PROCEEDINGS

Symposium: Concentrating Efforts to Reduce Disparities in Maternal and Infant Health in the Mississippi Delta

Thursday, September 8, 2022
Harvard T.H. Chan School of Public Health

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SCHOOL OF PUBLIC HEALTH

ATTENDEES

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Dean of the Faculty, Harvard Chan School

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John Green, PhD
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Owner and CEO, Six Dimensions

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Professor of Social and Behavioral Science and the Sumner and Esther Feldberg Chair of Maternal and Child Health, Harvard Chan School

PROJECT BACKGROUND

The Mississippi Delta Partnership in Public Health (MDPPH) is a collaborative project that seeks to advance health and well-being in the Mississippi Delta through community engagement, collaborative research, and leadership development.

In addition to the Harvard T.H. Chan School of Public Health, partnering organizations include the Community Foundation of Northwest Mississippi; Delta Directions Consortium; Harvard College's Phillips Brooks House Center for Public Service & Engaged Scholarship; Harvard Law School's Food Law and Policy Clinic, Mississippi Delta Fellowship, and Mississippi Delta Project; Mississippi State University's Shackouls Honors College and Social Science Research Center; Mr. and Mrs. Robert King; University of Mississippi – Center for Population Studies; and Winokur Family Foundation.

Maternal and infant health is a key focus of the project. In the United States, maternal mortality is higher than in peer nations and has increased in recent years. There is growing recognition of a need to focus on maternal and infant health as reproductive rights shrink, birthing units are closing across the nation, and large racial and geographic inequities in care and outcomes persist across the country, particularly in the Mississippi Delta region.

The MDPPH, in collaboration with the Delta Directions Consortium, Harvard Law School, and the Mississippi State Department of Health, gathered researchers, policy experts, local clinicians, local public health officials, funders, community partners and leaders for a half-day, in-person exploratory workshop focused on improving maternal and infant health in the Mississippi Delta region.

GOALS

The workshop set initial goals of 1) increasing awareness of the various efforts, issues, and progress related to disparities in maternal and infant mortality and morbidity in the Mississippi Delta area and 2) facilitating partners in exploring the potential for additional projects or expansion of existing projects.

INTRODUCTORY REMARKS

Attendees introduced themselves, and many spoke of their love for Mississippi and respect for the state's good, community-connected, and locally-informed work—work that can serve as the foundation for further success.

Lumas Helaire and Bizu Gelaye, two of the symposium's organizers, offered opening remarks, as did Harvard Chan School Dean Michelle Williams.

Helaire welcomed the participants and charged them with gathering their collective wisdom to identify the consortium's next meaningful projects. **Gelaye** reminded the participants that Mississippi has a history of public health innovation as home to the country's first community health center in Mound Bayou with roots in the Civil Rights movement. Out of hard circumstances, such as those in Mississippi, can come model solutions.

Dean Williams acknowledged the humbling nature of the work. Even though the United States spends more per capita on health care than other countries, our maternal and child death rates have been climbing since 1990. The Centers for Disease Control counts 66% of those deaths as preventable. Mississippi has the worst child and maternal health statistics of any state.

She noted the many social, political, and economic factors to untangle in searching for the "why." We need to look beyond strictly medical factors to factors such as housing insecurity, domestic violence, income inequality, and more.

And we need to look at racism – not race, but racism. Racism manifests in inequitable access to care, deliberate policy choices, and poor-quality treatment for Black people. But racism also has a daily negative impact on the physical and mental health of Black people.

Dean Williams closed with a commitment to tackling systems-level solutions and creating the next generation of public health leaders who will not stay in their lanes.

Why Black women? The answer is not race but racism.

Dean Williams

PANEL

Effective and ineffective lessons learned from current projects in the Delta

Emily Broad Lieb and John Green

Broad Lieb and Green spoke about lessons they have learned from their work in the Mississippi Delta.

As a Harvard law student and the first Delta Fellow, **Broad Lieb** learned to listen to people who are part of the community and workingon the ground; to approach the work with humility; that trusting relationships are key, and the value of working across disciplines. Now as director of Harvard Law School's Food Policy Clinic, she participates in the Delta Directions Consortium and continues to apply those lessons.

Green described the Delta Directions Consortium as a multi-disciplinary network of individuals, non-profits, and public and private universities, and funders whose diversity is its strength: "We don't all think the same, but we care about and work on the same issues." He emphasized the importance of transparency in the work, with all parties putting their needs and strengths on the table, and the importance of clearly articulating collective goals.

INITIATIVE

Maternal Health Research Centers of Excellence

Henning Tiemeier

Tiemeier, the third organizer, brought a specific challenge to the table: Could the group come up with proposals to submit for a funding announcement from the Eunice Kennedy Shriver National Institute of Child Health and Human Development at the National Institute of Health titled Maternal Health Research Centers of Excellence (U54 grant)? The overarching goal of the initiative is togenerate innovative approaches to address preventable maternal mortality (MM), decrease severe maternal morbidity (SMM), and promote maternal health equity in partnership with the communities that are most affected. The initiative includes three components (i) research project(s); (ii) equitable partnership with the community partners; and a (iii) research training program.

He encouraged participants to think big about this grant opportunity, which has a deadline of December 6, 2022.

PRESENTATION

Framing the landscape/ setting the stage

Nakeitra L. Burse

Burse, who founded Six Dimensions, a health care research and practice agency in Ridgeland, MS, asserted that we know what the problems are with maternal and infant health. We have the academic research, and we have the insights of Black mothers. Right now, what Mississippi needs is action based on that knowledge, not more research projects.

Burse's presentation grounded the current maternal and infant health crisis in the historical treatment of Black women as property, wet nurses, caregivers, and low-wage workers whose agency is consistently challenged, most recently with the Supreme Court decision to overturn Roe v. Wade.

She illustrated the crisis with the story of Harmony Stribling, who died along with her unborn child as her husband rushed her to a distant rural hospital. Harmony was suffering from acute preeclampsia. She and her baby could have survived with better pre-natal care if there had been a hospital closer by.

Because healthy individual decision-making is possible only 1) when people's basic needs are met and 2) when systems are functional and equitable, we need to shift the narrative from blaming Black women to fixing systems and addressing racism. We need sustainable philanthropy, advocacy, and meaningful community engagement.

Listen to Black Mothers.
Nakeitra Burse

GROUPS

At this point, participants divided into three breakout groups, which discussed different topics for approximately two hours before reconvening.

Group 1 • Improving access to care and quality of healthcare services for maternal morbidity and mortality

Emily Broad Lieb facilitator; Lumas Helaire; Mary Jean Brown; Nakeitra Burse; Sam Nagle; Bizu Gelaye; Sofia Leonard notetaker

Group 1's discussion largely focused on how to build the case for Medicaid expansion. Participants also discussed, the role of community health workers, sustainability of programs, and community trust.

Brown started by saying she is most interested in how to get Medicaid expansion for post-natal care and in making sure that programs do not come and go, which is largely a function of funding.

Burse surfaced the demand from decision-makers for data to make the case for expansion, and suggested looking at the strategies of other states, like Alabama, that have achieved expansion. **Nagle** said that when we have data, we need to make it known to the public so that decision-makers cannot ignore it or claim ignorance.

Another tool to persuade legislators and other decision-makers is communication. **Broad Lieb** suggested mainstream media campaigns and more guerilla tactics and making the affected community central to developing messaging.

A different kind of communication need is ensuring that mothers know their options, whether about Medicaid eligibility (**Burse**) or contraception (**Nagle**). Contraception knowledge and access is critical for pregnancy spacing, which contributes significantly to maternal health. **Burse** added that the community itself can disseminate information through peer-to-peer models.

Group members suggested solutions to contraception deserts, ranging from vending machines (**Burse**) to policy changes (**Nagle**) to battling misinformation (**Brown**).

The conversation turned to home visits from nurses, doulas, community health workers, and social workers. **Burse** noted that doulas are not welcome in hospitals and may not be reimbursable; but community organizations could give mothers access to doulas, who can teach breastfeeding – which provides mental health benefits to moms. According to **Gelaye**, Medicaid only pays for nurses.

Gelaye also raised the issue of trust when it comes to home visits: families do not want to be reported to CPS or other agencies. **Brown** said that community health workers are familiar and trusted. The challenge is to create a pathway for CHWs to play a bigger role in care.

On the issue of trust, **Burse** noted that some health care institutions do not venture into the communities they serve, missing out on building trust and relationships. A solution is to look at who you hire and make sure you are hiring from the community, so that the community is represented within the institution, and the right people are at tables where decisions are made. She noted that community health centers "are the cornerstones of communities in Mississippi. Everyone goes there to get health care."

The group ended discussing the importance of improving access to mental health care as an integral part of post-partum care, with a goal of catching post-partum depression early. **Broad** said, "Any improvement in mental health is a win for everyone."

Group 2 • Maternal mortality and morbidity

John Green facilitator; Rachel Landauer; Sannie Snell; Beryl Polk; Wesley S. Prater; Michelle A. Williams; Sophie Hathaway notetaker

Discussion in group 2 started with a call for systemic change and quickly moved to a focus on the need for community health workers.

Participants agreed that local departments of health are experiencing workforce shortages. The need for community health workers (CHWs) – whether employed by DOHs or hospitals or community groups – means a massive workforce development effort, specifically training and licensing trusted community health workers to do in-home work with mothers.

Landauer suggested soliciting ideas from CHWs themselves about what they need for certification and licensing.

Polk said, "There is no way that health departments can be on the ground doing all the work we need to do, so need to be utilizing community partners and giving grants where we can. We also need people living in that community who can make that difference."

Williams spoke about the need for financial investments in health care to go back into communities so that programs are sustainable, and so that funders can see return on investment. **Polk** connected this idea with the need for transparency and to feed data (as well as dollars) back into communities.

Hathaway noted that as a racial justice issue, data must be shared equally with the communities from which it is extracted.

Several participants asserted that coordination is as big a problem as funding. With WIC, social workers, and other actors going into the home, there is an inefficient duplication of services and mothers can be overwhelmed. Siloed works sometimes flows from funding requirements, said **Green**. When funders are overly prescriptive about how funds are spent, it can prevent potentially synergistic collaborations. **Prater** acknowledged that funders need to aid in collaborative work rather than reinforce silos.

Connecting two ideas, **Green** suggested that community health worker training should be imbued with a commitment to showing a return on investment. "Can we equip community partners to show return on investment, which will give them better data and support evidence-based work?" In response, **Landauer** pointed out the huge need for capacity building among community partners and the necessity of reducing cost barriers for community organizations even to engage with health systems.

At this point, **Green** recapped the conversation, noting calls for systemic change; better coordination; authentic engagement with community partners including capacity building and data exchange; and demonstrating return on investment.

The discussion delved further into how to coordinate funding. **Snell** wondered if community health centers could pool HRSA and SAMHSA funding, and **Green** expanded: "We could champion communities and health departments that are offering a suite of services that are coordinated, organized, and not just people competing for different pots of money."

The session concluded with a discussion of power. **Prater** asked, "How do we ensure that we are investing in community power and mobilizing people who are health protective as opposed to those who take away rights?" **Snell** agreed: "Voting needs to happen to save Mississippi."

The conversation turned to bringing more voices and interests to the decision-making tables. **Green** ended with the thought, "Our partners need to be different, because then we can tap into communities that we usually couldn't."

Group 3 • Infant mortality and morbidity prevention

Mobalaji Famuyide; Elizabeth Levey; Tess Lefmann; Maryanne Tomazic; Henning Tiemeier ***facilitator****; Nelson Atehortua De La Pena; Destiny Davis* ***notetaker***

Famuyide kicked off the discussion with a focus on regionalization, which she called "a dirty word in Mississippi" because NICUs, for many hospitals, are cash cows. There is a concentration of NICUs in the Jackson area and an extreme shortage elsewhere in the state. While regionalization could allow access to expert care for people across the state – but we need to ensure quality of care. **Tomazic** noted that hospitals serving uninsured patients are more likely to close.

Community health centers have long been a cornerstone to care in Mississippi and can be better utilized as a base for both pre-natal and pediatric care. CHC can help prevent babies ending up in the NICU, said **Famuyide**. But she also noted that many doctors have little knowledge or contact (or trust) with centers, resulting in a disconnect once women and babies are discharged.

Community health workers could make that connection as well as be a source of information for mothers and referral to other services. In fact, said **Lefmann**, "Mothers appreciated the support more than anything from the community health workers. They trusted the community health workers. That was their lifeline more so than any information or access to breast pumps." But funding for CHWs varies between counties and is for the most part private, with little to no hope of Medicaid funding CHWs.

Participants agreed that telehealth, raised by **Tiemeier**, could supplement but not replace in-person care – not only because of the inconsistent broadband availability throughout the state, but because of doctor unease with the technology, and a consensus that in-person relationship-building is important in the state's culture.

This led to conversation about trust in communities that are over-researched. **Famuyide** said that health providers need to be hired from within communities, be faces that patients see at church and the grocery store. "Identifying people and training people in the community that they can identify with helped us in that project [Right from the Start]. And I'm not saying that's the answer for everything, but it's one way that we were able to overcome some of the initial problems."

At the same time, said one discussant, "It's so much just about meeting basic needs before anything else and asking mothers to do anything beyond that is a big ask. Food. Water. Housing. Transportation. Basic income."

These are large problems, and while Medicaid expansion will not get political support at the top, "for these things to work in Mississippi, just like relationships and everything, it has to come from the grassroots, from local communities and then building models that can work in synergy," including perhaps funding for CHWs.

Turning to mental health, **Famuyide** described a model of embedding a mental health worker in the NICU to help mothers manage their emotions, which is especially helpful when the mental health worker is a person of color (most nurses are white). A University of Alabama-Birmingham survey of mothers identified maternal mental health as the number one post-partum issue.

Because of the stigma associated with mental health professionals, is there mental health work that community health workers could be trained to do?

One participant identified a problem of "over-diagnosis and under implementation. It's not so much a lack of ideas. It's getting things done."

Another disconnect is within the medical community, with physicians not being connected to and sharing information with each other. And Black physicians, where they exist, are unsupported and leave the state. The importance of mothers seeing providers who look like them cannot be overstated. **Famuyide** has created virtual state-wide grand rounds of her NICU, which 22 of the state's 25 medical schools have participated in. This is a good step.

SHARING TAKEAWAYS

The participants reconvened as one group to share takeaways and to plan next steps.

Group 1

Reported by Henning Tiemeier

- The lead theme was a plea to focus on proper implementation rather than more new interventions or data-gathering.
- Too many initiatives do something for a while, are partly successful, then leave.
- A silver bullet may be trusted community health workers, who could play a broader/more flexible role than social workers or nurses.
- Mental health workers function best when they come from the community and are based in community health centers.
- Children at higher risk should be followed for at least a year.
- Mother's mental health key for child health
- How to refocus on child and developmental screening.
- Telemedicine cannot replace IRL but can supplement it.
- Many families are struggling with basic needs, which complicates lactation support and other services.
- There is a strong case for the regionalization of services, which must come with strong coordination and communication.

Group 2

Reported by John Green

- There are already a lot of great community level programs. What are the gaps?
- We need to move beyond project-by-project work to systems change.
- Across efforts, we need better coordination matters, especially with community partners.
- Home visiting can be key.
- Return on investment is not going back to communities. It needs to be tracked.
- There are many impact investment models but nothing that we are using across projects.
- We need workforce development efforts and community collaborator training & capacity building around evaluation and data collection.
- Yet funding is often to implement the project, not to building capacity.
- Funding can create or reinforce silos.
- There was a general discussion about whether programs, interventions, actually work for pregnant moms with children?
- Civic engagement can support our work.
- Let us look at who is at the table and who needs to be at the table.

Group 3

Reported by Emily Broad Lieb

- Focused on policy, Medicaid expansion and racially motivated pushback against it.
- What are solutions to that challenge? Study of impacts of COVID expansion of post-partum care to 12 months.
- Guerilla marketing. State house, districts of key legislators showing unnecessary deaths; to change the conversation or capture the conversation.
- Look at other expansion states: LA, KY. Gather data.
- Contraception and challenges there. Getting contraception out in unconventional ways. Access to over the counter.
- Home visits: the barrier to getting trusted individuals. Leveraging already trusted orgs and placing community health workers w/in them.
- Workforce development – leverage into long-term opportunities, higher-paying path
- Misinformation. Trouble getting accurate information. Development of resources and how to get it out, peer-to-peer learning.
- Developing messaging and testing impacts; return on investment.
- Implicit bias training and nutrition training for MDs. One-hour continuing ed. Looking at impact.
- Mental health as a gateway/strengthening mental health system/gate to coordinated care
- Sometimes you have all the data but it may not resonate with legislators – other ways to apply pressure, through grassroots movements, using PR firms. To get legislators to respond.

NEXT STEPS

During the time allotted for small group discussions, multi-layered conversations surfaced—not specific project proposals but—overlapping themes that should inform future meetings and project proposals. Those themes are:

1. Sustainability

Project that are long-term rather than one-offs; building local infrastructure so that projects can last; and sustainable funding, with investments that return to the community.

2. Return on investment

Ability to show both private funders and government agencies the return on their investment; investments back into the community; and building data-gathering capacity at the local level.

3. Systems-level change

Moving beyond a project-by-project approach; making systems functional and equitable; addressing racism rather than race; and creating the next generation of systems-minded public health leaders.

4. Community trust

Hiring trusted community members and partnering with trusted community organizations; ensuring the community is at tables of power; transparency in research; returning data and value to the community; use of trusted community health workers especially for home visits.

5. Workforce development

Addressing acute worker shortages in departments of public health; creating long-term career pathways for community health workers, including training and licensing; enabling CHWs to do mental health work; and addressing community organization's ability to do evaluation and data collection.

6. Partners at the table

Focus on equitable relationships between and among partners; building relationships by going out into communities; getting the input of black mothers in building programs; ensuring that the community is at decision-making tables.

7. Coordination/regionalization

Creating regionalized services (including NICUs) to ensure statewide access to expertise; strong coordination and communication among and between DPHs, hospitals, and community partners to eliminate both redundancies and gaps in services.

A follow-up meeting in Mississippi will examine the themes that emerged from the September workshop and narrow the focus to specific projects that the consortium will take on. The ultimate outcomes may be a publication, a grant application, a course curriculum, policy recommendations, or a program.