limited, but efforts are underway to improve obesity surveillance in Maryland. The latest BRFSS data for adults indicates that almost half were overweight or obese and that these rates have increased over the past decades. Rising rates of childhood overweight and obesity were repeatedly identified as a concern by focus group participants, service providers and local health department staff. Two major factors accounting for the rise obesity rates include unhealthy eating habits and physical inactivity. Parents in our focus groups expressed concerns about school vending machines that promote unhealthy eating habits, a decline in physical education programs and outdoor recess time in schools, and an increased reliance on sedentary activities such as television viewing and computers for entertainment. Because Maryland currently does not have an obesity/overweight surveillance system for the entire child population, a performance measure will be developed in the next few years as data capabilities in this area improve.



Breastfeeding is recognized as the optimum form of nutrition for infants throughout the first year of life. While breastfeeding initiation rates in Maryland have been improving and are approaching the Healthy People 2010 goal of 75%, few Maryland moms continue to breastfeed beyond the early months. Survey data for 2003 estimate that at six months, two in five mothers continued to breastfeed and less than one in five breastfed exclusively. Because breastfeeding has long term benefits and is viewed as essential to giving infants an optimal nutritional start in life, Maryland has chosen the percentage of infants breastfed at six months as the state performance measure.

## **7. To improve systems of care for Children with Special Health Care Needs**

A problem highlighted in the needs assessment by both families and providers is the issue of "navigating the system" or finding out about available services within the community and gaining access to them. This is particularly troublesome for CSHCN and their families who require not only extensive health care services but also multiple family support services. The OGCSHCN has addressed this by funding information and referral mechanisms at the large specialty centers, at a Regional Resource Center on the Eastern Shore, and at Parents' Place of Maryland. However, the majority of these centers are located centrally within the state, and getting the word out has been slow. Not all local jurisdictions are equipped to assist families with locating needed services, and parents do not feel that that pediatrician's offices are a good source of information on accessing community resources. Pediatricians agree that they don't typically have this type of information. There is a need to improve the capacity of local jurisdictions and a child's medical home to quickly and efficiently disseminate information about community resources and to advertise the information and referral mechanisms that already exist. The selected state performance measure for this priority is the percentage of jurisdictions that partner with medical homes to develop and disseminate resource materials.

## **8. Improve the infrastructure for supporting systems of care for women, children and families**

This broad priority focuses on infrastructure level issues, namely data, work force and manpower maldistribution issues that impact the state's ability to serve mothers and children. The CAST- 5 process noted that Maryland's Title V Program has recently made substantial process in collecting and analyzing data since the last needs assessment. CMCH now employs both a senior level MCH epidemiologist and a family planning program epidemiologist. The PRAMS and YRBS datasets are now available. However, it was noted that current capacity remains insufficient for undertaking in-depth studies that could provide greater direction for development of MCH policies and interventions. For example, in the mid-nineties, Maryland had one of the nation's highest early prenatal care rates, but over the past several years, early prenatal care rates have declined significantly. The Program lacks sufficient capacity to fully examine the reasons for this decline. In this instance, staff had the expertise, but lacked the time to perform this in-depth analysis.

The CAST-5 discussions also revealed that the CMCH process for data analysis is not systematic and that greater understanding of the needs affecting the most vulnerable MCH populations in our state is the goal, then the environment for data sharing will need to be improved, in addition to work force development. The Title V Program plans to address these issues by identifying at least one major issue requiring in-depth study and analysis each program year. This work will be accomplished in partnership with other MCH serving agencies, where appropriate. The initial state performance measure for this priority will be the number of policy briefs developed.

Public health workforce and health manpower shortage and development issues were identified as a subset of this priority. A great deal of concern was expressed throughout the CAST-5 deliberations and in meetings with local health departments about the long term implications of the aging of the MCH workforce.

