

State Title V Program Approaches to Improving Birth Outcomes

Lowering Non-Medically Indicated Deliveries

The Role of AMCHP

AMCHP supports state maternal and child health (MCH) programs and provides national leadership on issues affecting women and children. We work with partners at the national, state and local levels to promote women's health; provide and promote family-centered, community-based, coordinated care for women and children; and facilitate the development of community-based systems of services for women, children and their families.

The AMCHP National Center for Health Reform Implementation provides state MCH leaders and their partners with the information, tools and resources to optimize the opportunities presented by the Patient Protection and Affordable Care Act (ACA) for improving services, systems and health outcomes for MCH populations.

Introduction

Overview of State Title V MCH Programs

States and Title V programs are well positioned to engage with stakeholders from every level, including providers, patients, payers and consumers, to work toward lowering the number of non-medically indicated deliveries before 39 weeks.

Integral to this effort to improve the health of babies and mothers are the public health leaders and that are funded by the Maternal and Child Health (MCH) Services Block Grant (Title V of the Social Security Act) funds – which is the only federal program that focuses solely on improving the health of all mothers and children.

All states and U.S. territories receive funds from the Title V MCH Services Block Grant to build a comprehensive system of programs, services, and supports for women and children. This federal program provides critical funds for improving infant and child health, reducing infant and maternal mortality rates, and providing prenatal care to low-income women. At least 30 percent of the Title V MCH Block Grant funds must address population needs for preventive and primary care for children, and another 30 percent must serve children with special health care needs. The remaining 70 percent of the funds provide states considerable flexibility to improve and support the health of MCH populations.

State Title V MCH programs administer numerous public efforts that are natural access points for building and strengthening integrated service delivery systems. These include prenatal care programs, home visitation, early intervention for children with developmental delays (Part C of the *Individuals with Disabilities Education Act*), Special Supplemental Food and Nutrition Program for Women, Infants, and Children (WIC) programs, specialty clinics for children with special health care needs, and statewide toll-free hotlines to facilitate access to care. Title V also is required by statute to coordinate with their state Medicaid program, offering an opportunity to provide expertise on lowering non-medically indicated deliveries before 39 weeks.

While no state program is singly responsible for maternal and child health, as neutral conveners, state Title V MCH programs can bring together public and private stakeholders to reach consensus on challenges in redesigning health care delivery to meet the unique needs of women and children, such as setting standards for care and devising new approaches to evaluate and pay for care. This unique role provides a strong foundation from which these stakeholders can work together to lower the rates of non-medically indicated deliveries before 39 weeks of pregnancy.

In recent years, increased attention and energy has focused on reducing infant mortality and improving birth outcomes in the United States. Both public and private organizations are investing time and funds on many fronts and in various methods and on many jurisdictional levels. This issue brief focuses on the recent efforts to reduce non-medically indicated deliveries before 39 weeks gestation and various methods that state Title V MCH programs are utilizing to improve birth outcomes. There is differing terminology in reference to these deliveries, with early elective and non-medically indicated deliveries before 39 weeks sometimes used interchangeably. For the purpose of this brief, non-medically indicated delivery before 39 weeks will be used.

The United States infant mortality rate of 6.05 infant deaths per 1,000 births in 2011, representing an 11 percent decline from a plateau from 2000 to 2005.^{1,2} A drastic increase in deliveries at 37-38 weeks gestation occurred from 1990 to 2006 (from 19.7 percent to 28.9 percent). (See Table 1 for definitions of gestation periods) Following many efforts at the hospital, local, state, and federal levels, 2011 saw a reduction in early term deliveries to 25.9 percent from 26.9 percent in 2011.³ (See Figure 1) Births occurring at 39 and 40 weeks gestation have also increased.⁴ Despite the decline in preterm births, there are still many deliveries that occur by induction of labor and cesarean delivery before 39 weeks gestation.⁵ Cesarean section rates in 2011 were 32.8 percent of all deliveries after a decline over the previous two years from 32.9 percent of all births, the first decline since 1996.⁶

Recent studies with large cohorts have increased the amount of supporting data indicating that there are risks associated with deliveries that occur before 39 weeks gestation. Infant mortality

increases for babies born just a few weeks early (2.1/1,000 births at more than 37 weeks compared to 7.4/1,000 births for those born from 34-36 weeks gestation)⁷ (See Table 2 for infant mortality rates by weeks gestation).

Term	Completed weeks* gestation
Post term	42 or more
Late term	41
Full	39-40
Early term	37-38
Late preterm	34-36
Early preterm	prior to 34

*The definition of completed weeks means, for example, 41 completed weeks and up to 6 days into the next week.

Term	Completed weeks gestation	2007 mortality rate for infants (per 1,000 births)
Full	39-40	2.1
Early term	37-38	3.1
Late preterm	34-36	7.4
Early preterm	Less than 34	107.1

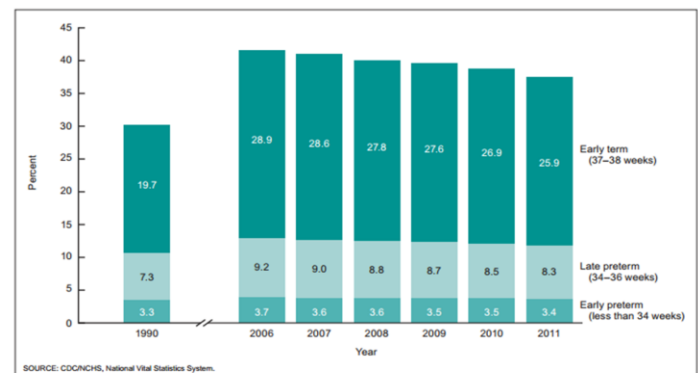


Figure 1. Births at less than 39 weeks of gestation: United States, 1990 and 2006-2011

Source: Martin JA, Hamilton BE, Ventura SJ, et al. Births: Final data for 2011. National vital statistics reports; vol 62 no 1. Hyattsville, MD: National Center for Health Statistics. 2013.

Not only are these early deliveries associated with a higher infant mortality, they also are associated with higher rates of morbidity when compared to full term deliveries. There is a nearly 18 percent increased likelihood for babies that are electively delivered by cesarean or induced at 37 weeks to be admitted to the neonatal intensive care unit (NICU). Babies that are born too soon are at higher risk for respiratory distress and feeding problems.⁹ (See

Table 3 for NICU admissions by weeks of gestation.)

	37 weeks	38 weeks	39 weeks
Percent NICU admissions	17.8	8	4.6

Besides the impact on the baby’s health, the mother also can suffer unnecessary side effects from non-medically indicated cesarean section deliveries. Recovery from these deliveries takes longer than vaginal birth and has a higher risk of complications.¹⁰

In addition to the impact on the health of mothers and infants, non-medically indicated deliveries before 39 weeks increase health care costs. For example, Medicaid paid for 55 percent of births in Texas in 2009. The estimated cost for the delivery of a healthy infant was \$404, while the cost for a preterm infant was as much as \$63,124. (See Table 4 for Texas Medicaid cost estimates) In 2007, the Texas Department of State Health Services found that 38.1 percent of single-birth inductions in 2007 were performed before 39 weeks of gestation, potentially contributing to negative birth outcomes for the mothers and infants but also contributing to likely avoidable health care costs for the state.¹¹ At the national level, from 2008- 2010 Medicaid paid for 48 percent of all births with wide variation among states.¹² Both states and the federal government have a stake in not only improving birth outcomes but also lowering non-medically indicated deliveries before 39 weeks and avoiding unnecessary costs to the system.

Reducing Prematurity is Key Priority at the National and State Levels

Reducing prematurity as a means to reduce infant mortality and morbidity and reduce health care costs is gaining momentum with several initiatives at the national level. Organizations and federal agencies such as the Health Resources and Services Administration Maternal and Child Health Bureau (HRSA MCHB), Centers for Medicare &



Medicaid Services (CMS), March of Dimes, the American Congress of Obstetricians and Gynecologists (ACOG), the Association of State and Territorial Health Officials (ASTHO), the Association of Women's Health Obstetric and Neonatal Nurses (AWHONN), and the National Governors Association (NGA) are all undertaking efforts to improve birth outcomes including reducing non-medically indicated deliveries before 39 weeks. [See Appendix A for a matrix of national and regional efforts to improve birth outcomes]

Many states have already made lowering the number of non-medically indicated deliveries before 39 weeks a priority in recent years as well. Through policy or program implementation, states have started to see positive results. Many of these initiatives are the result of collaborative partnerships among state and local MCH programs, community health centers, providers, hospitals and other key stakeholders. One of the most notable initiatives recently is the Collaborative Improvement and Innovation Network (CoIIN) to Reduce Infant Mortality. This public-private partnership brings together participants to learn from one another and national experts, share best practices, lessons learned and track progress.¹³ These partners bring resources, tools, measures, and quality improvement techniques to providers, administrators and public health leaders to improve birth outcomes. Currently, states in U.S.

Delivery of a healthy infant	\$404
Delivery of a preterm infant	\$63,124

Department of Health and Human Services (HHS) regions IV and VI are addressing five shared priorities to reduce infant mortality and improve birth outcomes. One of the priorities chosen by states is the reduction of non-medically indicated deliveries before 39 weeks. Two of the states highlighted in this issue brief, North Carolina and Texas are part of the current CoIIN effort.

Selected State Strategies with Title V Involvement

States across the country are implementing a variety of initiatives to reduce non-medically indicated deliveries before 39 weeks as well as improve birth outcomes. As a resource in states, Title V MCH programs play a key role in the implementation of these efforts. The following sections provide examples of how state Title V MCH programs are integral to the implementation of programs and policies to lower non-medically indicated deliveries and improve birth outcomes. In many ways, these initiatives are all related to quality improvement, but are grouped by the main facet of the initiative.

Voluntary Provider, Hospital Reforms, and Quality Improvement

Within the hospital setting, there are opportunities to implement quality improvement programs to reduce non-medically indicated deliveries before 39 weeks.

To improve patient outcomes, more than 3,700 hospitals are participating in the national Partnership for Patients program. This program is a public-private partnership with HHS and the hospital engagement networks (HENs)¹ to facilitate the adoption of evidence-based clinical practices that lead to improved patient safety. Reduction of non-medically indicated deliveries before 39 weeks is a focus within some of the HENs across the country, providing an example of how hospitals can engage in voluntary efforts that improve patient safety and lower costs of hospital care.¹⁴ State Title V programs are well situated as experts to provide input as well as bringing other stakeholders to the table if needed to help these efforts succeed.

Organizations such as the Joint Commission, the Leapfrog Group and the National Quality Forum are recognizing the importance of measuring and reporting on perinatal indicators that include measures the amount of non-medically indicated deliveries before 39 weeks.^{15,16,17} This focus and reporting on quality indicators related to obstetric

¹ Hospital Engagement Networks (HENs) work at the regional, State, national or hospital system level to help identify solutions already working and disseminate them to other hospitals and providers.



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care will add to the improvement of care and eventually improve the outcomes for infants and their mothers and are important information for states to consider.

California

According to state data, the California infant mortality rate has reached a record low of 4.7 infant deaths per 1,000 live births.¹⁸ However, California continues to advance efforts to maintain and improve this infant mortality rate through many programs. In collaboration with March of Dimes, and the California Maternal Quality Care Collaborative (CMQCC), California Department of Public Health (CDPH) Maternal, Child and Adolescent Health Program (MCAH) developed a toolkit to reduce non-medically indicated deliveries before 39 weeks gestation. The quality improvement toolkit, "Elimination of Non-medically Indicated (Elective) Deliveries Before 39 Weeks Gestational Age" is designed to decrease these in California and to help determine and disseminate best practices for prevention as well as effective strategies for supporting California health care providers in implementing those practices. The California MCAH also provided funding to San Bernardino Public Health Department with the goal of reducing non-medically indicated deliveries before 39 weeks countywide by educating clinicians, pregnant women, and community members on the risks of non-medically indicated induction. Title V funding was allocated to the San Bernardino Public Health Department to develop the "Labor Induction Toolkit," which contributed to the "Elimination of Non-medically Indicated (Elective) Deliveries Before 39 Weeks Gestational Age." Across California, the CDPH-MCAH Regional Perinatal Programs of California (RPPC), the CA Hospital Association, and March of Dimes (MoD) developed an environmental scan to assist each organization in assessing hospital progress on multiple points leading to the implementation and use of the toolkit. In addition to funding for the toolkit, the CMQCC would not have been possible without the funding from the Title V MCH Block Grant. The toolkit can be downloaded [here](#). The toolkit was the basis for a MoD collaborative project in which 25 hospitals in the "Big 5" states (California, Florida, Illinois, New York, Texas) representing 40 percent of the births in the nation demonstrated a reduction in elective singleton early

term deliveries from 17.8 percent to 4.8 percent during the one-year project period.¹⁹

Payment Reform

Payments made to hospitals and providers are another lever that some states are using to lower the rate of non-medically indicated deliveries before 39 weeks. According to a report published by CMS in late 2012, state Medicaid programs in nine states have implemented payment reforms aimed at reducing non-medically indicated deliveries before 39 weeks through financial incentives or disincentives.²⁰ These state Medicaid payment reforms include policies that:

- pay the same rate for a cesarean delivery as a vaginal birth
- lower the payment for non-emergency cesarean sections to a level below that of a vaginal birth
- offer hospitals a bonus payment for achieving a certain threshold reduction in non-medically indicated deliveries before 39 weeks
- non-payment for deliveries before 39 weeks that are not medically indicated

Given that Medicaid programs paid for nearly half the births in the United States from 2008-2010, payment reform is another method to improve birth outcomes and potentially provide savings to the health care system.²¹

Title V programs are required by statute to collaborate with Medicaid programs and bring valuable expertise such as data and metrics to the table as well as other stakeholders such as Medicaid and community-based organizations. The examples provided from North Carolina and Texas are examples where payment reform is part of a multi-faceted effort.

North Carolina

Quality improvement strategies linked to payment reforms are two of the main approaches that North Carolina is using to lower the rate of elective deliveries. The program is overseen and financed by the North Carolina Division of Medical Assistance (DMA), the state Medicaid agency, and operated by Community Care of North Carolina (CCNC), a private non-profit organization that contracts with DMA. A statewide program of community stakeholders that includes providers,

local health departments, local CCNC networks, and the state Division of Public Health (state Title V agency) work together to create a system of care through the use of a medical home concept for obstetric care, a pregnancy medical home (PMH). In partnership with local public health departments statewide, North Carolina also has implemented a pregnancy care management system for Medicaid recipients with risk factors for poor birth outcomes. By improving the quality of maternity care, the state hopes to improve birth outcomes, with a focus on preventing preterm birth. Providers that are part of the PMHs must agree to certain performance expectations, such as avoidance of non-medically indicated deliveries before 39 weeks of gestation, reducing primary c-section rates, using 17-alpha hydroxyprogesterone to prevent recurrent preterm birth and collaboration with pregnancy care management. Providers that are part of the PMH program receive both financial incentives for performance such as a higher reimbursement rate for vaginal deliveries, and reductions in paperwork such as not having to gain prior approval for ultrasounds. More than 350 practices and clinics in North Carolina contract with their local CCNC network to serve as PMHs.²²

Texas

In 2009, 25.6 percent of deliveries were induced in Texas. Furthermore, in 2007 70 percent of Medicaid costs for hospitalized newborns in Texas were attributed to prematurity and extreme prematurity.²³ The infant mortality rates among all groups exceeded the Healthy People 2010 Objective of 4.5 infant deaths per 1,000 live births. In an effort to improve these statistics, in 2011, the Texas Legislature allocated \$4.1 million in state general funds to promote further implementation of evidence-based interventions to reduce late pre-term births. As part of this effort, the Texas Department of State Health Services launched the Healthy Texas Babies initiative to lower the state infant mortality rate by reducing prematurity. Title V staff play an integral role in the implementation and management of the Healthy Texas Babies initiative. One of the key contributions to this effort has been an expert panel that meets every six months. Expert panel members include representatives of community organizations, insurance companies, hospital systems, members of faith communities, clinicians and others. One of the first



recommendations from the panel was to reduce non-medically indicated deliveries before 39 weeks.²⁴

The Texas Department of State Health Services and Medicaid program provided technical expertise to House Bill 1983, which called for provider training and education to reduce non-medically indicated preterm deliveries. Concurrently, Texas Medicaid was analyzing potential cost-savings and health outcome improvements for infants with the elimination of payment for non-medically indicated deliveries at less than 39 weeks gestation. Medicaid changed its policy in October of 2011, requiring delivering clinicians to add a modifier to claims indicating medical necessity for pre-39-week deliveries. Those that do not include this modifier or indicate that the delivery is non-medically indicated are denied Medicaid payment for the delivery.²⁵ To support changes in policy to Texas Medicaid, Title V staff provided valuable provider-level education through the agency's free Grand Rounds webinar. Title V staff also developed an online learning module for clinicians and accompanying video demonstrating effective negotiation between clinicians and patients who desire a non-medically indicated delivery before 39 weeks. Both the Grand Rounds and online module carry continuing education credits for providers. In addition to online provider education, Title V staff also developed an in-person, multi-site training for nurses, midwives, social workers, community health workers, and other stakeholders on the importance of a 39 week gestation in healthy pregnancies and information about the change in Medicaid policy. This was complemented at the community level by collaboration with the Texas chapter of the March of Dimes to disseminate 250,000 brochures and posters to WIC clinics around the state. The tools were showcased in a webinar on why the "Last Weeks of Pregnancy Count."

The Title V Role in Reducing Non-Medically Indicated Deliveries

This issue brief highlights a range of strategies that state Title V MCH Programs, and many stakeholders can use to reduce the rate of non-medically indicated deliveries prior to 39 weeks



gestation.

- Convene statewide task forces comprised of the state Title V MCH program, Medicaid agency, provider groups (e.g., obstetricians/gynecologists, family physicians), insurers, researchers, and others (e.g., state MoD chapter) to develop and advance a comprehensive plan for improving birth outcomes at the state and community level.
- Collaborate with partner organizations to obtain and leverage new funding strategies and opportunities presented by the *Patient Protection and Affordable Care Act* and state-level health reform to improve the funding of work to reduce non-medically indicated deliveries before 39 weeks such as The Strong Start for Mothers and Newborns Initiative funded through the Centers for Medicare and Medicaid (CMS).
- Use the flexibility of the Title V MCH Block Grant to sustain services, resources, and supports for improving maternity care and lowering non-medically indicated deliveries before 39 weeks that are not covered by other funding sources. These activities include convening stakeholder organizations, funding quality improvement initiatives and toolkits, and extending services to women who are not eligible for Medicaid to ensure they receive quality care.
- Collect, connect, and use public health and Medicaid data to inform policy and program development, and measure the impact of efforts. This includes providing county specific data to a range of stakeholders such as providers and advocates, and state legislators to make the fiscal case for lowering non-medically indicated deliveries before 39 weeks.
- Work with Medicaid to apply a core set of Medicaid quality measures that focuses on the continuum of perinatal care and risk.²⁶ The core set of quality measures for Medicaid eligible adults are currently voluntary for states to report on, but are important nonetheless. The initial core set of measures accepted by the Secretary of Health and Human Services includes the appropriate use of antenatal steroids, elective delivery prior to 39 completed weeks of gestation, medical assistance with smoking and

tobacco use cessation and prenatal and postpartum care rate.

- Work with Medicaid to implement a state option to finance Medicaid “pregnancy medical homes” that include quality measures and incentives that aim to reduce non-medically indicated deliveries before 39 weeks.

Conclusion

Title V programs are well positioned to act as a conduit, expert advisor, expeditor and sometimes funder of initiatives such as these to improve birth outcomes and reduce non-medically indicated deliveries. Success will require partnerships between Title V organizations, payers, hospital engagement networks, local health departments, consumers, community-based organizations and many more.

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This issue brief was authored by Carolyn McCoy, senior policy manager and is part of an AMCHP series of tools, documents and resources on implementation of the ACA and its impact on maternal and child health populations. For more information, please visit the AMCHP website at amchp.org. AMCHP staff can be reached by phone at (202)775-0436.



Appendices

Appendix A: A broad overview of initiatives to improve birth outcomes, some including efforts to reduce non-medically indicated deliveries before 39 weeks. Updated Oct. 23, 2013

This matrix includes examples of initiatives, programs, and strategies on national, regional, and state levels to improve birth outcomes in the United States. In general, initiatives and organizations included in this matrix make financial, organizational, or human resource investments in engaging partners to devise and implement strategies toward specific outcomes. This list is not intended to be comprehensive but rather a tool for considering the landscape of efforts to inform collective impact in improving birth outcomes.

National Initiatives			
Brief Summary of Initiative	Geographic scope	Funding	National partners
<p>The Secretary’s Advisory Committee on Infant Mortality (SACIM) hrsa.gov/advisorycommittees/mchbadvisory/InfantMortality/About/about.html The SACIM’s role is to advise the U.S. Department of Health and Human Services (HHS) Secretary on its programs directed at reducing infant mortality and improving the health status of pregnant women and infants. The committee is comprised of members from across the United States. Members include academic, state, and community-based stakeholders. In addition, several government agencies hold ex officio positions on the SACIM. The committee provides advice on how to coordinate federal, state, local and private programs and efforts designed to intervene in the health and social problems impacting infant mortality.</p> <p>In Jan. 2013, the SACIM submitted a report to the Secretary entitled “Recommendations for Department of Health and Human Services (HHS) Action and Framework for a National Strategy [on Infant Mortality].” The SACIM currently works to develop a companion strategy to improve preconception and maternal health.</p>	National	HRSA	<ul style="list-style-type: none"> • CDC • CMS • U.S. Department of Housing and Urban Development • U.S. Department of Labor

National Initiatives

Brief Summary of Initiative	Geographic scope	Funding	National partners
<p>CMS Expert Panel on Improving Maternal and Infant Health Outcomes Center for Medicaid and Children's Health Insurance Program (CHIP) Services (CMCS), Centers for Medicare and Medicaid Services (CMS) www.medicare.gov/Medicare-CHIP-Program-Information/By-Topics/Quality-of-Care/Maternal-and-Infant-Health-Care-Quality.html</p> <p>The Expert Panel on Improving Maternal and Infant Outcomes in Medicaid and CHIP was launched in June of 2012. Membership of the panel includes state Medicaid medical directors, Medicaid providers, consumer representatives and other experts in the areas of maternal and child health, Medicaid, advocacy and research. The expert panel was charged with exploring program policy and reimbursement opportunities that could result in better care, improve birth outcomes and reduce the costs of care for mothers and infants in CHIP. In August of 2013, the panel presented CMCS senior leadership with a set of strategies to support states and providers in improving maternal and infant health outcomes in Medicaid/CHIP. The strategies suggested by the panel will help CMCS and states as Medicaid expansion creates greater opportunities to enhance the care of women and therefore both maternal and infant health outcomes. Current and planned CMCS improvement activities will be leveraged to ensure an active and cohesive approach for advancing the shared goal of improving maternal and infant health outcomes among our partners.</p> <p>In December of 2013, the CMCS Crosswalk of Current Activities and Identified Potential Strategies was released and can be found here.</p>	National	CMS	<ul style="list-style-type: none"> • MoD • NASHP • ACOG • AWHONN • NGA • NICHQ • National Partnership for Women and Families • CDC • HRSA • AHRQ

National Initiatives

Brief Summary of Initiative	Geographic scope	Funding	National partners
<p>Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV) mchb.hrsa.gov/programs/homevisiting/ Health Resources and Services Administration (HRSA) (state MIECHV program) and Administration for Children and Families (ACF) (tribal MIECHV program), HHS The MIECHV program facilitates collaboration and partnership at the federal, state, and community levels to improve health and development outcomes for at-risk children through evidence-based home visiting programs.</p> <p>The statutory purposes of the program are to 1) strengthen and improve the programs and activities carried out under Title V of the <i>Social Security Act</i>; 2) improve coordination of services for at-risk communities; and 3) identify and provide comprehensive services to improve outcomes for families who reside in at-risk communities.</p> <p>The legislation requires that grantees demonstrate improvement among eligible families participating in the program in six benchmark areas:</p> <ul style="list-style-type: none"> • Improved maternal and newborn health • Prevention of child injuries, child abuse, neglect, or maltreatment, and reduction of emergency department visits • Improvement in school readiness and achievement • Reduction in crime or domestic violence • Improvements in family economic self-sufficiency • Improvements in the coordination and referrals for other community resources and supports 	National states and six jurisdictions; Indian Tribes, tribal organizations, and urban Indian organizations	Established under Title V of the <i>Social Security Act</i> , through the Affordable Care Act of 2010	<ul style="list-style-type: none"> • HRSA • ACF

National Initiatives

Brief Summary of Initiative	Geographic scope	Funding	National partners
<p>Healthy Babies President’s Challenge astho.org/healthybabies/ The Association of State and Territorial Health Officials (ASTHO) and the March of Dimes (MoD) have partnered to help states prevent preterm birth and infant mortality. The challenge asks state health officials to sign a pledge to:</p> <ul style="list-style-type: none"> • Publicly announce a goal to reduce the rate of premature birth by 8 percent by 2014 (measured against 2009 data) • Initiate and support programs and policies that reduce the premature birth rate • Build wider awareness of prematurity rates and other related MCH indicators 	50 state health officials (48 states, Puerto Rico and the District of Columbia) have accepted the pledge to reduce premature births by 8 percent by 2014	MoD offers support for states that sign on with the media package (Prematurity Campaign). Otherwise, efforts to reach target are expected to be funded through state agency funds.	<ul style="list-style-type: none"> • ASTHO • MoD • HRSA • CDC • AMCHP

National Initiatives

Brief Summary of Initiative	Geographic scope	Funding	National partners
<p>National Initiative on Preconception Health and Health Care (PCHHC) cdc.gov/preconception/index.html?s_cid=ncbddd_govd_123 The National PCHHC Initiative is made up of a steering committee and five workgroups – Public Health, Consumer, Policy and Finance, Clinical, and Surveillance and Research. They released the third Action Plan for the National Initiative on Preconception Health and Health Care here. The clinical workgroup also released, in draft in winter of 2013/14 Before, Between and Beyond Pregnancy. This toolkit is designed to be a "one stop" resource for clinicians and others who want to learn more about preconception health, its history, the evidence supporting it and strategies for incorporating relevant content into daily clinical practice.</p> <p>Every Woman Southeast agreed to be an “implementer” group for the Feb. 2013 Consumer Social Marketing Campaign – Show Your Love.</p> <p>This is the only national group with a specific focus on preconception health. They are working to get preconception health on the agenda of many other groups and initiatives.</p>	<p>National</p>	<p>CDC provides TA and leadership support. W.K. Kellogg Foundation has provided funds to three committees via the Every Woman Southeast coalition.</p>	<p>The Steering committee is comprised of national groups including:</p> <ul style="list-style-type: none"> • AMCHP • NACCHO • ASTHO • HRSA • CDC • AWOHNN • OMH • National Healthy Start • ACOG • Universities, health departments and others

National Initiatives

Brief Summary of Initiative	Geographic scope	Funding	National partners
<p>March of Dimes Prematurity Prevention, 39+ weeks campaign marchofdimes.com/pregnancy/pregnancy-39weeks In response to the Joint Commission’s perinatal care core measure set that includes the number of elective deliveries performed >37 and <39 weeks, the March of Dimes and partners created a quality improvement toolkit for professionals: Elimination of non-medically indicated deliveries before 39 weeks. The toolkit focuses on scientific evidence, implementation efforts, data collection and education.</p> <p>Healthy Babies are Worth the Wait (HBWW) marchofdimes.com/professionals/healthy-babies-are-worth-the-wait.aspx The HBWW initiative is both a model of collaboration among local- and state-level clinical and public health partners and a national public awareness campaign. As a collaboration model, HBWW engages the community in efforts to achieve its goals of decreasing preterm births, implementing preventable strategies against preterm births, and changing the attitudes and behaviors of providers and consumers. There are five core components (the five Ps) of the HBWW model: 1) partnerships and collaborations, 2) provider initiatives, 3) patient support, 4) public engagement, and 5) measuring progress.</p>	<p>National effort, California major participant</p> <p>National public awareness campaign</p> <p>HBWW intervention sites include KY (pilot), NJ and TX</p>	<p>MoD; Johnson & Johnson Pediatric Institute</p>	<ul style="list-style-type: none"> • State partners: California Maternal Quality Care Collaborative and the California Department of Health • MoD • Johnson & Johnson Pediatric Institute • Kentucky Department of Public Health

National Initiatives

Brief Summary of Initiative	Geographic scope	Funding	National partners
<p>Text4baby National Healthy Mothers, Healthy Babies Coalition text4baby.org Text4baby is the largest national mobile information service designed to promote maternal and child health through text messaging. Women who text BABY (BEBE for Spanish) to 511411 receive free text messages timed to their due date or their baby's birth date, through pregnancy and up until the baby's first birthday. The messages address topics such as labor signs and symptoms, prenatal care, developmental milestones, immunizations, nutrition, birth defect prevention, safe sleep, safety, and more. Text4baby is supported and promoted by a public-private partnership of more than 1000 health departments, academic institutions, health plans, businesses, and the federal government. Text4baby is the largest national mobile health initiative reaching more than 565,000 moms since launch in 2010.</p>	<p>Text4baby is available for free within the United States with participating cellular carriers. Any individual or organization is eligible to become a text4baby partner.</p>	<p>Johnson & Johnson, CMS, National Institutes for Health (NIH), Alliance Healthcare Foundation, California Wellness Foundation</p>	<ul style="list-style-type: none"> • Voxiva • The Wireless Foundation • DHHS • National, state and local partners
<p>The Raising of America theraisingofamerica.org (Formerly entitled the American Birthright Project, developed by the producers of Unnatural Causes) The Raising of America is both a public engagement campaign and a documentary focused on promoting an 'equal opportunity childhood' for every infant to improve individual life course outcomes and produce a healthier, safer, better educated and more prosperous and equitable America. The series and official companion website will release in 2014.</p>	<p>National public awareness campaign – any organization can sign up to be part of the endeavor</p>	<p>W.K. Kellogg Foundation The California Endowment CDC Blue Cross and Blue Shield of Minnesota Foundation</p>	<p>Campaign has more than 100 partners to date, including:</p> <ul style="list-style-type: none"> • AMCHP • Birthing Project USA • NACCHO • NHSA • Zero to Three <p>Full list on project website.</p>

National Initiatives

Brief Summary of Initiative	Geographic scope	Funding	National partners
<p>Birth Project USA – “The Underground Railroad for New Life” birthingprojectusa.org This is a volunteer effort to encourage better birth outcomes by providing practical support to women during pregnancy and for one year after the birth of their children. Their programs allow them to identify babies before they are born, watch them during childhood, and invite them to participate with their mothers in risk reduction programs in middle school and the Academy of Dreams during high school. They also provide guidance to fathers.</p>	National/ International Group. They do have a Sister Friend project in Memphis, TN.	W.K. Kellogg Foundation	W.K. Kellogg Foundation, Ashoka
<p>Best Fed Beginnings National Initiative for Children’s Healthcare Quality (NICHQ) nichq.org/our_projects/cdcbreastfeeding.html Eighty-nine hospitals have been recruited from across the country to participate in a 22-month learning collaborative to make system-level changes to maternity care practices in pursuit of Baby-Friendly designation. Participating hospitals are located in the 29 states with the lowest breastfeeding rates. These hospitals account for approximately 275,000 births/year.</p>	National	CDC	Baby-Friendly USA
<p>Reaching Our Sisters Everywhere – ROSE breastfeedingrose.org/ This group aims to improve access to breastfeeding in the African-American Community, reclaiming African-American women’s breastfeeding experience and reforming health care through breastfeeding.</p>	National	(TBD)	
<p>It’s Only Natural womenshealth.gov/itsonlynatural/ The purpose of this education campaign is to help African-American women and their families understand the health benefits of breastfeeding while providing practical tips and dispelling myths. The website also features stories of encouragement and inspiration from African-American mothers.</p>	National public awareness campaign	Office on Women’s Health, DHHS	

Regional Initiatives

Brief Summary of Initiative	Geographic scope	Funding	National partners
<p>Regional Collaborative Improvement and Innovation Networks (ColINs) A collaborative, multistate initiative aimed at improving infant health outcomes by reducing infant mortality and prematurity across the United States, particularly among disparate populations.</p> <p>Regions IV & VI:</p> <ul style="list-style-type: none"> Regional summit in New Orleans in January 2012; Regional ColIN meeting in Washington, DC in July 2012. At the January meeting, states set five goals for themselves. The ColIN initiatives reflect some but not all of these state goals. Current IV & VI ColIN strategy teams are organized around: enhancing perinatal regionalization, Medicaid financed interconception care, safe sleep, smoking cessation, and eliminating elective deliveries prior to 39 weeks. Next steps include implementing strategies at the state level, tracking process and outcome measures, and planning a 2nd face-to-face meeting <p>Region V</p> <ul style="list-style-type: none"> ColIN expanded to the region in March 2013 Strategies will likely focus on social determinants of health, SIDS/SUID, and preconception care <p>Other regions Region X and California received QI training at 2012 Block Grant Review. HRSA hopes to expand the ColINs to all regions in 2014. In July 2013, HRSA released a Funding Opportunity Announcement for providing support for the implementation of ColINs in the remaining seven HRSA regions. The National Initiative for Children’s Health Care Quality (NICHQ) was awarded this opportunity.</p>	HHS regions IV, V, VI	<p>HRSA/MCHB covered travel and meeting logistics for the in-person summit and the in-person components of the ColIN.</p> <p>HRSA/MCHB will offer funding to organizations providing support to the implementation of the ColIN in the remaining regions through a cooperative agreement.</p>	<ul style="list-style-type: none"> HRSA/MCHB CDC ASTHO MoD SACIM CityMatCH AMCHP NHSA Abt Associates NICHQ
<p>Every Woman SouthEast Coalition EveryWomanSoutheast.org</p> <p>EWSE is a multistate, multilayered partnership to improve the health of women and infants in the southeast United States. The initiative aims to foster capacity building and resource sharing, stimulate new ideas, develop new partnerships and promote effective programs and networks for moving the women’s health agenda forward in this region.</p> <p>EWSE has a leadership team with representatives from each state. They have three</p>	SE Region: NC, SC, LA, MS, GA, TN, AL, FL, KY	W.K. Kellogg Foundation	<ul style="list-style-type: none"> AMCHP ACOG NACCHO PCHHC MOD HRSA/MCHB

committees: communication, evaluation and pilot projects. They also have nine state teams – one per state. The W.K. Kellogg Foundation currently provides funding through EWSE for seven pilot projects among a number of complementary activities.			
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Selection of States/Locales

Brief Summary of Initiative	Geographic scope	Funding	National partners
<p>AMCHP Action Learning Collaboratives (ALCs) Optimizing Opportunities within Health Reform for Preconception Health With support from the W.K. Kellogg Foundation, AMCHP lead a project to increase the capacity of state maternal and child health (MCH) programs and other state-level stakeholders (e.g., Medicaid agencies, providers, local health departments, community health centers) to improve birth outcomes throughout the life course. Phase I of this project focused explicitly on developing opportunities to promote preconception health using opportunities presented by the ACA and health reform efforts overall (e.g., state Medicaid reform). Phase II of this project identified an additional cohort of state teams. AMCHP continued to focus on optimizing health reform to improve birth outcomes by expanding upon the work begun in project year one but also had a specific focus on developing a collective impact approach to coordinating the multiple, concurrent efforts and initiatives to improve birth outcomes through health reform.</p>	<p>2012-2013 AMCHP worked with teams from FL, MI, MS, NM, OK, OR. Cohort two (2012-2013) included AZ, DE, RI, IL, UT.</p>	<p>W.K. Kellogg Foundation</p>	<ul style="list-style-type: none"> • CityMatCH • NHSA
<p>Partnership to Eliminate Disparities in Infant Mortality CityMatCH, AMCHP, and the National Healthy Start Association (NHSA), with funding from the W.K. Kellogg Foundation, created the Partnership to Eliminate Disparities in Infant Mortality, with an aim to eliminate racial inequities contributing to infant mortality within U.S. urban areas. The Mission of the Action Learning Collaborative was to increase capacity at community, state and local levels to address the impact of racism on birth outcomes and infant health. The ALC brought together multi-disciplinary state/local teams to strengthen partnerships, build community participation and develop innovative strategies for addressing racial inequities in infant mortality in the United States. ALC teams were expected to combine their knowledge of evidence-based practices with local knowledge and problem solving, to move beyond what has typically been done to address infant</p>	<p>Cohort 1 state teams included Los Angeles, CA, Aurora, CO, Pinellas County, FL, Chicago, IL, Columbus, OH, and Milwaukee, WS. Cohort two included Fort Worth, TX,</p>	<p>W.K. Kellogg Foundation</p>	

<p>mortality. Creativity was encouraged, and participating teams were innovative in addressing challenges related to racial inequities in infant mortality, including the impacts of racism. The ALC teams committed to the following:</p> <ul style="list-style-type: none"> ▪ Work to assure community engagement, mobilization, buy-in and commitment to address racial inequities in infant mortality ▪ Establish diverse partnerships, including non-traditional partners ▪ Commit to focus work upon racism and its impact on birth outcomes and infant health ▪ Create an action plan to address disparities in infant mortality, including a plan for sustaining efforts ▪ Implement an action plan as part of a community-based effort to improve birth outcomes ▪ Make contributions and provide feedback on the development of materials and best practices related to addressing racial inequities in infant mortality ▪ Share products, results and experiences gained from ALC work with other participating teams and national, state, and local entities ▪ Engage in this work with passion, innovation, flexibility, courage, and optimism <p>Resources can be found here.</p>	<p>New Orleans, LA, New Haven, CT, Boston, MA, and the state of MI.</p>		
<p>March of Dimes - The ‘Big 5’ The March of Dimes Big 5 State Prematurity Collaborative is exploring data driven perinatal quality improvement through the development and adoption of evidence-based interventions and the data systems and tools required to track changes in specific perinatal issues and indicators. Recent efforts in CA, KY, NY, OH, NC and other states have led to innovative population-based data driven approaches that provide information on potentially effective initiatives. Lessons have been learned in states that have implemented such approaches and the Big 5 have reviewed these and other efforts to identify a shared agenda focused on eliminating elective deliveries < 39 weeks.</p>	<p>Five states: CA, FL, IL, NY, TX, with the goal of making a national impact</p>	<p>March of Dimes</p>	
<p>CMS Strong Start for Mothers and Newborns Initiative innovation.cms.gov/initiatives/strong-start/ With an overall goal to reduce the risk of significant complications and long-term</p>	<p>The Strong Start RFA was open to all</p>	<p>CMS Innovation Center was</p>	<ul style="list-style-type: none"> • CMS • HRSA • ACF

<p>health problems for both expectant mothers and newborns, the initiative utilizes two strategies 1) Public-Private Partnership to Reduce Early Elective Deliveries and 2) Funding Opportunity for Testing New Approaches to Prenatal Care.</p> <p>The Public-Private Partnership to Reduce Early Elective Deliveries will examine ways to promote best practices and support providers in reducing early electives deliveries prior to 39 weeks. It will also provide broad-based awareness building and dissemination of best practices for all MCH programs and stakeholders.</p> <p>The Funding Opportunity for Testing New Approaches to Prenatal Care will fund opportunities for providers, states and other eligible applicants to test the effectiveness of three enhanced prenatal care approaches (enhanced Prenatal Care through Centering/Group Visits, at Birth Centers or Maternity Care Homes) to reduce preterm births for Medicaid covered women at risk for preterm births. Twenty-seven Strong Start awardees were announced in Feb. 2013: innovation.cms.gov/initiatives/map/index.html#model=strong-start-for-mothers-and-newborns-initiative</p>	<p>geographic areas.</p>	<p>established through <i>Patient Protection and Affordable Care Act</i> (ACA) funding.</p>	<ul style="list-style-type: none"> • ACOG • MOD • HHS ‘Partnership for Patients’
<p>The National Governors Association’s (NGA) Initiative Learning Network to Improve Birth Outcomes nga.org/cms/home/news-room/news-releases/2013-news-releases/col2-content/more-states-to-focus-on-us-birth.html</p> <p>The goal of this Learning Network is to assist states in developing, implementing and streamlining their key policies and initiatives related to the improvement of birth outcomes, starting with low-income populations. NGA will convene in-state sessions with each selected state to facilitate this process and convene a networking conference for that group of states to share lessons learned and to further their respective planning process.</p> <p>Overall, the NGA does not intend for this to be a <i>new</i> initiative, but rather a <i>facilitative</i> effort to work with a selected group of states to meet the ASTHO Presidential Challenge (‘8 by 14’) pledge. The initiative strives to ‘meet states where they are at’ through facilitated expert design teams and learning networks among a group of states.</p>	<p>Nationally led, implemented at the state level.</p> <p>Since Fall 2012, NGA has released 3 rounds of RFAs. Included in all three rounds are AL, AZ, CT, HI, IN, LA, KY, MI, NJ, NM, NV, VA and WV.</p>	<p>This project is funded by the NGA.</p>	<ul style="list-style-type: none"> • ASTHO • HRSA • CMS • Childbirth Connection • MOD • AMCHP

At the conclusion of this project, NGA hopes to create best practice resources to share widely with other states.			
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Community-Based Initiatives			
Brief Summary of Initiative	Geographic scope	Funding	National partners
<p>Healthy Start mchb.hrsa.gov/programs/healthystart/ The Healthy Start program is an initiative mandated to reduce the rate of infant mortality and improve perinatal outcomes through grants to project areas with high annual rates of infant mortality. The program began in 1991 with grants to 15 communities with infant mortality rates 1.5 to 2.5 times the national average. Healthy Start projects address the significant disparities in the health of mothers and babies experienced by racial and ethnic minorities in communities that face many challenges, including inadequate access to care and limited funding. All Healthy Start projects provide the following core services: direct outreach and client recruitment, health education, case management, depression screening and referral, and interconception care services to for all participants. Healthy Start sites have been successful in reducing the number of infant deaths and babies born of low or very low birth weight.</p>	<p>Nationally run, community-based. A list of grantees can be found here.</p> <p>As of 2013, MCHB funds 105 grants serving areas or populations in 191 counties located in 39 states, DC and Puerto Rico.</p>	<p>Projects are funded by competitive grants through HRSA/MCHB</p>	

Community-Based Initiatives

Brief Summary of Initiative	Geographic scope	Funding	National partners
<p>The Best Babies Zone (BBZ) bestbabieszone.org/ The Best Babies Zone (BBZ) Initiative is an innovative, multi-sector approach to reducing infant mortality and racial disparities in birth outcomes and improving birth and health outcomes by mobilizing communities to address the social determinants that affect health. The BBZ vision is that all babies are born healthy, in communities that enable them to thrive and reach their full potential. The uniqueness of this national initiative lies in the fact that not only is the approach zonal, but it is comprehensive – addressing four critical sectors – economics, education, health and community – in order to strengthen environments that support better and healthier outcomes.</p>	<p>Three pilot cities include: Cincinnati, New Orleans and Oakland</p>	<p>W.K. Kellogg Foundation</p>	<ul style="list-style-type: none"> • UC Berkley • NHSA • AMCHP • CityMatCH
<p>Institute for Equity in Birth Outcomes (“Equity Institute”) CityMatCH citymatch.org/Projects/iebo The Institute for Equity in Birth Outcomes (IEBO) is a national initiative that brings a scientific focus to the persistent gap in birth outcomes. Institute teams are based in local urban health departments, drawing in additional leadership and partners from other sectors. During a two-year span, selected teams headed by CityMatCH member health departments will participate in the IEBO and will receive in-person as well as distance-based training to support them as they select, implement, and evaluate an equity-focused project.</p> <p>In the coming years, CityMatCH will release curriculum content and project reports, with the intention of hosting an Equity Institute Summit in 2015.</p>	<p>For a list of the teams in each cohort, please visit the IEBO website.</p>	<p>W.K. Kellogg Foundation</p>	

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