Association of Maternal and Child Health Programs  
Summary of State Maternal and Child Health Programs Survey  
About Late Preterm Birth  
2010

Introduction

From 1990 to 2006 the rate of infants born late preterm, or between 34 and 36 weeks gestation, increased 20 percent, from 6.8 to 8.1 percent. It is becoming increasingly recognized that infants born late preterm have a higher incidence of morbidity and mortality when compared with term infants born between 39 and 41 weeks.

In order to find out more information about what states are doing to address this rising issue, the Association of Maternal and Child Health Programs (AMCHP) conducted an online survey with its State Title V Program Directors in 50 states. Respondents from 34 states completed the survey. Almost three-fourths reported seeing an increase in late preterm births in recent years, and slightly over half said that their Maternal and Child Health Program was implementing initiatives or programs to address the issue.

Survey Methodology

The survey questionnaire was developed by AED with input from NICHD. AMCHP reviewed and programmed the questionnaire using the online survey software tool Zoomerang. A link to the survey was sent to AMCHP members from State Title V Maternal and Child Health Block Grant programs via email. Respondents were given three weeks to complete the survey. A total of 34 responded.

For the purpose of analysis, data was exported from Zoomerang into Excel. Frequencies were run for closed-ended questions and open-ended responses were reviewed to identify common themes and key issues that emerged.

---

2 Ibid.
General

76 percent (n=26) of respondents agreed that preterm birth is a growing problem in their state, while 18 percent disagreed (n=6). One respondent was unsure and one did not give an answer.

Chart I. Is preterm birth a growing problem in your state?

70 percent of respondents (n=24) said that they had seen an increase in late preterm births in their state in recent years, while 18 percent (n=6) said that they had not, 9 percent (n=3) did not know, and one did not provide an answer.

Chart II. Have you seen an increase in late preterm births (34-36 weeks) in your state in recent years?

Initiatives/Programs to Address Late Preterm Birth

Focus

Slightly over half of respondents (53 percent; n=18) said that their Maternal and Child Health Program was implementing initiatives or programs to address the issue of late preterm birth. Programs focused on a variety of audiences, and sometimes more than one audience, including: healthcare providers (n=13); pregnant women (n=8); and caregivers of preterm infants (n=6). Additionally, the following audiences were mentioned each by one person: the public; academia; perinatal systems of care; women of reproductive health age; health educators; school nurses; pharmacists; and at-risk women and their families. Chart III below depicts each initiative/program’s focus.
Components

Components of these initiatives or programs included: training of physicians (n=8); community-based education of pregnant women (n=7); training of nurses (n=5); and clinic-based education of pregnant women (n=4). Two individuals said that their program included education for pregnant women, but they did not specify where; and two mentioned training healthcare providers but did not specify the type of provider. Additionally, three individuals said that their program included media outreach and paid advertising. Other components mentioned each by one individual included: training of labor and delivery staff and pharmacists; needs assessments; advocacy; indicator development; surveillance; data analysis; communication of data; development of program recommendations; and program evaluation. Chart IV below depicts the components of each initiative/program.
Educational, Media, or Advertising Materials

Over half of the states had developed or were using educational, media, or advertising materials about late preterm birth. Tools such as meetings, webinars, educational toolkits and materials, and Web sites, such as Wisconsin’s Journey of a Lifetime Campaign [http://www.dhs.wisconsin.gov/healthybirths] are being used to educate women, providers, and hospitals in some states. In one state, a First time motherhood grant is being used to address this issue.

Rhode Island reported that prematurity has received extensive earned media and a Task Force Progress Report was presented during the state’s annual March of Dimes Prematurity Summit. Arkansas presented a white paper on infant death to several conferences, and Virginia convened a workgroup of interested public, private and professional perinatal experts to examine areas of infant mortality, including the topic of late preterm elective inductions. In Minnesota, the Minnesota Perinatal Organization has included the issue of late preterm birth in presentations at the annual conference for professionals.

The state of Ohio has developed an extensive initiative entitled the Ohio Perinatal Quality Collaborative. This program uses improvement science methods, to reduce preterm births and improve outcomes of preterm newborns in the state. Learning session materials, datasets, OPQC Toolkit, OPQC Neonatal Project Tools and OPQC Obstetric Project Tools (i.e., OB Charter, OB Topic Selection Matrix, OB Key Driver Diagram, OB Scheduled Delivery Forms, March of Dimes Scheduled Delivery Brochure in
Many of the states who responded were collaborating with or using materials produced by the March of Dimes. One state collaborated with its March of Dimes chapter and state Premature Infant Health Network to develop a social marketing campaign. In Minnesota, the March of Dimes is working on an initiative to reduce late preterm births by reducing elective inductions and c-sections before 39 weeks and is utilizing the brain card.

Other states have worked with the March of Dimes and other community and state partners to distribute information on late preterm birth, focusing on caesarean sections. These materials include brochures, posters and other materials produced by the March of Dimes, QUITline posters and handouts and WIC brochures.

Respondents were also asked which of the programs they had been implementing, or which of the materials they had been using were most successful. A number of respondents indicated that formation of a network or collaborative was successful, along with educational materials provided free of charge by outside organizations. The following programs: Healthy Start, Perinatal Collaboratives, and a Utah at Intermountain Healthcare were submitted in response to this question. The respondents reported that the most successful materials include the March of Dimes “Brain Card,” Web sites, prenatal visit checklists, brochures explaining hospital policy on elective deliveries at less than 39 weeks and free MedImmune materials.

**Technical Assistance Needs**

Respondents were asked if there were any gaps around preterm birth for which AMCHP could provide technical assistance. A number of states requested best practices and tools including:

- Sharing of state materials developed;
- Sharing of best practices on outcomes and care related to late preterm births;
- Sharing of current research and evidence-based strategies;
- Collection and dissemination of tools used across the nation; and
- Development of Webcasts and slide presentations for the public and providers.

Respondents also identified education gaps for patients and providers. Respondents felt provider education was needed to convince obstetricians that late preterm birth is a problem, to promote no elective inductions before 39 weeks unless medically indicated and to expand beyond the traditional emphasis on perinatal health to explore child health issues such as oral health, adolescent health, and obesity prevention.

Respondents felt education was needed for pregnant women and their families to avoid unnecessary elective inductions prior to 39 weeks. Education is also needed to promote early entry into prenatal care to help identify high risk conditions and to explain the importance of preconception/interconception care as a priority in interactions with Congress and federal partners.

Additionally, respondents identified the need for technical assistance for a substance abuse recommendation, especially around the SBIRT tool and the development of a standardized tobacco screening and referral system. Other respondents requested information on the impact of preconception healthcare on preterm births, how to develop and implement an effective social marketing program and the development of a state wide initiative to prevent late preterm birth.
The state of Virginia noted that the Institute for Healthcare Improvement Perinatal Bundles, related to Induction and Augmentation of Labor due to be initiated may help decrease the rate of preterm births. The Joint Commission of Health Care Accreditation indicator for reporting preterm inductions and ACOG discussions pertaining to this topic, the ability to retrieve concurrent, or within 6 months of delivery would be helpful.

Finally, Texas indicated that gaps exist related to identification, access to, and linkage of potential indicators and data sources to enhance surveillance. Suggestions regarding data linkage and further analysis would be welcome.