Pulse
A monthly newsletter from the Association of Maternal and Child Health Programs

Prematurity and Preconception Health
November 2008
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From the President

Prematurity and Preconception Care

By Nan Streeter, MS, RN

We all know that premature births are on the rise in spite of technological and pharmaceutical advances in the field. We have worked hard to promote the importance of prenatal care to assure healthy outcomes for mothers and their newborns. However, it is clear that prenatal care is too late to prevent poor pregnancy outcomes like prematurity. Instead, we need to redirect our efforts to promote and assure that women of childbearing ages receive preconception health care BEFORE conception.

Preconception health is all about assessing health status and possible risks before pregnancy. Folic acid is an example of preconception health care. Women reduce the risk of their infants having neural tube defects with folic acid intake prior to conception. Preconception health care can be an opportunity to assess possible risks for poor pregnancy outcomes, such as previous pregnancy history, medication, or chronic diseases such as diabetes or heart disease, etc. Some factors that can contribute to a poor pregnancy outcome can be ameliorated to reduce risks, such as change in medication or maintaining good glucose control. With all that we are learning about diabetes, gestational diabetes and the likelihood of developing diabetes later in life, it is clear that diabetes is one example of a chronic disease that can lead to heart defects,

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prematurity, and so on. AMCHP has been actively involved in the Preconception Health and Health Care national efforts. Magda Peck, CEO of CityMatCH and I are co chairing the public health workgroup along with the great support of CDC's Alison Johnson from the National Center on Birth Defects and Developmental Disabilities and Sam Posner from the National Center for Chronic Disease Prevention and Health Promotion. AMCHP staff members have participated on the public health workgroup which is addressing data needs, educational needs and integration of preconception health into public health practice. For example, offering preconception health assessment in family planning clinics, well women visits, etc., is an example of integration of services that might not necessarily be offered at the same time. If you are interested in participating in the national work going on in preconception health and health care, please contact AMCHP for further information.

From the CEO

Transition Time

By Mike R. Fraser, PhD

It is hard to describe the mood in Washington this week but there is definitely something different in the air. The election of our nation's first African American president brings excitement, a sense of possibility, and yes even elation to what is usually a very staid, suit-and-tie, tradition-bound city. Riding the subway to work the morning after the election was like attending a party on wheels – people were talking, sharing their newspapers, reflecting on the importance of what just happened and normally reserved Washingtonians looked at each other and smiled. November 4th was an amazing day for America regardless of your political convictions. It was a day to remember, to tell our children about, and to share in the celebration of all that is good about the peaceful transition of power, our democracy, and its ideals.

And now the question is not who will be our next president but rather what will he be able to do? How will he do it? Who will he call upon for help? Quickly after Obama's victory, pundits and politicos began to float the names of potential cabinet members, key staff leaders, and started putting together their list of who will fill important positions in the new Administration. Over the next few weeks we will have a good idea of who key leaders in the new Administration and Congress will be. In the next few months we should know key cabinet level appointments and start the process for Senate confirmation of top government appointees. Eager to start the work of a new Administration the transition is definitely "full-speed ahead," and moving rapidly to assure that on January 21st the president hits the ground running and is able to address key issues such as the economy, taxes, and health care.

So, what does November 4th mean for MCH programs?

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Transition Time

It is too early to tell but we have some signals from campaign documents and the "buzz" around town. The dire economic situation including a record Federal deficit estimated to be over half a trillion dollars, will constrain Federal investments in a number of areas. There are no quick fixes to this problem and much energy is and will be focused on addressing the economic challenges we face in the months, and years, ahead. Unfortunately, many predict that the new Administration's hands will be tied by the economic realities in which we find ourselves and limit the potential for major investments in programs including health.

Health care reform is on the transition agenda and work has already begun in the Senate to develop proposals for universal coverage for all Americans. In Obama's campaign documents there were a number of specifics about how to reform and improve health care in the United States. Exactly what this will look like remains to be seen but AMCHP is participating in discussions here in Washington and representing state MCH and CYSHCN programs in these conversations. These are exciting times and we are cautiously optimistic that we will see increased attention to maternal and child health in these reform debates even with the limitations and constraints on Federal spending. AMCHP will continue to provide updates on current happenings here in Washington in Member Briefs, Pulse, via our email legislative alerts, and on our website.

This issue of Pulse focuses on preconception care. Preconception care is a great example of a maternal and child health strategy that addresses a number of the important challenges highlighted above. We know that healthy women are more likely to have healthy babies, and investing in women's health is a smart and sound strategy for future health care initiatives. By investing in prevention and population health, preconception care can realize savings in future chronic disease spending not to mention savings by reducing negative birth outcomes. Clearly, increasing the focus on preconception care offers a number of benefits. AMCHP and your colleagues in maternal and child health programs continue to work on efforts to translate

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Transition Time

preconception care principles into MCH practice at the local, state, and Federal levels.

As AMCHP moves forward in this transition time it is good to know that sound strategies, such as preconception care, are tools in our MCH toolkit that can effectively and efficiently address the needs of MCH populations. We anticipate continuing to make the case not only for increased investments in MCH programs but also sharing the success of your work and the difference you make in your states and communities. While no one knows just what the future holds for MCH in the new Administration and Congress, we do know that transition times offer opportunities to rethink how things have been done in the past, emphasize the contributions of successful work, and enhance the role of MCH in the future. We are looking forward to reaching out to partners to move our shared MCH agenda forward, together. With your help we can use this transition time to recommit ourselves to educating and informing policymakers on MCH issues, and advocating for all women and children served by Title V programs nationwide.

Get Involved

Online Registration Now Available

Register today online to attend AMCHP's Annual Conference to convene on February 21-25, 2009, in Washington, DC.

AMCHP February Board Meeting

The next AMCHP Board Meeting will be held during our Annual Conference on Saturday, February 21 from 8 a.m. to 2 p.m. Additional information will be provided in the coming weeks. Board Members who will be attending should RSVP to Nora Lam or call (202) 775-0436.

AMCHP Business Meeting

All members, partners and staff are invited to attend a business meeting on Tuesday, February 24, 2009, from 11:45 a.m. to 12:45 p.m. during our Annual Conference in Washington, DC.

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Member to Member

Where do you see the greatest opportunities in making a difference on prematurity in the U.S.?

Alethia Carr
ECCS Director, Bureau of Family, Maternal & Child Health, Michigan Department of Community Health

In Michigan we use the information that comes from reviewing the perinatal periods of risk (PPOR) which affords a more targeted approach by offering a better understanding of infant mortality. PPOR suggested that maternal health is an area that can make a significant difference and in particular preconceptional health. Michigan has several initiatives operating to address this. The complexity of preventing premature births has made us look at the initiatives like spokes in a wheel.

Working to ensure that a woman is healthy before pregnancy is done through several initiatives to prevent unintended pregnancies. Offering an environment that helps women to have access to contraception is one effort. This helps to assure that each pregnancy is intentional and desired. We offer Title X Family Planning services, as well as administering the Medicaid waiver, called Plan First!, to allow income eligible women Medicaid coverage for contraception, who have no other insurance coverage. We also introduced a clinical guideline for discussing pregnancy "intendedness" with adults that was endorsed by Blue Cross Blue Shield of Michigan through the Michigan Quality Improvement Consortium, an avenue that establishes standards of care for medical providers. There is also an initiative that targets middle school parents, called Talk Early & Talk Often. This is designed to help parents develop the necessary skills to talk to their children about abstinence and sexuality.

Several years ago, Michigan implemented a project targeting the communities with the highest African American infant mortality rates to provide preconception health care to high risk women of child bearing age, including health education and service referral. Efforts are made to identify chronic illness in women and connect them with health care to assure adequate maintenance of their condition. This effort also involves community advocacy and mobilization for preconception health in order to generate community will and increase knowledge on the importance of healthy women for healthy infants. Future work includes establishing a medical home for all, which suggests potential benefits as well.

Finally, Michigan is working to identify guidelines for level of perinatal care in the state's delivery hospitals to assure that high risk women deliver their infants at the appropriate facility with the right mix of staff, equipment and professional expertise. Michigan had a state coordinated regional perinatal system a few decades ago, that went away in the nineties. The literature and national experts indicate that states with a regionalized and coordinated perinatal system of care assure better and appropriate care to women and infants.

Kevin Ryan, MD, MPH
Chief
Women's and Children's Health Section, North Carolina Division of Public Health

Improving the health of women prior to conception and reducing unintended pregnancies are the greatest opportunities to prevent preterm births and related disparities. Four North Carolina (NC) publications describe the health status of NC women and the opportunities to improve their reproductive health outcomes.[1,2,3,4] Healthy Start Initiative and First Time Motherhood/New Parent Initiative grant funds are providing the resources to improve the health of new mothers by linking them to health care, preventive health activities, and increasing community support. Access to family planning services has improved by increasing income eligibility for Medicaid enrollment through an 1115 Medicaid Waiver.

Administration of 17 alpha hydroxprogesterone caproate (17P) to prevent recurrent preterm birth is one of the few evidence based, clinical interventions to prevent premature births. If utilized as recommended by ACOG, 17P is very cost effective and will reduce the recurrence of preterm birth by over 33 percent among women with a singleton pregnancy and a prior spontaneous preterm birth.[5] Prior to 2007, few NC low income pregnant women received 17P. New funds provided by

Member to Member CONT.

Opportunities to make a difference on prematurity?

our General Assembly and recent coverage of 17P by our Medicaid Program has enabled us to provide 17P without charge to all high risk, low income pregnant women. Physician and patient oriented guidelines/ educational materials were developed with the support of a physician advisory group led by the UNC Center for Maternal and Infant Health. NC physicians and health departments can obtain clinical advice, order 17P, and obtain these materials through the Center's website (Look under progesterone).

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Feature

March of Dimes: Prematurity Awareness Month

By Phyllis Williams-Thompson
National Manager, Prematurity Campaign Outreach
March of Dimes National Office

One in eight babies is born prematurely. Millions of these children face serious health challenges or have trouble learning in school because they were born too soon. Even the best of care can't always spare a premature baby from lasting disabilities. And premature birth is the leading cause of newborn death in the United States. Prematurity is a complicated and difficult public health problem. Like heart disease, diabetes or cancer, it will take many years to achieve significant impact, but there has been, and will be progress along the way. The March of Dimes, as the leading nonprofit organization for pregnancy and baby health, is leading the way in finding solutions to the problems that threaten babies.

Since 2003, the March of Dimes has led Prematurity Awareness Month activities in November as part of its Prematurity Campaign. The goals of the campaign are to reduce rates of premature birth in the United States and raise awareness of this very serious and costly problem. With your help, we will reach the day when all babies are born full-term and healthy – just what all moms and dads dream of! Go to the 2008 Preemies Petition and click on get the widget!

Campaign Accomplishments

The March of Dimes has been focused on prematurity for five years creating awareness for the growing problem of preterm birth. What has been accomplished since the launch of the Campaign?

Leading the Way through Investments: Research and Grants

Supporting Prematurity Research: As part of the Prematurity Campaign, the March of Dimes started awarding a new series of research grants called the Prematurity Research Initiative (PRI). The PRI grants fund promising, innovative research into the causes of prematurity. The goal is to translate research findings into actions that will help prevent early births.

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March of Dimes: Prematurity Awareness Month

Since 2004, the March of Dimes has funded 34 PRI grants for a total of over $11 million. This funding has already resulted in promising discoveries.

In addition, March of Dimes chapters awarded more than $7 million in prematurity-related chapter grants in 2007, supporting programs related to disparities in preterm birth, smoking cessation, Centering Pregnancy® (group prenatal care), and other activities.

Leading the Way through Influence: Advocacy and Collaboration

The PREEMIE Act: The March of Dimes achieved a major campaign milestone when the PREEMIE Act (P.L. 109-450) was signed into law in December 2006. By approving the measure, Congress authorized expanded research, education and services pertaining to the growing problem of premature birth. Since then, March of Dimes has advocated for increased appropriations to federal agencies for prematurity-related research.

Surgeon General's Conference: The PREEMIE Act set the stage for a 2008 Surgeon General's conference to establish a public-private agenda to speed research and treatment of risk factors and causes of preterm labor and delivery. The March of Dimes is pursuing six key action items resulting from the conference.

The Institute of Medicine (IOM) Report: The IOM report "Preterm Birth: Causes, Consequences and Prevention," released in 2006, was cosponsored by the March of Dimes and other national organizations. The report raised the importance of prematurity on the nation's research agenda, and was the key platform for the 2008 Surgeon General's conference.

Leading the Way through Innovation—Pilots and Models with Promise

Demonstration Project in Kentucky: In 2006, the March of Dimes, the Johnson & Johnson Pediatric Institute, and the Kentucky Department for Public Health launched a prematurity prevention initiative, working with six Kentucky hospitals. The program is called Healthy Babies Are Worth the Wait. This effort helps women to stop smoking and access maternal services in their communities.

CenteringPregnancy®: In August 2007, the medical journal Obstetrics & Gynecology reported the results of a randomized, controlled trial that assessed this model of group prenatal care. Women assigned to group prenatal care were less likely to have preterm births than women who received standard one-on-one prenatal care (preterm birth rates of 9.8 percent and 13.8 percent, respectively). The March of Dimes is supporting development of CenteringPregnancy in several ways, including chapter-funded local projects.

Reducing Disparities in Premature Birth: Between 2002 and 2004, the preterm birth rate for African-Americans averaged 17.6 percent, compared to the national average of 12.3 percent. The U.S. Centers for Disease Control and Prevention (CDC) has funded the March of Dimes to develop model programs aimed at reducing disparities in premature birth. The program has tested a range of interventions in six states. In 2007, two programs were chosen for replication: group prenatal care (CenteringPregnancy®) and inter-conception (between pregnancy) care for high-risk women. The project has worked with local health departments, community-based organizations, faith-based groups and provider organizations.

NICU Family Support Project: Having a baby born prematurely, or with other medical conditions that require newborn hospitalization, can be a frightening, confusing and overwhelming time for parents and the whole family. The March of Dimes has now partnered with 100 hospitals to provide information and comfort to those families in crisis, helping them cope during hospitalization, the transition home, and in case of newborn loss.

For more information about the Prematurity Campaign contact: Phyllis Williams-Thompson at pwilliamsthompson@marchofdimes.com

Feature

Advancing Public Health Surveillance, Practice and Training to Improve Preconception Health

By Kay Johnson, MPH, EdM

Last month, CDC reported that, while data from the preliminary mortality file suggest a two percent decline in the infant mortality rate from 2005 to 2006, the U.S. infant mortality rate did not decline significantly overall or for any race/ethnicity group from 2000 to 2005 – meaning that disparities by race and ethnicity persisted. (MacDorman and Mathews, 2008) This is one indicator of the need for preconception health and health care, of the need for attention to women's health beyond prenatal care.

A Public Health Workgroup was launched to help implement the 2006 CDC Recommendations on Improving Preconception Health and Health Care (PCHHC). (Johnson et al., 2006) The activities and priorities of the Public Health Workgroup are focused in three areas:

1) Public Health Data and Surveillance;
2) Public Health Practice; and
3) Public Health Workforce Development (Education and Training).

The workgroup is co-chaired by Magda Peck, Nan Streeter, and Sam Posner.

The work is grounded in the assumptions that through leadership they can and must be influential and catalytic for advancing PCHHC in public health and that they must be strategic in our work given the growing number of related forces and efforts. The group shares a common understanding of the aim of preconception health and health care, which includes improving the health of women and infant, and is not just about addressing infant mortality as an outcome.

High priority work in public health data and surveillance includes support for: the reinstatement of preconception objectives for Healthy People 2020; measures of preconception health in MCH Block Grant performance measurement systems; and addition of key questions to relevant surveillance systems (e.g., PRAMS).

Development of an open-access library of indicators and a template state public health agencies can use to report preconception health data is underway. CDC leadership is at the core of these efforts. (Posner et al, 2008)

Priorities in public health practice include efforts to collect and disseminate promising and best practices, as well as to define standards of practice. This would under gird efforts to increase the integrate preconception health into public health practice – working with traditional partners such as Title V, Title X Family Planning, WIC, Healthy Start, and STD/HIV programs and non traditional partners such as schools, jails and social welfare agencies.

In terms of Public Health Workforce Development (Education and Training), efforts are underway to incorporate PCHHC into MCH training programs (undergraduate and other graduate education, GED, leadership and continuing education curriculum). Curricula tools, development of model course, and training materials will support these efforts.

Title V programs have a key role to play in advancing public health surveillance, practice and training to improve preconception health. In a forthcoming article, Kent and Streeter describe how Title V programs are maximizing opportunities to promote women's health, including preconception health. Key approaches include: improving state-level information systems; expanding programs to include preconception services; and leveraging policy change through partnerships. A session at the AMCHP 2009 annual meeting will describe some of the successes of "early adopter" states.

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Policy and Finance Strategies to Promote Preconception Health and Health Care

By Kay Johnson, MPH, EdM

The Centers for Disease Control and Prevention (CDC) has made recommendations for improving preconception health and health care aimed at achieving four goals (Johnson et al., 2006). These recommendations recognized the importance of policy and finance changes. In 2007, a Policy and Finance Workgroup — representing an array of organizations including professional associations, academic institutions, and government agencies — was launched to support implementation of these recommendations. It is co-chaired by Sara Rosenbaum, Kay Johnson and Alison Johnson.

Improving health coverage for women is one needed change. The Policy and Finance Workgroup developed consensus in support of a comprehensive, annual well-woman's health exam as a covered benefit in private and public health plans (from age 18). Adopting this approach in Medicaid, as well as private health plans, would be a major step toward assuring that preconception screening, education and interventions

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Strategies to Promote Preconception Health

are covered. This approach has a parallel in the well-child visits (e.g., Bright Futures, EPSDT) and Medicare.

In the absence of larger health care reforms, Medicaid coverage for low-income women has been recommended as a way to improve preconception health. Medicaid's family planning waivers could include basic preconception care including screening, education and/or interventions; however, federal rules for such waivers would have to be modified.

Additional public programs have great potential to improve preconception health and health care. State Title V programs can encourage development of a continuum of women's health services. The CDC and NIH have critical roles to play in advancing knowledge of science and best practice. Three existing federal programs that provide grants directly to community-based health service providers — the Community Health Center, Healthy Start, and Title X Family Planning programs — each provide capacity in communities with high concentrations of women at risk. Funding for these programs is currently below the level of funding needed to provide these services in all qualified communities. (Levi et al., 2007)

"Changes in public policy and health care financing, particularly health coverage and benefits are essential for improving preconception health and health care."

The Workgroup also has called for quality improvement efforts in key public programs. For example, to create:

- a women's health improvement collaborative in community health centers;
- a quality assurance project in Medicaid;
- a quality improvement project for Title X clinics;
- measures for screening in chronic disease or STI/HIV prevention programs; and
- special incentives for State Title V programs.

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Strategies to Promote Preconception Health

A special supplement of the journal *Women's Health Issue*s to be published next month describes the policy and finance context for improving preconception health and health care. (Johnson et al., 2008) It discusses current policies, as well as how preconception care fits into the larger debates on health reform.

We cannot hope to achieve our goals while half of low-income women of childbearing age lack health coverage. Access will be limited if private health plans do not cover comprehensive well-woman visits, including preconception screening. Efforts to serve high risk women rely on adequate funding for programs such as Title V and Healthy Start. Isolated family planning, prenatal care, and perinatal programs miss opportunities to provide the infrastructure for a continuum of services for women. Changes in public policy and health care financing, particularly health coverage and benefits are essential for improving preconception health and health care.

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Feature

Preconception Care and Adolescent Women

By Stacey Cunningham
Associate Director for Women's and Infant Health, AMCHP

Sharron Corle
Associate Director for Adolescent Health, AMCHP

There is increasing emphasis on preconception care in the maternal and child health community. What does this mean, however, for adolescent women – for whom we've been so actively trying to prevent conception? Furthermore, health habits initiated during adolescence can have a great impact on future health – and future pregnancy outcomes. Risk behaviors such as use of tobacco, alcohol and illicit drugs contribute potential threats to the health of young women. Risky sexual behaviors put teenagers at high risk for unintended pregnancy and HIV/STIs and their complications, which affect not only their current, but also their future, reproductive and sexual health. As the preconception care guidelines released by the Centers for Disease Control and Prevention (CDC) call for screening for sexual behavior, substance use, emotional health, nutrition/physical activity, safety and injury prevention – "preconception care" for adolescent women is simply another way to look at comprehensive adolescent health.

To consider this important issue and support AMCHP's lifespan approach to women's health, AMCHP's Women's and Adolescent Health teams are collaborating on a two-year initiative that will explore the integration of preconception health into state-level adolescent health efforts.

As part of this initiative, AMCHP will work with a small practice collaborative that will consider how states can create, implement and evaluate preconception care efforts with adolescent women. The practice collaborative will consist of four demonstration sites, each composed of four team members that would include an Adolescent Health Coordinator, Maternal and Child Health Director, Family Planning or Title X representative and one other representative (i.e. WIC

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Preconception Care and Adolescent Women

Coordinator or School-Based Health Coordinator). Demonstration sites will be selected through a Request for Proposal (RFP) process. Teams will be tasked with focusing on three of the 10 CDC Recommendations for Preconception Health - #1: Individual Responsibility Across the Lifespan, #2: Consumer Awareness, #4: Interventions for Identified Risks, and # 8: Public Health Programs and Strategies and Health Care - to determine how they will integrate preconception care into current adolescent health efforts. Over the next several months AMCHP will be convening a small advisory group to provide assistance with developing the RFP and fine tuning the project plan. Look for more information on this exciting new initiative in the coming months!

For information about this project or AMCHP's Women's or Adolescent Health work, please contact the following AMCHP staff: Stacey Cunningham and Sharron Corle.

State Prematurity and Preconception Success Stories

Alabama

By Janice M. Smiley, MSN, RN
Director, State Perinatal Program
Bureau of Family Health Services
Alabama Department of Public Health

The Alabama Department of Public Health, State Perinatal Program (SPP) provides and initiates activities to strengthen the perinatal health care system throughout the state. Provider education is one initiative the program utilizes to enhance perinatal health. The program provides outreach education for physicians and their office staff with the support of the March of Dimes. One-hour continuing education sessions are available to family physicians, obstetricians and pediatricians and their staff on varied topics, including:

- the importance of preconception healthcare counseling to all women of childbearing age;

State Prematurity and Preconception Success Stories CONT.

- smoking cessation-counseling training targeting pregnant women and families of infants;
- importance of folic acid supplementation for all women of childbearing age;
- importance of optimal weight prior to pregnancy; substance abuse patient education;
- safe sleep for infants; and
- the importance of breastfeeding promotion.

These educational programs have proven to be beneficial to the providers and the recipients of perinatal health care in Alabama.

Minnesota

By Mary Jo Chippendale, MS, PHN
Family and Women's Health Supervisor
Division of Community and Family Health, Maternal and Child Health, Minnesota Department of Health

Minnesota has one of the nation's lowest infant mortality rates for the overall population (4.8 deaths per 1,000 live births for 2003-2005). The rate masks racial and ethnic disparities in infant mortality for African American and American Indian families whose infant mortality rates are 8.7 and 8.6, respectively, for the same period. Eliminating disparities in birth outcomes is a state priority identified by our 2005 MCH Needs Assessment. We see promoting culturally specific pre and interconceptional care to populations of color and American Indians as an important strategy to reduce disparities.

Since 2006, Minnesota's MCH staff has been actively promoting preconception/interconception health to improve birth outcomes and promote women's health. Recognizing the need to work across many disciplines, the preconception planning group includes representatives from the March of Dimes, University of Minnesota, health care systems, local public health, the Medicaid program, and Healthy Start project. The challenge of integrating pre and interconception care

State Prematurity and Preconception Success Stories CONT.

into practice involves changing consumer knowledge and behaviors, clinical practice, public health programs and health care financing.

One strategic approach has been holding annual professional education conferences. The planning for the November 2008 conference began with a Diversity Round Table Structured Discussion with professionals representing and working with populations of color and American Indians. Their guidance regarding how different populations view preconception care, child spacing and other preventive health measures provided valuable input for the 2008 conference. The group described what culturally appropriate accessible care would look like, barriers within their communities, and suggested how to frame preconception care messages. Their ideas are included as presentations for the Second Annual Preconception Conference: Reaching Diverse Communities. We anticipate 200-300 attendees and to make important progress toward our goals of improving birth outcomes and women's health, and reducing disparities.

Mississippi

By Juanita Graham, MSN, RN
Health Services Chief Nurse
Mississippi State Department of Health

The Mississippi State Department of Health continues to rank infant mortality as the agency's highest priority. Mississippi has experienced little change in infant mortality over the past decade. The 2007 infant mortality rate was 10.1 per 1,000 live births. This rate is slightly lower than the two prior years but there continues to be a high proportion of infant deaths related to low birthweight and premature birth. Among 2007 infant deaths, approximately 66 percent were low birthweight (<2,500g) or very low birthweight (<1,500g) (Figure 1) and more than 56 percent were born premature (<37 weeks gestation) (Figure 2).

State Prematurity and Preconception Success Stories CONT.

Figure 1: Percent of Infant Deaths by Birthweight, Mississippi, 2007

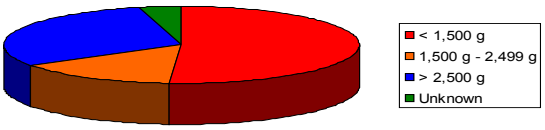
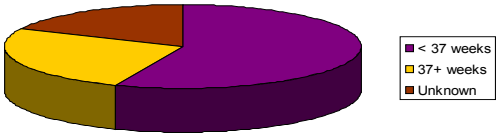


Figure 2: Percent of Infant Deaths by Gestational Age, Mississippi, 2007



Having identified low birthweight and prematurity as key contributors to Mississippi infant mortality, new funding has been acquired and new programs are being implemented to address maternal and infant health. In 2006, Health Services began to assess the relationship between maternal health and birth outcomes among Mississippi women.

Modeling after a program among high risk Georgia mothers (Dunlop et al, 2007), two projects were devised to work with women at risk for delivering a very low birthweight infant in Mississippi. The Metropolitan Infant Mortality Elimination (MIME) project is being implemented in the Jackson metropolitan area and the Delta Infant Mortality Elimination (DIME) project is being implemented in 18 Mississippi Delta counties. Combined, the DIME and MIME projects give varying perspectives – urban and rural -- of implementing interpregnancy care in Mississippi. Primarily, the projects seek to increase access to medical homes thus enhancing access to women's preventive healthcare and chronic disease management. Outreach and educational services will be provided at individual, community, and professional education levels.

State Prematurity and Preconception Success Stories CONT.

Spaces of Hope in Harlem

By Julius Dasmariñas
Evaluation Director, Central Harlem Healthy Start
Northern Manhattan Perinatal Partnership

Spaces created for human use and consumption known as the built environment can have debilitating impact on the health of marginal and vulnerable populations. In low-income neighborhoods where parks and sidewalks are unsafe, groceries lack healthier food options, and housing is decrepit, residents are observed to suffer more from obesity, depression, violent behavior, and poor birth outcomes. Add racism into the mix and the consequences could be worse. Poor birth outcomes for many African Americans, for instance, have been related to maternal stress and depression caused by life-long exposure to racial prejudice and discrimination and, to a certain extent, its translation in physical, social, economic and service milieus.

In Harlem, however, significant gains have been achieved in improving the health of mothers and their infants through interventions that dually address individual needs and structural reforms in the built environment.

Through clinical and group education intervention of the Northern Manhattan Perinatal Partnership (NMPP), a not-for-profit organization, and its Central Harlem Healthy Start Program, over 9,500 women and their children have been linked and maintained in care. Since the program's inception in 1990 when the infant mortality rate (IMR) was 27.7 infant deaths per 1,000 live births, the IMR in Central Harlem has plummeted to 5.2 infant deaths per 1,000 live births in 2004, much better than the national IMR of 6.78; from 2001 to 2007 on average, there had been less than 10 infant deaths per 1,000 live births within the community.

The agency also actively advocated for reforms in urban services that directly affect the health of its target population. NMPP embarked on a campaign to reduce the number of bus depots in the community because

Success Stories CONT.

Spaces of Hope in Harlem

of the established correlation between the type of air quality and diesel engine fumes emitted by buses with low birth weight. It likewise supported the building of supermarkets that provide healthier foods to its constituents while ensuring that the bid of the New York City government to construct 165,000 affordable housing is realized. Many Healthy Start consumers have availed of the over 82,000 units that had been built so far and are now raising their families in a decent and secure environment.

To sustain their family's economic and physical well-being, NMPP introduced a job readiness program that had placed over 890 women in full-time and part-time employment. At the policy level, it supported the empowerment-zone legislation initiated over a decade ago which infused Harlem with up to $300 million in block grants for community revitalization and job-creation projects. With the advent of gentrification and its social and economic cost on poor and working class residents, NMPP coalesced with like-minded groups to put pressure on local public leaders and private sector representatives to increase the growth of affordable housing and help boost the business acumen of local vendors so they could compete with larger stores that have settled on 125th street.

'Taking care of one's space' is something that NMPP instills among its consumers and partners. Whether it is through group work where mothers express their personal troubles and understand the societal basis of their predicament as they learn to deploy effective strategies for managing their pregnancy, or through the agency's advocacy of equitable urban policies that mediate the built environment, the charge of the agency is as clear as ever. NMPP remains determined and hopeful to establish a healthy community for mothers and children in Harlem one space at a time.

Movers & Shakers

The Life Course Perspective:

Improving Health Outcomes across the Lifespan

By Cheri Pies, MSW, DrPH
Director, Family, Maternal and Child Health Programs

Over the past four decades, millions of dollars have been directed to large-scale national efforts to ensure that every woman, regardless of her ability to pay, has access to quality prenatal care services. Despite the successful implementation of comprehensive prenatal care services, significant and substantial disparities in birth outcomes between racial and ethnic groups still persist. A broad new paradigm is emerging in MCH among some leading practitioners, academics, and MCH policy advocates that has the potential to expand our practice, with a focus on addressing racial-ethnic disparities in birth outcomes and the broad environmental determinants of health.

This Life Course Perspective (LCP) offers a new way of looking at an individuals' health over their life span, not as disconnected stages (infancy, latency, adolescence, childbearing years) unrelated to each other, but as an integrated whole. It suggests that a complex interplay of biological, behavioral, psychological, social and environmental factors contribute to health outcomes across the span of a person's life and builds on recent social science and public health literature that posits that each life stage influences the next.

In 2006, Michael Lu, Milton Kotelchuck, Padmini Parthasarathy, and Cheri Pies formed the Life Course Work Group (LCWG), to examine the application of the Life Course approach for the MCH field. In June 2008, with funding from The California Endowment, we brought together 25 national MCH experts for a two-day meeting to begin a substantive dialogue about the application of the LCP to MCH and identify how five distinct MCH areas – theory, research, practice, policy, and education and training – would need to change and evolve in order to utilize the LCP in the field.

Movers & Shakers CONT.

The Life Courese Perspective

There are several concrete outcomes that will be developed as a result of the National MCH Life Course Work Group meeting. One outcome of interest to AMCHP is the Life Course Perspective Toolbox. This will be a web-based toolkit (on the CityMatCH site beginning in 2009) which will include a full report of the National meeting, as well as a policy briefings, a Life Course bibliography, and tools for agenda setting for MCH research and policy arenas. In addition, it will contain PowerPoint presentations and related educational materials about the Life Course Perspective and it's integration into MCH for use by academics and practitioners in classroom and on-the-job settings.

For more information about the Life Course perspective and the work being done in Contra Costa County, California, visit here.

View from Washington
Change is in the Air

By Brent Ewig, MHA
Director of Public Policy & Government Affairs, AMCHP

Major change is coming to Congress, the White House and the nation! Regardless of your political affiliation, the election results reflect a strong desire among voters for a new direction. It is our hope that this direction will include renewed support for MCH, and we want to share several actions AMCHP is taking to adapt our strategies to the new political landscape in Washington to better advocate on your behalf.

It is first worth noting that the paramount rate-limiting factor for any change will be the record federal deficit, estimated to be exceed half a trillion dollars next year. This means AMCHP will need to re-double our efforts to advocate for MCH funding by sharpening our message to reflect the current economic crisis. Now more than ever we need to demonstrate how investments in MCH services are cost-effective and an investment in our economic future.

While there is good reason to believe we will have a more receptive audience in Washington, it is also instructive to recall that the Title V MCH Block Grant only increased by about $30 million in the early years of the Clinton Administration when there was last one-party control in Washington. Clearly we have a lot of work to do, and we believe that with your help AMCHP can make an effective case to improve MCH funding and support in the years to come.

Preparing for a New Administration

As AMCHP CEO Mike Fraser notes in his column, the buzz in Washington is all about transition. There are three key issues we are engaging in with during this transition: who will be the key new health policy leaders in the Obama Administration; what they will propose in their budget; and what leadership they will provide on

View from Washington CONT.
Change is in the Air

health care reform. Things are fluid and changing daily, but here's what we know so far:

On personnel, it is still too soon to know who the key leaders at HHS will be, but we do expect that Cabinet nominees including HHS Secretary will be put forward in the weeks and months ahead. [Note: At press time, it is being reported that former Senate Majority Leader Tom Daschle is President-elect Barack Obama's choice to lead the Department of Health and Human Services.] Sub-cabinet leaders will also be nominated in the months to come but expect anywhere from 6 to 12 months for a full contingent of HHS political appointees to emerge.

We do know who some of the key health advisors were in the campaign, and expect they will continue to be influential in the transition and shaping early health proposals in the Administration. Two of the key advisors AMCHP will be reaching out to include Neera Tanden and Dr. Dora Hughes. Ms. Tanden was the Director of Domestic Policy for the Obama Campaign and formerly served as Sen. Clinton's Legislative Director. Dr. Hughes is Sen. Obama's legislative assistant for health in his Senate office and formerly worked at the Commonwealth Fund. There are many others who will be influential – likely including several former Clinton Administration officials. We will look to connect with them all to share our advocacy priorities on your behalf. Please let us know if you have any relationships with any of the expected key players as that access can be tremendously helpful to reinforce AMCHP's advocacy messages and get insight into potential new priorities.

Switching to the issues, on budgets again the controlling factor will be the exploding federal deficit and the pressure that will create to hold the line on any new spending. We do know that Candidate Obama was clear that they would look line by line through the budget to make sure they are rewarding programs that work and eliminating those that don't. Fortunately, Title V's recent top PART rating provides confidence we can demonstrate results, but it's unclear if incoming Administration will use that tool or something new. Either way, we will be sharing information with the

View from Washington CONT.

Change is in the Air

President's transition team about Title V and why support at the fully authorized level of $850 is needed.

We also know that Sen. Obama stated repeatedly on the campaign trail that health reform will be a top priority in his Administration. While most are familiar with the broad outlines of the plan he campaigned on, the actions now really turns to Capitol Hill where key committees are taking his lead and beginning to explore what kind of reform is possible.

To convey our message, we have drafted a set of AMCHP's Principles for Health Reform which were developed by our Legislative and Health Care Finance Committee and endorsed by our board in the week after the election. These will be shared with both the Obama transition team and every single member of Congress and their staff. To support our other advocacy, we also developed a 100 Day MCH Policy Agenda to convey AMCHP's support for a range of practical MCH budgetary, legislative and regulatory priorities that the new Administration can use to inform their early agenda and begin within their first 100 days. While the list of policy options is not comprehensive, we hope it conveys a practical set of things Congress and the Administration can achieve for MCH while the broader health care reform dialogue begins.

In the months ahead, we will include additional perspectives on what the changes in Congress mean for future MCH policy, and what to watch for in the debate on health care reform.

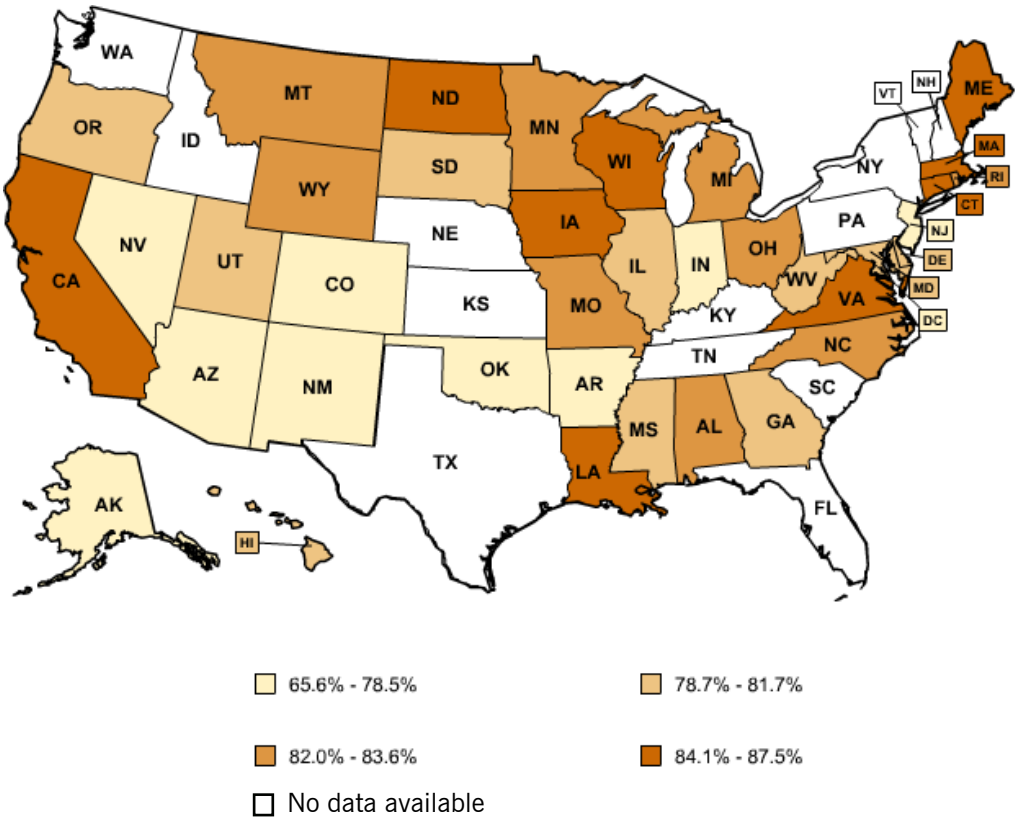
In the meantime, I want to highlight how AMCHP Members can become more involved in our advocacy efforts during this critical and exciting time:

- Let us know if you have relationships with key national policymakers that already are or can become champions for MCH.
- Educate new members of Congress and their staff by sharing one-pagers and information on what the impact of Title V is in your state and where you stand on the national and state Title V performance measures.
- Document and share impact of eroding funding, ideally through stories that demonstrate the impact on individual's lives and specific communities.
- If you haven't already, sign up for AMCHP's Legislative Alerts and watch for them in early '09.
- If allowed by your state's regulations, begin planning now to make Hill visits during AMCHP's Annual Conference on Monday February 23rd!

Change is definitely in the air in our nation's capital. We look forward to continuing to work together to make MCH a top priority with the new Administration and the 111th Congress.

Data and Trends

Percentage of Mothers Beginning Prenatal Care in the First Trimester, 2005



Notes: Data are for 2005.
Excludes data for
Florida, Idaho, Kansas, Kentucky, Nebraska, New Hampshire, New York, Pennsylvania, South Carolina, Tennessee, Texas, Vermont, and Washington, which implemented the 2003 Revision of the U.S. Certificate of Live Birth after January 1, 2005.

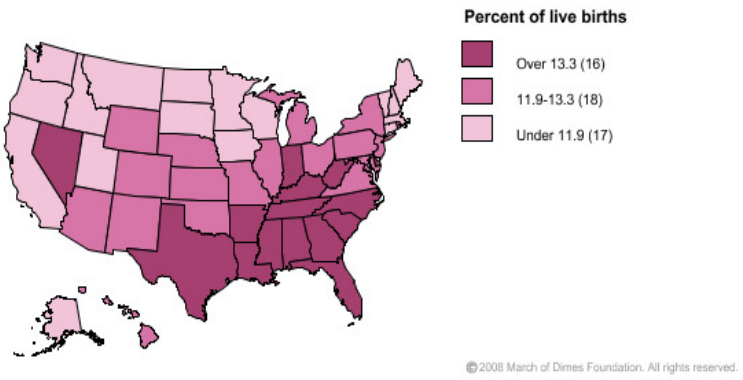
Prenatal care data based on the 2003 Revision of the U.S. Certificate of Live Birth are not comparable with those based on the 1989 Revision of the U.S. Certificate of Live Birth.

Sources: Centers for Disease Control and Prevention. National Center for Health Statistics. VitalStats. http://www.cdc.gov/nchs/vitalstats.htm. Accessed 6/24/2008.

Data and Trends CONT.

Preterm birth

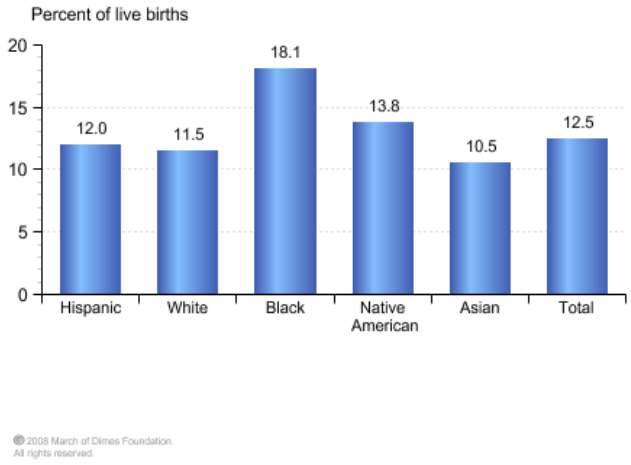
US, 2005



Preterm is less than 37 completed weeks gestation.
Source: National Center for Health Statistics, final natality data. Retrieved November 5, 2008, from www.marchofdimes.com/peristats.

Preterm by race/ethnicity

US, 2003-2005 Average



All race categories exclude Hispanics. Preterm is less than 37 completed weeks gestation. Categories do not sum to total since missing ethnicity data are not shown.
Source: National Center for Health Statistics, final natality data. Retrieved November 5, 2008, from www.marchofdimes.com/peristats.

Resource Bank

AMCHP Resources

Smoking Cessation
AMCHP collaborated with the American College of Obstetricians and Gynecologists, the Planned Parenthood Federation of America and the Women's Tobacco Prevention Network to develop and implement the Action Learning Lab. The purpose of the ALL was to increase the capacity of the state teams to advance their state action plans they began to develop in the first phase of the ALL in March 2004. States had the opportunity to share challenges, provide input on addressing the challenges, and spent a majority of their time together refining their state action plans. To download the report, visit here.

Preconception Health Case Study- California
This case study provides an overview of innovative approaches to preconception health and health care implemented by the Maternal, Child and Adolescent Health (MCAH) Division of the California Department of Public Health.

MCH and Chronic Disease Fact Sheet
This fact sheet examines the effects of chronic disease on women of reproductive age, the importance of integrating MCH and chronic disease, and the existing state performance measures that address chronic disease.

Oral Health
MCHB along with other partners is working to improve access to oral health services for pregnant women and to provide oral-health-promotion and disease prevention information for women and their families. The following documents have been prepared for public use:

Access to Oral Health Care During the Perinatal Period: A Policy Brief was developed to help professionals and the public better understand the importance of oral health during the perinatal period. The brief describes barriers to accessing oral health services and information.

Two Healthy Smiles: Tips to Keep You and Your Baby Healthy is about the importance of oral hygiene and oral health care during pregnancy. Topics include brushing, flossing, eating healthy foods, and getting dental checkups and treatment.

- Tri-fold brochure
- 8-1/2 x 11 inch fact sheet

Oral Health Care During Pregnancy: A Summary of Practice Guidelines summarizes the New York State Department of Health's publication, Oral Health Care During Pregnancy and Early Childhood: Practice Guidelines, which is geared toward prenatal and oral health professionals. The guidelines are intended to bring about changes in the health care delivery system and to improve the standard of care for pregnant women.

Other publications include:
Maternal Oral Health Resource Guide provides information aimed at improving oral health care for pregnant women. It is divided into three sections: journal articles, materials, and organizations.

Oral Health and Health in Women: A Two-Way Relationship provides general information and national data on women's oral health. Topics include women's oral health status, the relationship between oral health and general health in women, oral health care, and strategies for improving women's oral health. (2 pages)

Research to Policy and Practice Forum: Periodontal Health and Birth Outcomes: Summary of a Meeting of Maternal, Child, and Oral Health Experts is a report from a December 2006 forum that addressed the relationship between periodontal health and birth outcomes. Meeting materials are also posted online.

Preconception/Prenatal

Mother's Weight Gain During Pregnancy and its Impact on Baby's Weight
A new study has found that women who gained more

Resource Bank CONT.

than 40 pounds during their pregnancies were nearly twice as likely to have a heavy baby. The study was conducted by the Kaiser Permanente Center for Health Research and is published in the November issue of Obstetrics & Gynecology. Researchers found that more than one in five women gains excessive weight during pregnancy, which doubles her chances of having a baby weighing nine pounds or more. The study followed over 50,000 women who gave birth in Washington, Oregon and Hawaii from 1995-2003. More than 20 percent of the women who gained more than 40 pounds (the maximum recommended pregnancy weight gain) gave birth to heavy babies. In contrast, less than 12 percent of women with normal weight gain had heavy babies. Women who gained more than 40 pounds and also had gestational diabetes were at greatest risk. However, when these women gained less than 40 pounds, their risk was greatly reduced. Larger babies pose serious risks for during childbirth, including vaginal tearing, bleeding, c-sections, stuck shoulders and broken collar bones. Access the study online here.

Folic Acid Awareness and Latina Mothers
A study in the October 1, 2008 edition of the Journal of Women's Health examines Latina mothers' folic acid awareness, knowledge and behaviors in order to understand their reactions to advertising concepts and draft educational materials. The goal of the materials was to increase folic acid consumption through the use of a daily multivitamin. This study presents three phases of research that led to the development of Spanish language print advertisements, posters, a brochure, and radio ads that promote folic acid consumption in a manner that addresses the needs of Latina mother. Each year, approximately 3,000 pregnancies in the US are affected by neural tube defects (NTDs), serious birth defects of the brain and spine. Daily consumption of folic acid can reduce the incidence of NTDs by 50% – 70%. To access the study, visit here.

American College of Obstetricians and Gynecologists (ACOG)
Contains brochures, booklets, policy statements, and other materials about preconception and pregnancy for health professionals- topics include health care for underserved women, perinatal HIV, smoking cessation, and women with disabilities. Note: Many resources on the site are accessible to members only.

Association of State and Territorial Health Officials (ASTHO)

- Bringing home better birth outcomes. This issue brief examines home visiting as a strategy employed by state health agencies to deliver public health interventions aimed at improving birth outcomes.
- Preconception care fact sheet. This fact sheet addresses the need to promote women's health before conception and presents the many opportunities that exist for states to improve women's and children's health.
- Preconception care efforts at the state and local level. This issue brief provides general information on preconception and interconception care and examples of federal, state, and local initiatives promoting preconception care and interconception care. The brief is intended to inform state and local health officials and health department staff about preconception care and its role in promoting optimal health for women and infants.

Centers for Disease Control and Prevention (CDC) Division of Reproductive Health. Contains links to reports, data, and other resources about pregnancy and prenatal care, including maternal morbidity and mortality; smoking; alcohol use; folic acid consumption; violence; workplace hazards; and racial and ethnic disparities. Recent resources include

- Safe motherhood: Promoting health for women before, during, and after pregnancy. At a glance. (2008).

CityMatCH. Contains tools and resources for implementing the Perinatal Periods of Risk (PPOR) approach for mobilizing urban communities to reduce

Resource Bank CONT.

feto-infant mortality in U.S. cities. Also presents publications about perinatal HIV prevention in urban communities.

March of Dimes (MOD)
Offers perinatal statistics, continuing-education modules, and medical reference information on topics that include preconception, pregnancy, prenatal screening, and genetics. Recent publications include

- Costs of maternity and infant care. (2007).
- Diabetes in pregnancy. (2006).
- Healthcare costs of having a baby. (2007).
- HIV and AIDS in pregnancy. (2006).

Womens's Health USA 2008 Databook
Now in its sixth year, the Databook is a concise reference for policymakers and program managers at the Federal, State, and local levels to identify and clarify issues affecting the health of women. The Databook brings together the latest available information for various agencies within the Federal Government, including the US Department of Health and Human Services, the US Department of Justice, and the US Department of Labor. Free hard copies will be available at the HRSA Information Center- 1-888-ASK-HRSA and online here.

Prematurity
Preterm Delivery and Depression During Pregnancy
A recent study has shown that depressed pregnant women have twice the risk of preterm delivery than pregnant women with no symptoms of depression. Conducted by the Kaiser Permanente Division of Research, the study is published online in *Human Reproduction*.

Researchers found that the risk of preterm delivery grows with the severity of depressive symptoms. The study authors interviewed 791 pregnant Kaiser Permanente members in San Francisco city and county from October 1996 through October 1998. They found that 41 percent of the women reported significant or severe depressive symptoms. The women with less severe depressive symptoms had a 60 percent higher risk of preterm delivery – defined as delivery at less than 37 completed weeks of gestation – compared with women without significant depressive symptoms, and the women with severe depressive symptoms had more than twice the risk. For more information, a press release on the study is available online. Or, access the study here.

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