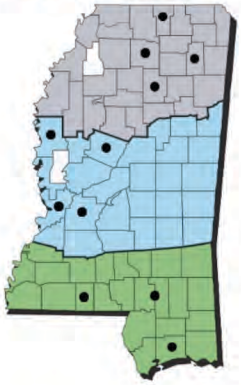
Title V Maternal and Child Health 2020 Needs Assessment, Data Brief 3

Perinatal/Infant Health Domain

Mississippi State Department of Health

This data brief is one of a six-part series that describes the methods and findings from Mississippi's 2020 Title V Maternal and Child Health Needs Assessment. For more information on Title V Maternal and Child Health and needs assessment, please see Data Brief 1: 2020 Needs Assessment Overview and Methods. Additional data briefs in the series present findings for other maternal and child health population domains.

How did we collect information?



The Mississippi State Department of Health partnered with the Applied Evaluation and Assessment Center at the University of Alabama at Birmingham (UAB) School of Public Health to conduct the 2020 needs assessment. UAB collaborated with The University of Southern Mississippi Institute for Disability Studies, Mississippi Community Education Center, and the Family Resource Center of North Mississippi to promote needs assessment activities. Needs assessment methods encouraged broad stakeholder engagement and included focus groups, key informant interviews, surveys, and analysis of Federally Available Data.

All elements of the data collection plan were designed to be accessible and encourage participation from a diverse population.

- *Focus group locations*

Colors indicate counties from which responses were received and are categorized by public health region.

Broad Stakeholder Engagement

Federally Available Data	Surveys					Focus Groups		Key Informant Interviews
Key MCH indicators provided to states	Maternal and Child Health (online)	Healthcare providers (online)	Adolescents (online)	YSHCN (online and paper)	Families of CYSHCN (online and paper)	•Women •Parents/caregivers of infants, children, and adolescents •Adolescents/young adults		Representatives of local, state, public, and private group that work with MCH population
	577	104	58 *(176 total)*	62	167	11 groups	75 participants	20 interviewees
	Total stakeholders engaged: 1,239							

**Some respondents did not meet age established range for adolescents; these responses were analyzed with the general Maternal and Child Health survey.*

Health Equity and Disparities

Promoting equity and reducing disparities in outcomes are core values for the Mississippi State Department of Health and the Title V MCH Needs Assessment. National indicator data show differences in outcomes based on woman/infant's race, ethnicity, socioeconomic status, urban/rural, and type of insurance. Stakeholders expressed differences in access to services, treatment experiences, and perception of quality of care based on geographic location, race, ethnicity, socioeconomic status, primary language, and insurance type. Health disparities not only affect groups facing inequities, but also limit overall improvements in quality of care and the health status for the broader population, resulting in unnecessary costs. All Mississippians benefit when we promote equity and reduce disparities through policies, practices, and organizational systems.

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Discrimination, bias, and differences in quality of care based on race/ethnicity, socioeconomic status, marital status, age, disability status, insurance status/type, primary language, sexual orientation, and weight

- Individuals may receive poor quality care as a result of their socioeconomic and insurance statuses.
- Health care providers do not listen to and include patients in decision making. The health care system is not patient or family-centered.
- Spanish Speaking/Latinx communities experience language-related barriers to care:
  - o inaccurate translation of paperwork
  - o poor quality of interpretation
- The quality of care available for individuals, including children, who are undocumented was perceived to be poor.

Lack of or inadequate access to comprehensive reproductive health care

- Stakeholders would like to have their reproductive choices respected by their providers. They are not confident they receive accurate information from providers, especially regarding C-sections.
- Stakeholders would like more reproductive health education, covering safe sex, healthy pregnancies, what to expect during labor and birth, and postpartum mental health.
- Substance use during pregnancy, especially by teens, is concerning.
- The high C-section rate may be due to provider preference and providers' aversion to risk. Providers may schedule repeat C-sections for subsequent births without assessing need.
- There is a need to provide prenatal care for pregnant women who are immigrants.

Inequitable access to health resources (including delivery hospitals) based on race/ethnicity, socioeconomic status, geographic location, and education

- Barriers to health care and health maintenance include:
  - o socioeconomic status
  - o education
  - o neighborhood crime and safety
  - o relationships
  - o childcare
  - o policies and politics
  - o literacy
  - o equitable educational opportunities
- Health care workforce shortages limit access to care within a reasonable distance, especially for specialty care.
- Restrictions in scope of practice for advanced practice providers further limits access to care.
- Lack of transportation, lack of awareness of available resources, and fragmented systems of care are barriers to accessing care.
- Quality of care may be poor, especially in rural areas. Provider education is needed on evidence-based care, cultural competence, and resources available in the community.

Lack of supports for pregnant and parenting teens and young/new parents

- Stakeholders perceive teen pregnancy as an increasing issue due to lack of education and parental involvement.
- Young parents need classes and resources regarding infant and child care, including increased access to home visiting programs.
- Immigrant communities may have a special need for infant safety education including breastfeeding, safe sleep, shaken baby syndrome, baby proofing

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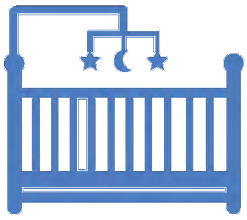
the home, etc., bearing in mind people come from different cultures and may not have the same level of awareness.

High levels of infant mortality (and associated factors of preterm birth and low birth weight)

- Infant care education from providers may be inconsistent and incomplete. Lack of infant care knowledge is perceived as the main cause of infant deaths.
- Robust, hands-on parenting education and in-depth discussions with providers were recommended solutions.
- Systemic racism and implicit bias impacts the care people of color receive and may contribute to the state's high infant mortality rate. Women of color, especially Black women, may not be taken seriously by providers when they believe they or their infant require care.
- Addressing inequitable access to care, especially due to race, is important to reduce the infant mortality rate.
- Poor quality pediatric care may contribute to infant deaths. Public insurance policies restricting covered care may result in children not receiving necessary care to avoid deaths.
- Late entry into prenatal care may contribute to infant mortality. The general public is unhealthy and there is a connection between maternal and infant health.
- Social determinants of health may be the predominant underlying cause of infant mortality. This includes:
  - o housing insecurity
  - o low level of adult health literacy
  - o unemployment/ underemployment
  - o poverty
  - o food insecurity
- There is a need to change the culture around how people think about health so that preventive health behaviors, like safe sleep, breastfeeding, and healthy eating, are normalized. Key informants felt there is a need for community education programs to address these topics.



High levels and worsening trends of sleep-related/SUID deaths

- Some stakeholders were aware of safe sleep guidelines but have difficulty putting recommendations into practice.
- The education caregivers receive about safe sleep is limited to printed materials and short conversations with providers. Expectant parents would appreciate a "refresher" even if they already have children.
- Top reasons families may have difficulty following safe sleep guidelines were:
  1. Feel having baby in bed makes night-time feedings easier
  2. Other people in the family haven't done all of these things
  3. Prefer a "family bed" or to have baby sleep in the bed with family
- Providers need training and education so that families hear consistent messaging regarding safe sleep. Education should be extended to other caregivers, such as grandparents.

Lack of or inadequate access to breastfeeding supports

- Providers encourage mothers to breastfeed. Mothers who chose not to breastfeed were frustrated that their providers did not respect their choice.
- Limited breastfeeding education and support services, including access to qualified lactation support professionals, are available. Businesses and workplaces may not support breastfeeding.
- Women who experience breastfeeding challenges may not be connected to resources beyond a limited amount

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of breastfeeding education immediately after birth.

Lack of or inadequate access to comprehensive mental health services (prevention, crisis care, postpartum)

- Mental health services are perceived as largely unavailable to those who are uninsured, underinsured, or are covered by Medicaid.
- Emergency psychiatric care may be available in some communities but non-urgent and preventive mental health services are not.
- Many stakeholders described issues with postpartum depression and anxiety.
- Stigma surrounding mental health and fear of having children taken by Mississippi Department of Child Protective Services (MDCPS) may prevent individuals from seeking care when they need it.
- Spanish speaking women may not have access to any mental health providers, especially in rural areas, due to the language barrier.

Inadequate or lack of comprehensive, affordable health and dental insurance

- Lack of insurance was the main barrier to health care access. Acquiring insurance is confusing. Out-of-pocket expenses exceed what most families are able to pay.
- 14% of survey respondents reported that they or someone in their house did not have health insurance; the most common reason stated for not having health insurance was that it is too expensive.
- Extending Medicaid to a year postpartum would promote preconception care, prenatal care and lead to healthy pregnancies by improving continuity of care for women before and between pregnancies to manage chronic conditions and adopt healthy behaviors.

Lack of or inadequate substance abuse treatment (smoking, alcohol, and drugs) and prevention education, including detox, addiction, and rehabilitation/recovery services

- Individuals in need of treatment may feel hesitant to participate in residential rehabilitation because most facilities are not family-centered, forcing parents to leave their children.
- More drug treatment programs are needed for pregnant women.
- 46% of family survey respondents don't know or aren't sure of the trends on how Mississippi is doing related to neonatal abstinence syndrome (NAS) while 45% reported an increasing trend.

What We Know: Federally Available Data

Perinatal/Infant Health Indicators	Value*	How does Mississippi compare to the U.S.?	How has Mississippi been doing?
Risk-appropriate perinatal care – very low birth weight babies born in hospitals with Level III+ NICU	81.7%	NA	Trending better
Breastfeeding – ever	63.2%	Worse	Trending better
Breastfeeding – exclusively through 6 months	13.0%	Worse	Trending better
Safe sleep – infant placed on back	56.9%	Worse	Trending slightly better
Neonatal abstinence syndrome (NAS)	3.0 per 1,000	Better	Trending worse
SUID mortality (sleep-related)	152.9 per 100,000	Worse	Mixed
Infant mortality	8.7 per 1,000	Worse	Trending better
Preterm birth	13.6%	Worse	About the same
Low birth weight	11.6%	Worse	About the same
Early elective delivery	2.0%	Same	Trending better

**Data values are most-recently available as retrieved from https://mchb.tvisdata.hrsa.gov/PrioritiesAndMeasures/NationalPerformance-Measures and https://mchb.tvisdata.hrsa.gov/PrioritiesAndMeasures/NationalOutcomeMeasures*