



**Montgomery County, MD Improved Pregnancy Outcomes Program  
Fetal & Infant Mortality Review Board Community Action Team  
Fiscal Year 2020 Annual Report**



***A poor pregnancy outcome or infant death is a loss for our entire community. The Improved Pregnancy Outcomes Program, which consists of the Fetal / Infant Mortality Review Board and Community Action Team, works to ensure that all babies are born healthy in Montgomery County. Their efforts help us understand the reasons behind these tragic losses and recommend actions to improve pregnancy outcomes.***





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**Our sincere thanks to each of our FIMR Board and Community Action Team members for your expertise and commitment to improving the lives of all women and infants in our community. We remain grateful to our FIMR Board & Community Action Team Co-Chairs, and FIMR CAT Program Volunteer for their outstanding leadership and dedication.**

**FIMR BOARD CO-CHAIRS**

**Carol Garvey, MD, MPH**  
Community Advocate  
Health Officer, Ret.

**Arva Jackson, MSW**  
Community Advocate  
FIMR Co-Chair Emeritus

**CAT CO-CHAIRS**

**Monica Howard, MD**  
Physician, Private Practice

**Pat Keating, RN, BSN**  
Holy Cross Hospital, Retired

**FIMR CAT PROGRAM VOLUNTEER**

Carol Jordan, MPH, BSN, RN  
Montgomery County DHHS, Retired

**PROGRAM STAFF:**

**Sheilah O'Connor**, Program Manager  
Improved Pregnancy Outcomes Program  
Child Fatality Review Team

**Carroll Piacesi**, Principal Administrative Aide

**MESSAGE FROM TRAVIS GAYLES, MD, PhD**  
**MONTGOMERY COUNTY HEALTH OFFICER & CHIEF, PUBLIC HEALTH SERVICES**



As the Improved Pregnancy Outcomes Program 2020 Annual Report goes to press, Public Health is engulfed in the COVID-19 crisis, which is testing the limits of our resources and challenging staffing and budgetary constraints. COVID-19 has also given us another clear example of how a health emergency can disproportionately affect people of color.

The Fetal & Infant Mortality Review (FIMR) Board and Community Action Team (CAT), which make up our program, have endeavored for decades to address persistent and alarming racial disparities in infant mortality. This Annual Report was created to highlight program efforts during FY 2020. We were very fortunate to have another year of outstanding leadership led by FIMR Board Co-Chair Dr. Carol Garvey and Co-Chair Emeritus Arva Jackson, CAT Co-Chairs Dr. Monica Howard and Pat Keating, and FIMR CAT Program Volunteer Carol Jordan. I extend my sincere gratitude to them and to all the volunteers for the countless hours, energy and unwavering dedication they bring to the team and our initiatives.

The FIMR Board and CAT represent a wide range of public agencies, hospitals, private organizations and other advocates working together to improve women's reproductive health. We thank each of you for your expertise and commitment to improving the lives of women and infants in our community. The work you do matters and is deeply appreciated.

We are pleased with the progress of our Babies Born Healthy (BBH) Program, which provides nurse case management services to at-risk pregnant women who live in zip codes with high numbers of fetal and infant loss. The BBH Program works very closely with FIMR/CAT, and during the year ahead will continue promoting its *Speak Up* initiative to empower pregnant women to voice their concerns and ensure they are being heard by their health care providers.

I also want to acknowledge the African American Health Program's S.M.I.L.E. Program, which provides nurse home visiting services to pregnant Black/African American women and their infants up to their first birthday. These are just two examples of how Public Health Services addresses racial disparities related to maternal and infant health.

Equity requires directing attention and resources to groups that have greater needs due to a history of exclusion or marginalization. FIMR/CAT will continue to target the population most at risk for poor pregnancy outcomes, i.e., Black/African American women. A recent March of Dimes Consensus Statement states that we must "engage in health system reform, including re-educating providers on implicit racial bias to better serve the highest risk population." My office will continue to send letters twice a year to obstetricians to alert them about racial disparities and provide contact information for the BBH and S.M.I.L.E Programs.

In 2020, the Montgomery County Council passed the Racial Equity & Social Justice Act and declared racism as a Public Health crisis. These are important steps to bringing attention to and validating the mission of FIMR/CAT and many other health and social service programs in the County.

There is much work to be done, including at the Federal government level, and I commend all of our dedicated workers here in Montgomery County. I sincerely believe you are making a difference.

Thank you.



## LETTER FROM FIMR BOARD & COMMUNITY ACTION TEAM CO-CHAIRS

On behalf of the Montgomery County, MD Improved Pregnancy Outcomes Program, which includes the Fetal & Infant Mortality Review (FIMR) Board and its Community Action Team (CAT), we are pleased to share our Fiscal Year 2020 Annual Report.

We sincerely thank all of the dedicated volunteer members who lend their expertise and wisdom to this process. And we are truly fortunate to have the leadership and commitment of Sheilah O'Connor, DHHS Program Manager, who oversees the Improved Pregnancy Outcomes Program and the Child Fatality Review Team.

If there is any silver lining to the COVID -19 crisis, it's that it has focused attention on what our members have been discussing for years - the stark and unacceptable racial disparity and health inequity in the Black/African American population. This year's report includes specific sections on COVID-19 and Pregnancy, as well as Racial Disparity and Health Equity in Pregnancy Outcomes, both of which are important and timely topics.

For the first time, we have included a section on Oral Health and Pregnancy written by Beth McKinney of the DHHS Dental Program. There are also brief program summaries from the Babies Born Healthy Program, the S.M.I.L.E Program and the Maternity Partnership Program. FIMR/CAT wholeheartedly supports these evidence-based nurse case management initiatives and will continue to advocate for their ongoing funding.

The dire racial disparity in birth outcomes for Black/African American women should be a call to action in this County and across the nation. It is Public Health's mission to advocate for the underserved and the vulnerable in our community. By listening to the voices of women of color, we can implement better approaches and strategies to protect the most at-risk populations.

In the Fall of 2020, FIMR/CAT will present a symposium with representatives from all of the birthing hospitals in the County to discuss how their institutions are addressing the racial disparity concern and to receive updates from each on COVID-19 and pregnancy outcomes. In addition, during FY21 FIMR/CAT will focus on pre-conception health, improving access to birth control, education about inter pregnancy spacing, increasing awareness of eclampsia, and continuing to address racial disparities in pregnancy outcomes.

The Improved Pregnancy Outcomes Program sincerely thanks Montgomery County Health Officer Dr. Travis Gayles for his ongoing support of our mission and goals and for acknowledging the importance of the work we do. Dr. Gayles has sent two letters to County obstetricians during this past year to promote greater awareness of the racial disparity and the unique needs of Black/African American pregnant women.

The Improved Pregnancy Outcomes Program Fiscal Year 2020 Annual Report follows.

**FIMR Co-Chair:**

**Carol W. Garvey, MD, MPH**

Community Advocate  
Health Officer, Retired

**FIMR CAT Volunteer:**

**Carol Jordan, MPH, BSN, RN**

Montgomery County DHHS, Retired

**CAT Co-Chairs:**

**Monica Howard, MD**

Physician, Private Practice  
Community Advocate

**Pat Keating, RN, BSN**

Holy Cross Hospital, Retired



## **FETAL & INFANT MORTALITY REVIEW BOARD & COMMUNITY ACTION TEAM**

### **OUR VISION**

All infants of all races are born healthy in Montgomery County, Maryland.

### **OUR MISSION**

To increase healthy pregnancy outcomes and address related racial disparities by improving health care delivery systems and community resources in Montgomery County, Maryland.

### **WHO WE ARE**

The **Fetal & Infant Mortality Review (FIMR) Board** is made up of a wide range of health care providers and includes obstetricians, neonatologists, and other physicians, hospital nurses, public health nurses and other officials, mental health providers, social workers and healthcare insurers.

The **Community Action Team (CAT)** is an advisory and advocacy group that includes dedicated representatives from community non-profits, local and state agencies, youth and parenting groups, bereavement support programs, hospitals and a host of other public and private organizations.

### **HISTORY OF FIMR & CAT**

- Established in 1988 by the Federal HHS Health Resources & Services Administration in five states to identify factors that contribute to fetal/ infant loss and improve health care delivery systems. Maryland began its FIMR Program in 1997. The Montgomery County FIMR Board & CAT were created in 1998.

### **FIMR & CAT GOALS**

- The FIMR Board is responsible for conducting de-identified reviews of fetal / infant loss among County residents to identify non-clinical factors contributing to poor pregnancy outcomes. The Board recommends changes to health care delivery systems and identifies community resource needs. Our goal is to reduce fetal / infant mortality, address racial disparities in pregnancy outcomes and promote good preconception health.
- In 2019, the Maryland Department of Health directed FIMR programs to temporarily pause case reviews and devote resources to carrying out key recommendations via the Community Action Team, particularly those related to addressing racial disparities in birth outcomes. The FIMR Board is resuming case studies in 2020.
- The CAT advocates for healthcare delivery system changes and improved community resources that benefit all pregnant or postpartum women, but especially the most at-risk and vulnerable. Black/African women in our County have a two-to-three times higher rate of infant mortality and poor pregnancy outcomes than women of other races.
- The CAT focuses on:
  - + Promoting awareness of these racial disparities;
  - + Improving collaboration and continuity of care starting with pre-conception health;
  - + Engaging the provider community to be aware of racial disparities and implicit racial bias;
  - + Encouraging patient empowerment via a “Speak Up” campaign;
  - + Advocating for community engagement and education;
  - + Continuing to support Nurse Case Management Programs in Montgomery County (Community Health Services, Babies Born Healthy, SMILE Program and the Maternity Partnership Program), which provide evidence-based services to populations most at risk for fetal / infant loss.



## RACIAL DISPARITIES AND HEALTH EQUITY IN PREGNANCY OUTCOMES

Racial inequities in pregnancy outcomes is a tragedy that demands focused and sustained action.

Infant mortality throughout the United States and in Montgomery County is two to three times higher among Black / African American mothers than for their white counterparts. Low birth weight and prematurity are almost one and one-half times as high for the Black/African American population, often resulting in a lifetime of health issues that include physical and intellectual challenges.

Black/African American women across the United States are three to four times more likely to die from pregnancy-related causes than white women, and Black/African American babies are twice as likely to die before their first birthday.

A 2018 Montgomery County study indicated that while maternal mortality was very low, severe maternal morbidity was higher than the national rate. Black/African American and Hispanic women were 61% and 46%, respectively, more likely to experience severe maternal morbidity than white women. These glaring and persistent irregularities in pregnancy outcomes and severe maternal morbidity should be unacceptable to all and must be addressed.

The March of Dimes stated recently that the racial disparity in pregnancy outcomes “is the result of deeply entrenched structural racism” (Stacey D. Stewart, MOD Newsletter, June 8, 2020).

Birth equity means that all moms and babies have the opportunity to attain good health and that conditions for optimal births are assured for everyone. Equity requires doing things differently to achieve different results.

Achieving equity in pregnancy outcomes is a moral imperative. We must acknowledge implicit bias, those attitudes and stereotypes that affect our understanding, decisions and actions in an unconscious manner. In a recent focus group held by our Babies Born Healthy Program, Black / African American women said they are sometimes not listened to by providers and their concerns were not taken seriously.

In maternal interviews done for FIMR case reviews, several women who had a pregnancy loss did not recall receiving information about something as simple as kick counts, which might have alerted them that their babies were in trouble.

Such concerns are not limited to Montgomery County. Focus groups convened by the New York City Department of Health also found that Black / African American women do not feel their health care providers always listened to them. These women said that judgment, disrespect, bias and outright racism impacted the care they received. By listening to women of color, we can develop relevant, culturally competent solutions.

We must also look at systemic changes for access to contraceptives and finding creative ways of improving preconception health.

How can we do things differently to bring about change? Disparities in infant mortality and maternal morbidity are complex problems stemming from factors that include poor preconception health, short intervals between pregnancies, lack of access to care, inconsistent standardization of care, bias and racism.

Stress, especially, long-term chronic stress, can affect a pregnant woman and her unborn baby ([yahoo.com/babybrain](http://yahoo.com/babybrain)). Researchers are trying to better understand the biology of stress and how prolonged adversity for a mother caused by bias, racism, poverty, joblessness, exposure to violence, food insecurity and myriad other factors can affect the development of the baby in the womb.





In 2020, the Montgomery County Council passed the Racial Equity and Social Justice Act to systematically change the culture and address racial inequity in health and other matters. (The final bill, as passed, can be viewed at: <https://www.montgomerycountymd.gov/COUNCIL/Resources/Files/RacialEquity/Bill27-19.pdf>).

The need for this is especially apparent in the work done by FIMR/CAT and Public Health Services. It means focusing on those most at risk: Black/African American pregnant women.

Evidence-based programs such as dedicated nurse case management and home visiting for pregnant women with appropriate caregivers have been shown to work. Programs in Montgomery County using this model include the Babies Born Healthy Program, the African American Health Program S.M.I.L.E. Program, and the Maternity Partnership Program.

Nurse case managers in these programs offer regular home visiting and address not only medical issues, but also focus on mental health issues and social determinants of health that can impact pregnancy outcomes.

Montgomery County has made progress in promoting the health of *all* mothers and babies in our community. However, closing the gap on long-standing disparities requires more resources, if we are to achieve true equity in birth outcomes.



## **COVID-19 AND PREGNANCY**

**(All data and statistics are based on currently available information at time of publication.)**

The COVID-19 pandemic has been one of the most critical tests of our resilience on a global scale in our lifetimes. COVID-19 statistics for pregnant women in Maryland and Montgomery County, MD are not available at this time. But early national data shows that COVID-19 has taken a disproportionate toll on people of color, creating yet another health care disparity affecting our vulnerable communities.

A recent national study suggests that pregnant women with COVID-19 are more likely to be hospitalized and are at increased risk for ICU admission and mechanical ventilation than non-pregnant women with COVID-19. This same study said that from January to June 2020, there were 9,989 cases confirmed and reported for pregnant women with COVID-19. This is likely an underrepresentation of the true number of cases. Of these, 26 women died.

The majority of these confirmed cases were in the 20-24 year old age range. More than 40% were Hispanic; 24% were White; and 23% were Black/African American. (National Center for Immunization & Respiratory Diseases, Division of Viral Disease; 6-25-20).

**<http://www.cdc.gov/coronavirus/2019-ncov/cases-updates/special-populations/pregnancy-data-on-covid-19.html>**

Most early studies have reported that COVID-19 does not appear to be transferred from pregnant mothers to their newborns via vertical transmission. But there are still many unknowns. We do know that COVID-19 associated with respiratory insufficiency in late pregnancy can complicate labor and delivery and creates a complex clinical scenario. Clinicians should counsel pregnant women and those contemplating pregnancy about the potential risk for severe illness from COVID-19, and measures should be emphasized for pregnant women and their families.

A small study at Northwestern University looking at the placentas of recently delivered women with COVID-19 showed evidence of injury to the placentas, such as abnormal blood flow between the mothers and their babies in utero, and also the presence of blood clots.

While most of the babies in this study were delivered full term after otherwise normal pregnancies, there remains a risk that some pregnancies will be compromised if the mother has COVID-19. One of the scientists involved in this study, Dr. Emily Miller, stated that “placentas get built with enormous amount of redundancy...so even though only half of it is working, babies are often completely fine.”

These early studies point to some potential complications for some and a need for increased monitoring for all pregnant women with confirmed COVID-19.

One final note is on breastfeeding. Breastfeeding provides significant protection against many illnesses. It is not known whether COVID-19 can be transmitted through breast milk or if any viral components, if transmitted, are infectious.

According to the CDC as of late June 2020, it is unlikely that COVID-19 can be transmitted through breast milk. <https://www.cdc.gov/coronavirus/2019-ncov/hcp/care-for-breastfeeding-women.html>. Clinicians and Nurse Case Managers should counsel breastfeeding mothers on how to minimize risk of transmission via respiratory droplets or close contact with the newborn.



## **PROGRAMS TO IMPROVE BIRTH OUTCOMES & ADDRESS RACIAL DISPARITIES**

### **MATERNITY PARTNERSHIP PROGRAM**

The Maternity Partnership Program is a public/private partnership between the Montgomery County Dept. of Health and Human Services (DHHS) and two local hospital systems, Holy Cross Health and Adventist Health Care. The Partnership provides comprehensive prenatal care, home-based case management and dental care to approximately 1,800 low income, uninsured, pregnant women each year. The Program was developed in 1989 in response to a surge in immigrants settling in the area who were ineligible for Medicaid Assistance (MA) and unable to afford prenatal care services. In its first year, it supported 866 pregnant women. Since that time, the number of enrolled women has grown significantly with year-to-year fluctuations based on immigration, pregnancy rates and changes in MA regulations.

The program's outcomes are consistently positive, with low birthweight, preterm birth, and infant mortality rates well below the State and County averages. In 2018, the infant mortality rate among program participants was 3.2 infant deaths/1,000 pregnancies while the overall infant mortality rate in Montgomery County was 8.5 infant deaths/1,000 pregnancies. Additionally, the program is successful in linking mother and baby to primary care, promoting breast feeding and increasing length of time between pregnancies.

The program provides cost savings to Montgomery County. In 2019, it served 1,472 pregnant women. Of those, only 3%, or 46 women, gave birth to low birthweight babies. Considering that the overall low-income population has a 6% low birthweight rate, one can assume that without the program intervention, 68 additional babies would have been born low birthweight. It is estimated that a low birth weight baby costs \$19,217 more than a healthy birthweight baby. In 2019, the savings due to the Maternity Partnership was over one million dollars (\$1,302,660).

### **BABIES BORN HEALTHY**

The Montgomery County Babies Born Healthy (BBH) is an initiative developed in response to Montgomery County's high disparities in infant mortality rates. The BBH Program is a comprehensive program that delivers targeted services to pregnant women residing in zip codes 20903, 20904 or 20906. These zip codes have some of the highest adverse pregnancy outcomes in the County. All pregnant women residing in these zip codes are eligible for the program, but the primary target group is African American women who are recipients of Medicaid. A total of 133 women have participated in BBH since the program began in FY19. Some 95% of the infants were delivered at term, and 5% were delivered preterm. More than 93% of the infants were normal birthweight. 90% of the mothers breastfed their infants at birth and 26% breastfed them for six months or longer.

#### **Services include:**

- + Home visiting and incentives for participation
- + Prenatal education and childbirth education
- + Parenting support
- + Breastfeeding education and nutrition education
- + Access to community resources
- + Help with transportation to prenatal appointments
- + Assistance with childcare while attending prenatal appointment

For more information, please call 240-777-3118.

<https://www.montgomerycountymd.gov/HHS-Program/PHS/PHSBabiesBornHealthy-p65391234.html>



## **AFRICAN AMERICAN HEALTH PROGRAM**

The African American Health Program's mission is to eliminate health disparities and improve the number and quality of years of life for African Americans and people of African descent in Montgomery County, MD. Its goals are to:

- + Raise awareness in the Montgomery County community about key health disparities;
- + Integrate African American health concerns into existing services and programs;
- + Monitor health status data for African Americans in Montgomery County;
- + Implement and evaluate strategies to achieve specific health objectives.

Its strategy is to bring together community partners and resources in a collaborative and effective manner to support AAHP goals. AAHP focuses on six major health areas: infant mortality, HIV/AIDS, diabetes, oral health, cardiovascular disease, and cancer.

Services provided include outreach, health education, support groups, and nurse case management. The program is staffed by a wide range of healthcare professionals, including physicians, registered nurses, health educators, and community outreach personnel.

For more information: <http://aahpmontgomerycounty.org/>

## **START MORE INFANTS LIVING EQUALLY HEALTHY (S.M.I.L.E.) PROGRAM**

African American women are more likely than Caucasian and Hispanic women to experience an infant loss in the first year of their child's life. They are also more likely to experience Sudden Infant Death Syndrome (SIDS). Maternal complications are more frequent during their pregnancy. Factors such as stress, absence of prenatal care, teen pregnancy, advanced maternal age, substance abuse, cord/placental complications, and history of premature births are said to drive the prevalence of infant mortality among Black women.

Infant mortality is defined as the death of an infant before the age of one year, per 1000 live births. A disproportionately high infant mortality rate exists in the African American population.

The Start More Infants Living Equally Healthy (S.M.I.L.E.) provides the tools and support that aim to improve the likelihood of healthy birth outcomes. The program is administered by registered nurse case managers who are passionate, loyal, and highly committed to partnering with you from pregnancy to your baby's first birthday. The care provided includes:

- + Childbirth and Breastfeeding Education classes;
- + Case management of mothers and infants, including home visits and telephone consultations;
- + Ongoing breastfeeding support after delivery;
- + Customized referrals to public and private community resources;
- + Support groups and networking opportunities.

For more information, please call 240-777-1833. <http://aahpmontgomerycounty.org/maternal-and-child-health/>



## **ORAL HEALTH AND PREGNANCY**

**Beth McKinney, RDH, Public Health Dental Program**

Maintaining good oral health contributes to a healthy pregnancy. While there is no direct causal effect between periodontal disease and poor birth outcomes, oral health is still vitally important during pregnancy. Hormonally induced gingivitis can lead to severely swollen gums and increased bleeding, even in the presence of good home care. Professional help may be necessary to control inflammation.

Pyogenic granulomas (the old term was pregnancy tumors) are more likely to form in oral tissues during pregnancy. Small ones resolve on their own after delivery, but larger ones that interfere with eating require professional removal. Tooth decay is common in women from lower socio-economic groups and it can become more severe during pregnancy because of dietary changes. Aching teeth preclude pregnant women from eating a nutritious diet.

Many of the bacteria causing these oral diseases, as well as inflammatory products the body produces to fight them, are able to pass through the placenta. Also, clients are at a particularly receptive time for education about the oral health of infants and prevention of Early Childhood Caries.

Maryland adopted guidelines for dental treatment of pregnant women in 2018. They affirm what the research has shown: all dental treatment is safe during pregnancy. This includes but is not limited to x-rays, local anesthetic, fillings and extractions.

Dental treatment should not be delayed because of pregnancy. Dentists who were previously reluctant to treat women during pregnancy now have more willingness to do so supported by state and national guidelines. However, PRAMS data shows that pregnant women in Maryland are still reluctant to visit a dentist during pregnancy. This is despite several programs, including Medicaid, offering dental coverage.

The Montgomery County Dental Program serves low- income pregnant women in conjunction with the Maternity Partnership Program. The dental program does not have the capacity to see every client. Thanks to some screening by nurses, patients are triaged and referred to the dental program. In FY19 the program saw 870 clients. In FY20 due to the shut down necessitated by the coronavirus, the program saw only 512 in the first three quarters.

Challenges in providing oral health services to pregnant clients include availability of public transportation, low health literacy, lack of expedient appointments, culturally competent care, overcoming myths and phobias surrounding dental care, financial barriers, childcare barriers for appointments, and the biggest one of all according to surveys – lack of time.

A recommendation that would overcome nearly all of these challenges would be to utilize dental hygienists working with teledentistry models to screen, treat and educate patients in obstetrician /gynecologist offices when their pregnant clients visit for their prenatal checkups.



## EMERGING TRENDS IN FETAL & INFANT LOSS

### Overview of Mothers with Fetal / Infant Loss in 2019



#### FETAL ONLY (52):

White: 21%  
 Black /AA: 37%  
 Hispanic (any race): 35%  
 Asian: 4%  
 Other: 3%

#### INFANT ONLY (33):

White: 21%  
 Black / AA: 36%  
 Hispanic (any race): 24%  
 Asian: 15%  
 Other: 3%

#### FETAL & INFANT COMBINED:

White: 21%  
 Black /African American: 36%  
 Hispanic (of any race): 31%  
 Asian: 8%      Other: 4%

#### EDUCATION:

< 9 <sup>th</sup> grade: 12%	Some College: 4%
Some High School: 6%	Bachelors Degree: 25%
High School Diploma: 19%	Advanced Degree: 20%

INSURANCE: Private: 60%    Medicaid: 33%    Other: 4%  
 Unknown: 3%

**2019 PRELIMINARY NUMBERS INDICATE 85 LOSSES (52 FETAL & 33 INFANTS) IN MONTGOMERY COUNTY**

#### DISPARITIES

+ Black/African American women accounted for 36% of losses but represent less than one-quarter of all births in Montgomery County. Their losses remained relatively unchanged from 35% during 2016-2018 (three-year average). Black/African American women remain at higher risk for poor pregnancy outcomes regardless of their education, income or frequency of prenatal care.

#### EDUCATION

+ Higher education levels among women who had a loss reflect the fact that Montgomery County residents, on the whole, are highly educated. Among women who experienced a fetal or infant loss in 2019, 45% had earned a Bachelors degree or higher. Montgomery County has one of the state's most highly educated populations, with 59% having earned a Bachelors degree, compared to 40% for Maryland residents overall.

+ Women who held a BA degree represented 25% of the total in 2019, a notable increase from 12% during 2016-2018.

#### INSURANCE STATUS

+ The number of privately insured women who experienced fetal or infant loss increased substantially to 60% in 2019 from 47% during 2016-2018. Data from 2020 and beyond will clarify whether this will be a sustained trend.

+ 33% of women who had a loss were Medicaid insured, a slight decrease from the 35% seen in 2016-2018. No one was identified as military or "self pay", which typically accounts for approximately 5% of the women.



## Maternal Characteristics Related to Fetal / Infant Loss

1 or More Risk Factors in Pregnancy: 74%  
Most common were Overweight / Obesity & Advanced Maternal Age

Normal weight: 25% Overweight: 43% Obese: 24%  
Underweight: 0% Unknown: 7%

< 20 years: 2% Age range: 18 - 46 years old  
20-29 years: 24%  
30-39 years: 66%  
40 years or more: 7%

No prior Loss: 92%  
1 Prior Loss: 4%  
2 Prior Losses: 2%  
3 or More Prior Losses: 0%

PNC Starting in 1<sup>st</sup> Trimester: 52%  
2<sup>nd</sup> Trimester: 12% 3<sup>rd</sup> Trimester: 0%  
Any Prenatal Care: 64% Unknown / missing: 36%



### RISK FACTORS

+ 74% of women in Montgomery County who had a loss in 2019 began pregnancy with at least one risk factor.

### OBESITY

+ Overweight women accounted for 43% of those who experienced fetal or infant loss in 2019, a significant increase from 20% reported in 2016-2018 (three-year average). Obese women accounted for 24% of women who had a loss last year and nearly half of this group were morbidly obese, with a Body Mass Index at 40 or higher. The large increase in obesity prevalence involves too few women to be considered a trend. However, national data indicates that obesity is common before & during pregnancy and is associated with a higher number of poor pregnancy outcomes.

### MATERNAL AGE

+ We continue to see increasing numbers of mothers in the 30-39 age group, which stood at 66% in 2019. Montgomery County typically has the oldest mothers in the state. Maternal ages ranged from 18 to 46 years old last year.

### PRIOR LOSS

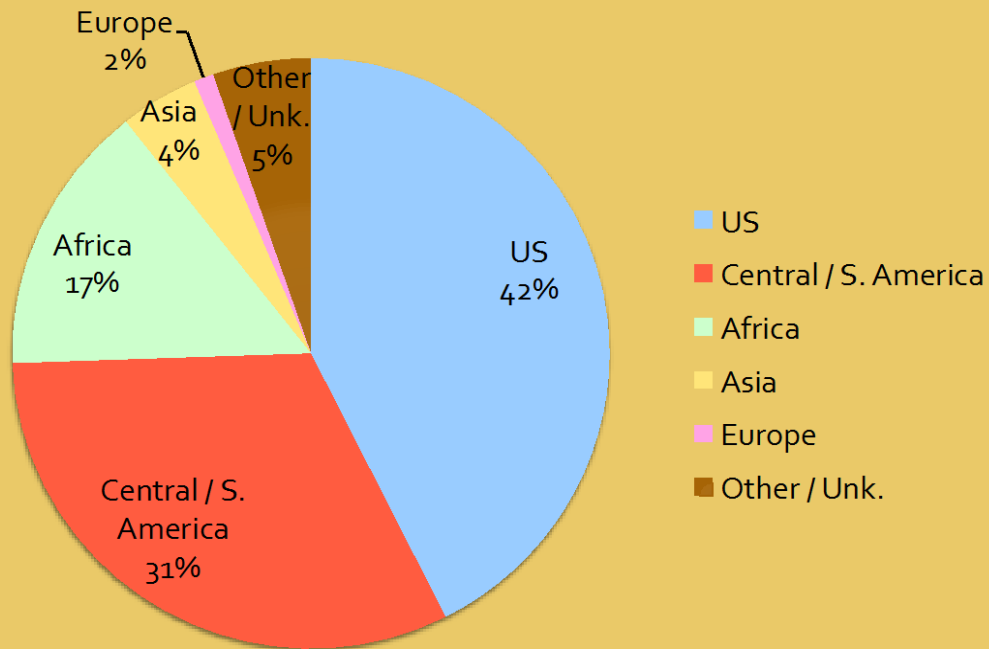
+ For the vast majority of women (92%), this was their 1<sup>st</sup> loss.

### PRENATAL CARE

+ Some 52% of women began prenatal care in their 1<sup>st</sup> trimester and another 12% began care in the 2<sup>nd</sup> trimester.  
+ Nearly two-thirds (64%) of all of women who experienced loss had at least some prenatal care.



## Region of Origin for Mothers Who Had F / I Loss in 2019



### U.S. BORN MOTHERS

- + In 2019, the share of mothers experiencing loss who were born in the United States stood at 42%.
- + For the last several years, U.S. born mothers have represented less than half of all women experiencing fetal or infant loss.

### MOTHERS FROM OTHER COUNTRIES

- + Women from Central America, South America and Caribbean countries accounted for 31% of losses during 2019.
- + Mothers born in African nations represented 17% of all fetal and infant losses in 2019. Asian and European mothers continued to represent a relatively small share of all losses, at 4% and 2%, respectively.
- + There was a relatively high share of women (5%) whose region or origin was listed as other or unknown.
- + A similar breakout regarding region of origin was noted for fathers.





## Cause of Death for Fetal & Infant Loss in 2019

### Fetal (52 Losses)

1. Cause Unknown
2. Fetal Anomalies
3. Maternal Condition / Disease;  
Premature Rupture of  
Membranes

### Infant (33 Losses)

1. Extreme Prematurity
2. Congenital anomalies
3. Preterm Premature Rupture of  
Membranes

### FETAL CAUSE OF DEATH

- + There was no known cause cited in nearly half of all fetal losses (44%) in 2019.
- + Fetal anomalies accounted for 27% of the total.
- + For the first time, maternal condition / disease is cited as a top cause of loss (8% of fetal cases).
- + Premature rupture of membranes was also cited in 8% of losses last year.

### INFANT CAUSE OF DEATH

- + With regard to infants, the top three causes remained unchanged from 2018.
- + Nearly two-thirds (61%) were due to extreme prematurity.
- + 12% of infant deaths were attributed to congenital anomalies, and 12% to preterm premature rupture of membranes.

### AUTOPSIES

- + Encouraging parents to consider an autopsy following fetal or infant loss is a frequent FIMR Board recommendation.
- + Autopsies were conducted for 21% of all losses in 2019.



## RECOMMENDING CHANGE & TAKING ACTION

### FIMR BOARD GENERAL RECOMMENDATIONS

- + Promote preconception care, including linking to primary care.
- + Promote interconception care & good health prior to pregnancy.
- + Consider pregnant Black / AA women high risk & enroll in case management.

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### TOP RECOMMENDATIONS - FISCAL YEAR 2019:

- Refer to S.M.I.L.E. or Babies Born Healthy Program for any future pregnancy
- Refer to weight management programs & encourage healthy nutrition
- Refer to tobacco education & cessation programs
- Encourage effective communication between PT and provider
- Provide comprehensive health education





## WHERE WE GO FROM HERE...

Throughout this Annual Report, we have seen that social determinants including stress and other chronic medical conditions, place of residence, family history, and access - or the lack thereof - to high quality medical services can impact the course of a women's pregnancy and health of her infant. This is true for women across the socio-economic spectrum and regardless of whether or not they are privately insured.

These factors must be kept uppermost in our minds as we seek effective ways to reduce fetal and infant mortality, with particular emphasis on addressing alarming racial disparities in birth outcomes.

Infant mortality has been identified by the Maryland Department of Health as a high priority health issue. This welcome development, combined with the recent focus on racial equity across the nation, provides an opportunity to improve birth outcomes for *all* women in Montgomery County.

Programs that include Babies Born Healthy, S.M.I.L.E. (Start More Infants Living Equally Healthy), and the Maternity Partnership Program demonstrate the benefits of focusing resources on at-risk populations of pregnant women.

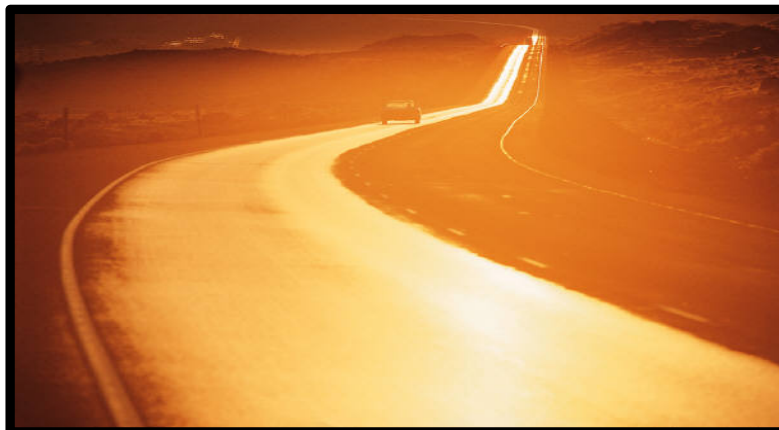
The Montgomery County FIMR Community Action Team (CAT) also plays a key role in this effort. Communities across the country are demanding change, and our CAT provides an effective mechanism for prioritizing and implementing improvements at the local level.

In the year ahead, we are resuming FIMR Board case study reviews. These in-depth medical case reviews typically include an interview with a mother who recently had a fetal or infant loss. It is a critical piece of the case review and provides a voice to bereaved parents and their experience.

Addressing racial disparities will continue to be at the forefront of our efforts. The FIMR Board and CAT will also focus on the following:

- + Women who experienced a prior fetal or infant loss;
- + Women who had a prior pre-term birth;
- + Women who begin pregnancy with risk factors that include obesity, hypertension, diabetes & other conditions;
- + Women who received limited fetal movement education during 2<sup>nd</sup> and 3<sup>rd</sup> trimester.

**A strong partnership with public agencies, private organizations and other community groups is crucial to our case reviews and community initiatives. What cannot be accomplished alone becomes possible through our combined efforts. We are grateful for your continued commitment.**





# CONSENSUS STATEMENT

## BIRTH EQUITY FOR MOMS AND BABIES

Advancing social determinants pathways for research, policy and practice

### BACKGROUND

Founded by President Franklin D. Roosevelt in 1938 to drive the discovery of a polio vaccine, March of Dimes succeeded in this mission and provided all children with access to this lifesaving therapy. Throughout his 12 years in the White House, President Roosevelt continued his crusade to improve the lives of children by proposing economic solutions across the nation to ensure fair wages, decent housing, appropriate medical care and quality education (Franklin D. Roosevelt Presidential Library and Museum, no date). President Roosevelt's pursuit of economic and social equality and the human rights work of First Lady Eleanor Roosevelt offer critical insight for the current work of March of Dimes (Glendon, 2001).

The mission of March of Dimes today is to lead the fight for the health of all moms and babies. Nearly half a million babies in the U.S. are born prematurely each year. Women of color are up to 50 percent more likely than white women to give birth prematurely, and their children can face a 130 percent higher infant death rate than children born to white women (March of Dimes Perinatal Data Center, 2018). In this country, black women have maternal death rates over three times higher than women of other races (Callaghan, 2012). In addition to the human toll, the societal cost of premature birth is at least \$26 billion per year (Institute of Medicine, 2007).

### APPROACH TO GENERATING CONSENSUS

In response to the rising rates of preterm birth as well as persistent racial and ethnic disparities, the March of Dimes Prematurity Collaborative (Collaborative) was formed in 2017 to achieve equity and demonstrated improvements in premature birth. Equity is justice and fairness (Braveman, Arkin, Orleans, Proctor & Plough, 2017; March of Dimes, 2018).



It implies equal rights, but it is not the same as equality. Equity requires directing more resources to groups that have greater needs due to a history of exclusion or marginalization (March of Dimes, 2018). In 2018, the Collaborative expanded its focus to include the health of moms because strategies used to address premature birth and its associated disparities can help prevent other maternal health problems.

Recent trends in prematurity and maternal death demand a deeper examination into causes and contributors of disparities for Native American and African-American women, the groups of women with the most disparate birth and maternal outcomes (Centers for Disease Control and Prevention, 2018 a,b). Psychosocial and economic factors, along with physical environments that affect maternal and birth outcomes, should be considered in any examination into root causes of birth and maternal disparities (Schroeder, 2007). This consensus statement examines social factors that contribute to birth and maternal health outcomes, including prematurity and offers guidance to:

[MARCHOFDIMES.ORG](https://www.marchofdimes.org)

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FOR THE FULL MARCH OF DIMES STATEMENT: <https://www.marchofdimes.org/materials/Collaborative-HE-Workgroup-Consensus-Statement.pdf>

## Appendix B – Sample Letter from Health Officer



### DEPARTMENT OF HEALTH AND HUMAN SERVICES

Marc Elrich  
County Executive

Raymond L. Crowel, Psy.D.  
Director

October 8, 2019

Dear Physician:

In honor of the recent *National Infant Mortality Awareness Month*, I am writing to provide you with information about Public Health resources that may be of value to your patients.

These resources address the persistent racial disparities in birth outcomes. In Montgomery County and across the nation, Black/African American women continue to have higher rates of fetal and infant loss than any other race. They are more than twice as likely to experience a loss than white women, both nationally and locally here in Montgomery County.

Community surveys and interviews with Black/African American women who have suffered a loss indicate that many were not aware they were at any higher risk than women of other races. Providers are oftentimes unaware of this, as well. Racial disparities are also seen in severe maternal morbidity. In Montgomery County, non-Hispanic Black/African American women have a severe maternal morbidity rate 60% higher than white women. The rate among Hispanic women is 45% higher than their white counterparts. These disparities present a challenge to us all.

The Federal Government has called for enhanced monitoring of infant and maternal mortality. The American Academy of Pediatrics recently released a policy statement on the effects of stress and, particularly stress on the developing fetus caused by implicit racial bias.

The policy notes that stress affects a developing fetus and can cause pre-term birth and low birthweight. For more information about the AAP statement, go to:

<https://www.aappublications.org/news/2019/07/29/racism072919>.

We need your help to increase awareness about these alarming trends. Will you please share with your staff that Black/African American women present a greater risk for poor pregnancy outcomes which can't be explained by the usual risk factors of poverty, lack of insurance, low educational attainment, or late prenatal care?

Simply being Black/African American is a risk factor for a poor birth outcome and therefore needs to be monitored more closely.

Public Health Services

401 Hungerford Drive • 5<sup>th</sup> Floor Rockville, Maryland 20850 • 240-777-1603 • 240-777-1494 FAX • MD Relay  
711 [www.montgomerycountymd.gov/hhs](http://www.montgomerycountymd.gov/hhs)

Montgomery County Department of Health and Human Services, Public Health Services has two programs offering dedicated case management to pregnant African American women at no cost, and I hope you'll consider making referrals to these programs:

- The SMILE Program enrolls pregnant Black/African American women up to 28 weeks gestation without regard to income, providing nurse home visiting during pregnancy and up until the infant's first birthday. The program can be reached at 240-777-1833 or [info@aahpmontgomerycounty.org](mailto:info@aahpmontgomerycounty.org).
- The Babies Born Healthy Program provides case management services and lactation consultation to pregnant Black/African American women who are Medicaid insured and reside in zip codes 20903 or 20904. The program can be reached at 240-777-3118 Monday through Friday, between the hours of 8:00 a.m. and 4:30 p.m. and referrals can be faxed to 240-777-3054.

Thank you for all you do to improve the health and well-being of pregnant women in Montgomery County. I look forward to providing additional updates throughout the year.

Sincerely,

**Travis Gayles, MD, PhD**  
**Health Officer and Chief**  
**Public Health Services**

TG:ss

**Public Health Services**

401 Hungerford Drive • 5<sup>th</sup> Floor Rockville, Maryland 20850 • 240-777-1603 • 240-777-1494 FAX • MD Relay  
711 [www.montgomerycountymd.gov/hhs](http://www.montgomerycountymd.gov/hhs)





**Montgomery County, Maryland  
Improved Pregnancy Outcomes Program  
Fetal & Infant Mortality Review Board & Community Action Team**

**Sheilah O'Connor, Program Manager  
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