



# PULSE

A MONTHLY NEWSLETTER FROM THE ASSOCIATION OF MATERNAL AND CHILD HEALTH PROGRAMS

## Infant Mortality September 2010

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## From the President

### Infant Mortality: Our Past, Present & Future Albatross

By Phyllis J. Sloyer, RN,  
PhD, FAHM, FAAP



Despite research, funding, and practice, we certainly can't claim U.S. infant mortality rates to be our hallmark of success. While we did dramatically reduce these rates in the 20th century through a series of technological advances, we can't claim that we have continued progressively reducing our rates. In fact, we know that there are multiple issues impacting the rates, including all of the social and environmental threats we face; threats of poverty, poor nutrition, unsafe neighborhoods, environmental hazards, impediments in our health care delivery system, lack of supportive families and other variables that are the ingredients in a volatile recipe for increased infant mortality.

This issue of *Pulse* will explore some of those variables and provide examples of promising practices. While we begin to look at interventions that address some of the social and environmental detriments to a healthy outcome, we must also recognize that the health care delivery system has changed. Many of us remember the successes of regionalized perinatal care and have watched the evolution or devolution of regionalization. New ingredients have been added to the mix, including various models of managed care and the principles inherent in balancing cost and quality. Future policies that address infant mortality must be based on a formula that attends to the social, economic, environmental variables influencing individual health plus the organization, financing, and management of health care delivery systems.

## From the CEO Improving Birth Outcomes for All

By Michael R. Fraser, PhD  
CAE

AMCHP joins the National Healthy Start Association and other local, state, and national partners in marking Infant Mortality Awareness Month. Infant mortality highlights many critical maternal and child health issues and pulls us all together around a single shared goal: preventing infant death and supporting families to assure a healthy start for all children.



Why are babies dying? Experts point to several reasons, but congenital malformations, disorders related to short gestations and low birth weight, and sudden infant death syndrome account for almost half of all infant deaths. Maternal and child health programs have been successful in addressing infant mortality and reducing infant deaths in many ways. These include:

- Working to assure pregnant women have access to and utilize prenatal health care services. We know that early and continuous access to prenatal care helps prevent and address health conditions and behaviors that result in poor birth outcomes, including premature birth.

- Supporting health promotion and disease prevention campaigns that address infant mortality and healthy pregnancy, for example programs that encourage the use of folic acid to prevent birth defects and the “Back to Sleep” campaign that has dramatically reduced the incidence of unexpected infant death nationwide.
- Partnering with other groups to address infant mortality at the local, state and national levels. For example, many state Title V programs partner with local Healthy Start programs to address infant mortality in communities nationwide with higher-than-average infant mortality rates and use lessons learned though Healthy Start with other communities in their states.

Prenatal care, health promotion campaigns and partnerships: these are classic maternal and child health interventions that have made a huge difference in improving birth outcomes over time. But there is so much left to do – and much that focuses beyond our core competencies in prenatal care and health education. How else are maternal and child health programs addressing infant mortality?

First, we have seen many state programs increase their focus on addressing the root causes of health disparities and health inequities. The unfortunate reality is that infant mortality disproportionately impacts the economically disadvantaged, and racial and ethnic minorities. For example, according to CDC data, the African American infant mortality rate is more than twice that of white Americans. Despite declines in the infant mortality rate overall the gap between white and black persists. Addressing this gap means dealing with the complex issues of racism and inequality. Difficult? Yes. Impossible? No.

Through innovative programs, including Kellogg Foundation funded work in which AMCHP has participated with CityMatCH and the National Healthy Start Association, we are bringing members together to discuss how to address racism and eliminate disparities in birth outcomes. New Kellogg Foundation investments in racial healing work at the local level will also provide excellent examples from which we all can learn. I am excited by the opportunities to replicate these kinds of programs nationwide as best practices emerge from Kellogg’s ground-breaking work in

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## From the CEO CONT. Improving Birth Outcomes for All

this area and similar work by many others. We have a long way to go, but we are committed to promoting programs that address health inequities and promote good health for all.

Second, the emerging focus on the “life course” perspective is an exciting opportunity to address a host of MCH issues, including infant mortality. We all realize that attempting to undo the impact of a lifetime of poor health and stress in the nine months preceding birth is next to impossible. Instead, by optimizing health across the life course MCH professionals can help promote better health outcomes at all stages of life. How exactly we do this in state MCH programs is still being defined, but my guess is that in the next several years we will see tremendous leaps forward in our understanding of how to integrate MCH interventions at all life stages leading to better health for women, children, and families. And that will translate into better health outcomes for all women.

So, as we acknowledge the pressing reality of infant mortality this month – and all year – let’s look both at what we know works in improving birth outcomes as well as those innovative and potentially difficult areas that call for increased attention by MCH programs nationwide. AMCHP looks forward to sharing those with you as we recommit ourselves to addressing infant mortality with our partners in the states and nationwide.

## Feature

### Collaborative Efforts to Address the Impact of Perinatal Regionalization on Infant Mortality

**By Wanda D. Barfield, MD, MPH**

*Director, Division of Reproductive Health, National Center for Chronic Disease Prevention and Health Promotion, Centers for Disease Control and Prevention*

**Charlan D. Kroelinger, PhD**

*Acting Team Lead and Senior Scientist  
Maternal and Child Health Epidemiology Program  
Division of Reproductive Health, National Center for Chronic Disease Prevention and Health Promotion*

**Vanessa A. White, MPH**

*Associate Director, Women’s & Infant Health  
Association of Maternal & Child Health Programs*

AMCHP has been partnering with federal agencies and academic institutions to advance the definition and measurement of perinatal regionalization. The following is an overview of recent activities.

#### ***What is perinatal regionalization and how does it impact infant health?***

Perinatal regionalization is a system of designating where infants are born or are transferred based on the amount of care that they need at birth. In regionalized systems very ill or very small infants are born in hospitals that are able to provide the most appropriate care, with high-level technology and specialized health providers. Regionalized systems define hospitals at risk-appropriate levels; Level III hospitals, for example, provide the most appropriate care for the sickest infants. Regionalized systems are often designed, designated, and managed by state health departments, but in some states hospital networks or non-profit groups make these decisions. Infants receiving risk-appropriate care are hypothesized to be more likely to survive when born too little or too soon. The goal of a regionalized system is to reduce infant deaths.

#### ***How are the current systems evaluated?***

There are limited formal evaluations of these regionalized systems. There exist multiple measures of regionalization including reporting of the percentage of very low birth weight (VLBW) infants born at facilities for high-risk neonates (National Performance Measure # 17 [NPM 17], Health Resources and Services Administration/Maternal and Child Health Bureau; HRSA/MCHB). Additionally, information reported on the Certificate of Live Birth (BC) (2003 revised version) may be used to estimate the number of VLBW infants who receive appropriate care, specifically, in a Neonatal Intensive Care Unit (NICU).

#### ***What are leading agencies and institutions doing to help public health professionals better understand the impact of perinatal regionalization on infant health?***

In 2009, AMCHP, the Centers for Disease Control’s Division of Reproductive Health (CDC/DRH) and HRSA/MCHB sponsored a meeting on the impact of perinatal regionalization and infant health. Attendees included selected state maternal and child health (Title V) directors,

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### Collaborative Efforts to Address the Impact of Perinatal Regionalization

perinatal health researchers, and representatives from the American Academy of Pediatrics, American College of Obstetricians and Gynecologists, and National March of Dimes. Specifically, the meeting focused on assessing the similarities and differences of these regionalized systems in different states across the US. Additional topics included discussion of the national indicators used to measure risk-appropriate care, particularly NPM 17 (HRSA/MCHB). Meeting attendees described their state's regionalized system and provided the most recent information on VLBW infants born at risk-appropriate facilities. Work from this meeting culminated in attendees recommending further development of guidelines for standardizing regionalized systems.

This meeting was triggered by preliminary results of a CDC review of all current literature examining the impact of risk-appropriate care on infant survival. Researchers from CDC/DRH, the Rollins School of Public Health, Emory University, and the University of Maryland, School of Medicine conducted a meta-analysis of published research on risk-appropriate care in the US. The major finding from this work indicates that VLBW and very preterm infants born outside of a level III hospital are at an increased likelihood of neonatal death or death prior to discharge from the hospital. This work was published this month, National Infant Mortality Awareness Month, in the *Journal of the American Medical Association* (Lasswell SM, Barfield WD, Roach RR, Blackmon LR. Perinatal Regionalization for Very Low-Birth-Weight and Very Preterm Infants—A Meta-analysis, *JAMA* 2010; 304.9: 992-1000).

Additionally, the CDC has also conducted analyses of the percentage of VLBW infants admitted to the NICU following delivery. This research was conducted using information obtained from the National Center for Health Statistics reported by the 19 states that have implemented the revised 2003 BC which contains information on NICU admission. Findings from this research suggest that 77% of VLBW infants were admitted to a NICU in 2006. This percentage is low considering the high mortality rate of these infants. As noted by CDC/DRH Director and neonatologist, Wanda Barfield, MD, MPH “these recent scientific findings indicate that more work must be done to better understand the impact of risk-appropriate care on babies born too little or too soon. Our regionalized systems must be systematically evaluated to determine effective care of neonates and prevent infant death”.

AMCHP, CDC, HRSA/MCHB, and states will continue to partner on this important maternal and child health topic. For more information, visit [here](#).

The findings and conclusions in this article are those of the authors and do not necessarily represent the official position of the Centers for Disease Control and Prevention.

### Partnership to Eliminate Disparities in Infant Mortality

**By Jessica Hawkins, MPH, CHES**

*Program Manager, Women's and Infant Health, AMCHP*

**Brenda Thompson, MPH**

*Project Coordinator, CityMatCH  
University of Nebraska Medical Center*

In 2008, CityMatCH, the Association of Maternal & Child Health Programs (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. The purpose of the project is to eliminate racial inequities contributing to infant mortality within U.S. urban areas. The first activity of the partnership was an 18-month long Action Learning Collaborative (ALC). The emphasis of this team-based ALC was on innovative approaches to reducing racial inequities in infant mortality in urban communities, with particular attention paid to the impact of racism.

The following six teams were selected through a competitive process to participate in the ALC: Los Angeles, CA; Aurora, CO; Pinellas County, FL; Chicago, IL; Columbus, OH and Milwaukee, WI. The teams were composed of a traveling team of five to eight members who participated in on-site meetings of all ALC teams. In addition, each team had non-travel members, which included a diverse group of individuals within the state and community. Composition of the teams varied, with required members including the state Title V/MCH director, MCH leadership from the local health department and leadership from the local Healthy Start Program. Throughout the ALC, CityMatCH, AMCHP and NHSA provided the six teams with technical assistance including tools for action planning and evaluation, informational calls, and resources to assist

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### Disparities in Infant Mortality

in carrying out selected strategies. These components and the ALC process overall assisted teams in furthering their understanding of racism and its connections to birth outcomes. With this enhanced understanding, teams then identified strategies to pursue in their communities and states.

ALC teams were encouraged to develop strategies related to any aspect of addressing racism and infant mortality that they thought was appropriate for their community and state. After realizing the importance of continuing their own education and training, most teams pursued strategies on two levels — the first involved on-going individual and team development and the second involved external activities such as community awareness events. Additional examples of team strategies include:

- Developing a training toolkit for healthcare providers
- Developing media campaign and “empowerment coaching” designed to promote the positive roles of African American males & fathers
- Completing PPOR analysis to guide efforts
- Making the business case for why this work is needed and develop a plan for involving business partners
- Designing a website to provide info, resources and best practices relating to infant mortality and undoing racism

In the fall of 2010, AMCHP, CityMatCH and NHSA will release a team profiles report intended to be a product for states and communities to use as they work to address racism and its impacts on infant mortality. The report will provide a snapshot of work conducted during the 18-month ALC. Efforts and strategies described, and resources provided in the report may be readily utilized in other communities throughout the United States and will hopefully spark ideas for additional ways to address racism and its impact on infant mortality.

For more information contact, [Jessica Hawkins](#) or [Brenda Thompson](#).

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### A Spotlight on SUID & SIDS Prevention Efforts

The impact of SUID and SIDS in infant mortality continues to be an important public health issue nationally and states are tackling this issue using a variety of strategies, from forging federal-state partnerships to expanding upon the current research in the field to ensuring that there is consistent prevention messaging. In this article, AMCHP highlights some of the great work that is being done to reduce infant mortality, and shares some of the challenges and successes of translating research and data into practice in the field.

#### **Federal and State Agencies Collaborate to Improve Surveillance System for Infant Deaths**

Each year approximately 4,500 U.S. infants die suddenly with no immediately obvious cause of death. Sudden infant death syndrome (SIDS), a type of sudden unexpected infant death (SUID), is a leading cause of infant mortality. However, SIDS is prone to discrepancies in classification, hindering our ability to accurately monitor and understand SIDS and SUID trends.

Death certificates, the primary source for surveillance, cannot fully describe the circumstances leading to SIDS and other SUID, indicating the need for a more comprehensive source of surveillance data. State public health departments, program prevention planners, medico-legal investigators, and researchers have all expressed the need for enhanced surveillance data to monitor trends and characteristics associated with SIDS and other SUID, evaluate case investigation practices, and ultimately prevent many infant deaths.

CDC has built partnerships with several state health departments and HRSA's National Center for Child Death Review to enhance surveillance and ultimately reduce infant deaths. In August 2009, CDC awarded funding to Colorado, Georgia, Michigan, New Jersey, and New Mexico to participate in the CDC SUID Case Registry (SUID-CR) Pilot Program. With this funding, states are linking child death review data, death scene investigation and pathology data to create state-based surveillance systems. CDC will pool state data to create a multistate surveillance system that can generate public health surveillance information at the national, state, and local levels that is more detailed and timely than is currently available.

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### A Spotlight on SUID & SIDS Prevention Efforts

As of June 2010, pilot states have identified 269 SUID cases. Also, each state has developed strategies to work with local medico-legal professionals to improve data collected at the scene and have encouraged their participation in multidisciplinary review meetings. Beginning in October 2010, Minnesota and New Hampshire will also participate in the pilot program.

#### **The Study of Attitudes and Factors Affecting Infant Care (SAFE)**

The purpose of this project is to continue to evaluate trends in infant sleep practices and the dissemination and adoption of the American Academy of Pediatrics' and the Public Health Service's "Back to Sleep" recommendations to reduce the risk of SIDS by expanding on current studies with a new study that examines in greater depth the factors influencing these trends and the racial disparity. The SAFE study will survey mothers of infants ages two to four months about infant care practices including sleep position, bed sharing and pacifier use. This new strategy will institute specific methodologies designed to illuminate risk factors for non-compliance in the particularly vulnerable socioeconomic and minority populations. With this approach, we will: 1) evaluate trends, in a nationally representative sample, with regard to each of the three recommended infant sleep practices - supine sleep position, non-bed sharing and use of pacifier; and 2) identify and quantify specific barriers - socio-demographic, cultural, and ethnic - to adherence to infant sleep practice recommendations, particularly, but not exclusively, in vulnerable populations and in those with lower compliance with recommended sleep practices.

#### **Successes and Challenges to SIDS and SUID Prevention: Perspectives from the Field**

Translating the latest SIDS/SUID data for programmatic efforts can at times be challenging. Even today, there is still some confusion about Back to Sleep and Safe Sleep messages, and often the terminology we use can be unclear and inconsistent (i.e., sudden infant death, sudden unexplained infant death, sudden unexpected infant death, sudden unexpected death in infancy, etc.). There are also cultural practices and personal values that may affect adherence to public health recommendations or lead to different interpretations and perceptions of these messages.

Although challenges exist, there have been many successes at the programmatic level. Some of these successes include improved health education campaigns to disseminate prevention messages, an expansion of the Back to Sleep campaign to include additional environmental risk factors, and an increased awareness of infant sleep environment and its contribution to infant mortality. Additionally, programs are beginning to more effectively address the role of cultural competency when creating prevention messages. On a larger scale, there is an overall shift towards an integrated systems change approach to address SIDS, SUID and sleep-related infant death.

#### **Recommendations for SIDS and SUID Prevention Messaging**

Creating back to Sleep and Safe Sleep messages that are clear and consistent is essential for preventing infant death. It is also important to stress the preventative nature of SUID (i.e., it is not an unavoidable event). Messages from all sources (media, health providers, public health, advertisers, etc.) should be consistent in order to increase the credibility and power of the information, and these messages should be reinforced whenever and wherever possible.

*AMCHP would like to thank the following contributors for making this feature story possible:*

#### [Centers for Disease Control and Prevention](#)

##### **Mary Adkins, RN, MSW**

*Program Director, Tomorrow's Child*

##### **Eve R. Colson, MD**

*Associate Professor, Pediatrics  
Yale University School of Medicine*

##### **Sandra J. Frank, JD, CAE**

*President, Association of SIDS and Infant Mortality Programs*

##### **Rachel Y. Moon, MD**

*Children's National Medical Center  
Professor of Pediatrics  
George Washington University School of Medicine and Health Sciences*

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### Special: Celebrating the 75th Anniversary of Title V

**By Dr. James F. Quilty, Jr.**

*AMCHP President from 1989-1991*

My tenure as AMCHP presidency and events immediately afterward championed the indomitable bond linking MCHB and its first Director Vince Hutchins with AMCHP. We experienced genuine pride in advancing the health of America's mothers and children during those years. However, historical events at the decade's inception dwarfed our accomplishments as surely as Shakespeare's Hamlet role overwhelmed that of his friend Horatio.

My introduction to MCH in early spring 1981 came during its potential Waterloo. Never politically strong MCH found itself clamoring for life vests. President Ronald Reagan's "Morning Again in America" budget that year targeted MCH and other health and human service programs for fiscal bludgeoning. That spring - paraphrasing Hemingway - "the bells soon would toll for MCH." Those in the know at MCH federally and AMCHP understood: the daunting task of reversing the projected budget cuts amounted nearly to a mission impossible.

Having taken the Title V position two and half months previously I understood practically nothing of the looming destruction. During the previous five and a half years, following return from Bangkok and the Foreign Service Medical Corps, I assumed increasingly complex administrative responsibilities. In Ohio, Antoinette Eaton, MD, soon to become the first woman President of the American Academy of Pediatrics, recently had resigned as Ohio's MCH Division Chief. She encouraged me to consider replacing her. Since the line to assure my family received a paycheck was remarkably short - and with Toni's gentle prodding, abetted by Elizabeth Aplin, MD (who had saved Ohio's then Crippled Children's Bureau) - I accepted and embarked upon a challenging, mostly satisfying 12-year odyssey.

The still un-energized state Title V directors would convene in March in San Diego, CA for that year's annual meeting. My personal thoughts probably drifted further from MCH issues than those of most directors. My Uncle John, a World War II interloper from his native Buckeye state to California in 1942, had sustained a "widow-maker" heart attack days before the meeting began and died several weeks later. The trip thus blended family and official business. By the meeting's second day its altered

course truncated much of the family time. AMCHP in those years played a lesser role in national maternal and child health policy development. Ideas meshed with visionary leadership to sustain MCH through decades of lean funding. Since its inception in 1912 as the Children's Bureau and its 1935 statutory incorporation as Title V of the Social Security Act, MCH limped along relying upon our shared vision. The Bureau performed multiple vital tasks but always lacked sufficient funding. Medicaid enactment in 1965 nearly vitiated our *raison d'être*. Now Reagan promised to balance the budget, while reducing taxes, on the sinewy structures of MCH and safety-net companions. After all these programs, administratively speaking, became non-essential that spring. These programs' eviscerated budgets would absorb a retroactive 25 percent budget cut. The administration promised a further 25 percent cut for its next fiscal year. A further budget move placed many previous stand-alone programs into a MCH Block Grant! States would make their own decisions on division of Block funds.

After the first day, schmoozing about in a lovely hotel among the gentle breezes of Mission Bay, I spent the evening with Johnny's family. My parents arrived as Dad bid a tearful adieu to his younger brother. The next day AMCHP changed forever. The now deceased Drs. Ed Liss from Illinois and Iowa's John McQueen and other knowledgeable colleagues, whose names would quickly become family to me, preempted the scheduled session to invoke what I'll call 'Josie's Probing Question': "Are you (i.e., Directors) just going to let this budget hacking happen?!"

Who's 'Josie'? Hopefully all AMCHP readers have heard of Josie Gittler! An attorney in Iowa's School of Law, AMCHP's legendary lobbyist worked with Dr. McQueen, Director of Iowa's Program for Handicapped Children. All State Title V Directors would become well acquainted with Josie over the next few months. That day, knowing little about the issues, I merely listened as Bernie Guyer (MA), Bill Hollinshead (RI), Dick Nelson (MN), Peter Van Dyck (UT) and a symphony (except for a mild nay-saying cacophonous undertone) of other state leaders collegially formulated a detailed plan to reverse the intended budget rollback. Several hours along Josie accepted the directors' invitation to lead our educational effort of Congress (nobody mentioned lobbying). Many directors, here-to-for precluded from contact with their Congressional delegation,

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### Special: Celebrating the 75th Anniversary of Title V

committed themselves - where not forbidden by state statute - to herald the agreed upon agenda upon Josie's beckoning.

The meeting's final day established a component of AMCHP as a 501(C) 3 organization. The plan's vital link was Josie. She would reach designated state directors wherever they happened to be and whenever exigent time frames demanded it. That spring Josie and Dr. McQueen synchronized our many Congressional blitzes, by phone and foot to educate targeted offices. Under Josie's leadership we implemented a comprehensive lobbying plan, developed extensive call lists, and coordinated our nascent plan with AAP, Children's Defense Fund and other such organizations.

Fortune shone upon MCH that late summer 1981. When President Reagan signed the annual HHS budget we celebrated MCH's return to nearly full funding. We also celebrated the new AMCHP.

Like all needed directors, I participated liberally in these 'educational' efforts. My formal AMCHP roles began two years later in a vote for Region V AMCHP Councilor. Ed Liss and I tied. Ed, 'complaining' he was too old, withdrew (each of us had voted for the other). In 1987 the directors voted me President-elect. During my executive years, AMCHP established a permanent Washington, DC presence with Cathy Hess as our first director. No decision in those years turned out better. Catherine demonstrated imaginative, organized and dedication skills daily. AMCHP became 'a player' inside the beltway thanks to her leadership. She selected talented, equally talented professional staff. Working closely with Dr. Hutchins we maintained our organization's now modestly robust presence. Speaking of Dr. Hutchins - he never forgot MCH's target population. He traversed the MCH landscape with a political acumen that generally served his staff and the several states - the boots on the ground - extremely well and eminently fairly. For Dr. Hutchins his "fire in the belly" was an understanding of our fragile human nature. He could play a waiting game while simultaneously encouraging - through a camouflaged answer - others to pursue ends he was prohibited from pursuing. He was forever leading even while following. He would bend aside when directed. But he never moved out of the way!

Hundreds of phone calls, dozens of trips to our nation's

capital, national speeches ad absurdum and an amazing Ohio Title V staff allowed me to devote hundreds of hours to AMCHP, all time well spent! Kathy Peppe, RN, MSN, followed me as Ohio's Title V director and several years later as AMCHP President. She epitomized the quality of our MCH program.

Throughout my 12 years as a Title V director AMCHP annually helped repulse efforts by MCH budget slashers. As in many states we used MCH Block funds to encourage state General Assemblies to increase state budgets as our fore-bearers in the 1912 Children's Bureau had done. As depicted memorably at the start of Title V's 50th anniversary celebratory film, the family of MCH must remember always to never cease pushing those 'buggies.'

Additional work always remains! Good luck in your continuing efforts.

## Member to Member

***Congratulations on meeting all five of the Healthy People 2010 goals for breastfeeding. What projects have you been working on at the state level that have contributed to this success?***

**Cristi Litzsinger, RD, LD, IBCLC**  
*Idaho WIC Breastfeeding Coordinator*  
*Idaho Department of Health & Welfare*



In Idaho, breastfeeding rates in the early postpartum period historically have met or exceeded the Healthy People 2010 goals. However, the duration rate goals have only recently been met. With the support of Title V funding, many types of programs and projects have been implemented in Idaho through MCH, in order to increase the breastfeeding duration rates. The following is a sample of programs or projects that have occurred in the past five years that have promoted and supported breastfeeding.

In 2007, Idaho MCH sponsored Nancy Wight to present at a breastfeeding pre-conference at the Idaho Perinatal Project conference. The Idaho Perinatal Project Conference is an annual conference that attracts healthcare and community providers from around the state in the fields of obstetrics, neonatology, pediatrics and others. In 2008, Idaho MCH sponsored Paula Meier to

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present at the Idaho Perinatal Project breastfeeding pre-conference. In 2007 and currently, MCH has supported the State WIC Program in working with Local Breastfeeding Coalitions around the state to implement the Breastfeeding Friendly Employer Project. Breastfeeding Coalitions provide employers with technical assistance needed in order to become a Breastfeeding Friendly Employer. Idaho WIC and MCH are committed to continuing to work on interventions that promote breastfeeding in Idaho.

### **Chris Fogelman, RD, MPH, LN, CLC**

*Breastfeeding Coordinator*

*Public Health Nutritionist*

*Montana WIC Program*

*Montana Department of Public Health and Human Services*



The Montana WIC Program has promoted and supported breastfeeding for many years. In 2004, funds earmarked for Breastfeeding Peer Counselor Programs (BPCP) became available. Ravalli County WIC became the pilot BPCP. Since then we have added additional programs; in 2011, we will have 12 BPCP serving over half of our pregnant and breastfeeding participants.

State and local staff attended several different Loving Support and Certified Lactation Counselor (CLC) trainings. Local programs are alerted to other breastfeeding training. Support for continuing education credits to maintain CLC certification is available.

In meeting the HP2010 goals, Montana WIC did not work alone. We worked with the Nutrition and Physical Activity Program to coordinate our efforts. WIC joined with others across the state to establish the Montana State Breastfeeding Coalition.

In recent legislative sessions, Montana added two new laws which 1) require state, county and city governments, universities, colleges and public schools to make worksite accommodations for breastfeeding employees and 2) deferment of jury duty for breastfeeding women. Montana WIC and the Department of Public Health and Human Services supported the legislation. Leading by example, WIC worked to establish a breastfeeding room in our building.

### **Audrey Knight MSN, RN**

*Child Health Nurse Consultant*

*Maternal and Child Health Section*

*New Hampshire Department of Health*

*and Human Services, Division of Public*

*Health Services*



MCH cheered on as Governor John Lynch proclaimed the first week in August 2010 New Hampshire Breast Feeding Awareness Week. By working with partners like WIC, MCH has worked hard to improve breastfeeding initiation and duration rates throughout the state.

Breastfeeding has been identified as a priority for MCH-funded community health centers and prenatal programs. In New Hampshire, MCH requires the state-funded community health centers to develop a quality improvement performance measure of exclusive breastfeeding through an infant's first three months. To enhance collaboration with the WIC Program at both the state and local agency level, to improve breastfeeding rates, increase mutually enrolled clients, and better utilize services, MCH and WIC surveyed its local agencies in 2009 and followed it with a daylong workshop to share best practices. Collaborations like these translate into improved outcomes for moms and babies.

At the state systems level, MCH participates on the New Hampshire Breastfeeding Task Force, which successfully assisted in the passing of legislation in 1999 supporting a woman's right to breastfeed in public. The task force is now focusing on increasing its "Baby Friendly"-designated hospitals. Working with healthcare facilities is an important strategy to provide a supportive pathway for women to achieve their breastfeeding intentions and guide the training of healthcare professionals in breastfeeding support.

## Success Stories

### Delaware's Efforts to Reduce the Infant Mortality Rate

**By Walt Mateja**

*Director, Child Health Programs*

*Delaware Health and Social Services*

For the past five years, the Delaware Healthy Mother and Infant Consortium (DHMIC) has been working toward implementing 20 recommendations aimed at reducing infant mortality in Delaware. The recommendations were originally issued in 2006 by a governor appointed Infant Mortality Task Force. The DHMIC and its working subcommittees are composed of a consortium of public health professionals including neonatologists, maternal-fetal medicine specialists, registered nurses, internists, hospital administrators, nonprofit organization directors, federally qualified health care center directors, state legislators, concerned citizens, researchers and staff at the Delaware Division of Public Health. The Infant Mortality initiative is allocated state general funds dedicated to research and support of evidence-based interventions aimed at reducing infant mortality.

Since the initiative began, the Delaware Division of Public Health (DPH) has worked toward implementing evidence-based interventions during the preconception prenatal, postpartum and interconception periods for women considered high-risk (i.e., uninsured or underinsured, member of a minority, residing in a ZIP code identified as having a high proportion of infant deaths, living with a chronic disease, or experienced a previous poor birth outcome such as premature delivery, low birth weight delivery, stillbirth, fetal or infant death). These interventions provide preconception and interconception wellness visits for women and supplemental care during pregnancy and up to two years postpartum for mothers and infants. The high-risk criteria were developed through research using state vital records data, CDC recommendations for preconception care, and Fetal Infant Mortality Review pilot data. As of June 2009, the prenatal and postpartum program has served more than 4,700 pregnant women in Delaware. In a state that averages about 13,000 births per year, the program has impacted almost 20 percent of all live births. During the same time period, almost 25,000 women have been served in the preconception component of the program. Evaluation of the effectiveness of both programs is in progress; however, preliminary results suggest significantly lower rates of pregnancy complications and infant deaths among these high risk

women. Statewide, the infant mortality rate has dropped from 9.2 per 1,000 live births during the 2001-2005 time period to 8.5 per 1,000 in the 2003-2007 time period.

### Kentucky's Efforts to Reduce the Infant Mortality Rate

**By Ruth Ann Shepherd, MD, FAAP, CPHQ**

*Director, Division of Maternal and Child Health*

*Kentucky Department for Public Health*

**Tracey D. Jewell, MPH**

*Epidemiologist, Division of Maternal and Child Health*

Infant mortality is a reflection of the health status of a population as well as an indication of maternal health, quality of care, access to care, socioeconomic conditions and public health interventions. Several of the strategies utilized in Kentucky to address infant mortality include the Health Access Nurturing Development Services (HANDS) program, Healthy Babies are Worth the Wait (HBWW) and the Jefferson County Infant Mortality Project.

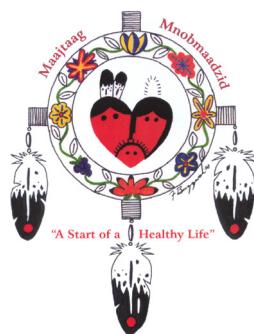
**HANDS:** This statewide home visitation program provides services to first time parents that are at-risk or overburdened. Established in 1998 to address high rates of child abuse, the program goals are to increase positive pregnancy and child health outcomes, optimize child growth and development, reduce child maltreatment and improve family functioning. Previous outcome studies have shown lower rates of preterm birth, child abuse/neglect, and infant mortality among participants. In state fiscal year 2009, 11,171 families received HANDS services.

**HBWW:** This program, a partnership between the Kentucky Department for Public Health, March of Dimes and Johnson and Johnson Pediatric Institute, provides an innovative approach to prematurity prevention by addressing the multiple determinants of preterm birth, a leading cause of infant mortality. The project goal is to demonstrate a 15 percent reduction in preventable singleton preterm births. Community health leaders implement multiple interventions to reduce preterm birth and improve systems of care. Materials include a Community Toolkit for Prematurity Prevention available [here](#). Preliminary evaluation indicates a reduction in preterm birth among the intervention sites.

## Success Stories CONT.

**Jefferson County Project:** The Jefferson County Infant Mortality Pilot Project was coordinated by the Kentucky Office of Health Equity and the Center for Health Equity at Louisville Metro Public Health and Wellness. It was developed to address the role of contextual factors in the increasing infant mortality rates among African Americans. Focus groups were conducted with participants from the West End of Jefferson County in Louisville. Numerous priority themes emerged including safety, neighborhood appearance/environmental hazards, poverty, housing, local assets, social services, teenage pregnancy/parenting, health access, education, physical fitness opportunities and substance use. The pilot results will be used to inform future programming focused on eliminating health disparities in infant mortality.

## Maajtaag Mnobmaadzid Michigan Inter- tribal Council Healthy Start Project Partners with Michigan Title V to Address American Indian Infant Mortality



**By Elizabeth Kushman, MPH**

*Project Director*

*Maajtaag Mnobmaadzid Healthy Start  
Inter-tribal Council of Michigan*

Prior to funding of the Inter-tribal Council of Michigan Healthy Start project in 1997, no state or federally funded maternal and child health (MCH) programs in Michigan had targeted the American Indian population. Data on American Indian birth outcomes were generally lumped into and reported under a racial category called “Other” in state analyses and reports. Indian Health Service Statistics for Michigan Tribes reflected only a small portion of the American Indian population and were not available by county. This lack of data and lack of programmatic focus was all the more compelling given that American Indian infants in Michigan die at two to three times the rate of

white infants, and the rate of SIDS and SUID deaths was four to six times higher.



The Inter-tribal Council of Michigan Healthy Start project provided a new opportunity to explore and address these disparities. The program provides home visiting to at-risk families and also builds awareness of American Indian maternal and child health issues. Collaboration with the state continues to grow as a successful and important aspect of the program. The project has made great strides toward increasing awareness and institutional commitment, as well as toward building capacity at its eight Tribal and Urban Indian service delivery sites across the state. “Our capacity and sophistication in using data to provide population surveillance, needs assessment and program evaluation has increased greatly, in large part due to our collaboration with representatives from the Michigan Department of Community Health. They are a critical partner in the overall success of our project,” said Elizabeth Kushman, the project’s Director. Engaging with partners to address structural and policy-related issues that impact infant mortality is a key strategy of the Healthy Start national model. Over the past 12 years, examples of collaboration with Title V include:

- Establishment of a statewide Fetal and Infant Mortality Review (FIMR) Committee to review selected American Indian infant deaths in Michigan. While project staff coordinate and manage data related to FIMR, the state has supported this effort through training, technical assistance, access to records, and financial contribution toward medical case abstraction costs.
- Membership of a State Infant Mortality program staff member on the Healthy Start project consortium to facilitate communication;
- Presentation of American Indian data by Healthy Start staff at state-sponsored Infant Mortality and Maternal Mortality meetings;

## Success Stories CONT. Maajtaag Mnobmaadzid MI Inter-tribal

- Inclusion of American Indian infant mortality as a priority issue and goal in the Michigan Title V Needs Assessment and Five Year Plan;
- Signing of data use agreements with the State Vital Records Division to provide access to de-identified birth and infant death records to enhance surveillance of American Indian birth outcomes, maternal risk factors and infant deaths as part of Healthy Start project evaluation.

For more information about the Maajtaag Mnobmaadzid Michigan Inter-tribal Healthy Start Project, please visit [here](#).

## The Commissioner's Working Group on Infant Mortality in Virginia

**By Karen Remley, MD, MBA, FAAP**  
*State Health Commissioner*  
*Virginia Department of Health*

State Health Commissioner Karen Remley, MD, MBA, FAAP formed the Commissioner's Working Group on Infant Mortality in 2008 to address Virginia's infant mortality rate. The workgroup brings together leaders from the health care industry, community and faith organizations, the business community, insurers, educators and associations such as AARP, March of Dimes and NAACP. The goal of the workgroup is to improve Virginia's infant mortality rate by engaging key stakeholders to work jointly with the Virginia Department of Health (VDH) through the development and implementation of creative/innovative prevention.

The workgroup has used a number of innovative approaches to improve Virginia's infant mortality rate. In the beginning, a social networking site was used to gain members and keep them informed. Once the group was well established, a link on the Virginia Department of Health's [website](#) was created to facilitate the sharing of current resources and post workgroup activities. Slides were made available to all members who were encouraged to make local presentations and increase awareness of infant mortality in their localities. In addition, the presence of AARP on the workgroup evolved into a project focused

## Success Stories CONT. Working Group on Infant Mortality

on grandparents as caregivers and trusted sources of information for their daughters and granddaughters. The grandmothers' campaign resulted in fact sheets developed by VDH being placed on AARP's website addressing such topics such as talking to your daughter about pregnancy, infant safe sleep and SIDS, and injury prevention for children. Likewise, AARP launched an online forum, "Ask the Commissioner," in which forum members were able to ask the State Health Commissioner questions about child and maternal health. The workgroup came together to support and implement text4baby, a new free mobile information service providing timely health information to pregnant women and new moms through a baby's first year. Members of the workgroup with other key stakeholders formed the implementation team and participated in the testing of the service prior to the national launch. The workgroup continues to meet regularly and is dedicated to not only reducing the overall infant mortality rate but also the racial disparities. Efforts to improve access to early and timely prenatal care, increasing professional and families' knowledge of available resources, and engaging the historically black colleges and universities as key partners are continuing.

## Wisconsin's Efforts to Eliminate Racial and Ethnic Disparities in Birth Outcomes

**By Patrice Mocny Onheiber, MPA**  
*Director, Disparities in Birth Outcomes*  
*Bureau of Community Health Promotion*  
*Division of Public Health*  
*Wisconsin Department of Health Services*

Wisconsin's initiative to eliminate racial and ethnic disparities in birth outcomes continues to gain momentum. A new [legislative special committee](#) on infant mortality will begin in September 2010. The committee will examine the causes of infant mortality; evaluation of public and private efforts; coordination between public health and Medicaid; successful programs in other states; the public health costs of not addressing the problem; and developing a strategic proposal, including any necessary legislation, addressing in particular disparity rates in different geographic areas of the state.

## Success Stories CONT.

### Wisconsin's Efforts in Birth Outcomes

The Title V MCH program has been instrumental in keeping infant mortality as a priority in the state. The recently released [Healthiest Wisconsin 2020](#) state plan includes an overarching focus on health disparities. The Healthy Growth and Development section describes the life-course approach, including the contributors to poor outcomes, and the interventions needed in our work. Reducing racial and ethnic disparities in birth outcomes, including infant mortality has become a 2020 objective and one of the departmental priorities that is tracked and monitored.

Other recent developments in the state include the funding of 4 MCH Collaboratives in the communities of Beloit, Kenosha, Milwaukee, and Racine. The Wisconsin Partnership Program of the University of Wisconsin School of Medicine and Public Health has begun its \$10 million [Life-course Initiative for Healthy Families \(LIHF\)](#) to address the high incidence of African-American infant mortality in the state. The Title V Program is an active partner in these efforts. Through our social marketing efforts, we continue to expand the reach of messages for healthy birth outcomes. We partnered with text4baby at the outset of this national campaign and are incorporating text4baby in our Journey of a Lifetime campaign. We have increased our social media networking activities and will extend these into September, during Infant Mortality Awareness month. Finally, we will be presenting our ABCs for Healthy Families and Journey of a Lifetime campaign this year at the American Public Health Association meeting in November. To learn more, visit [here](#).

## View from Washington

### Key Provisions of the Affordable Care Act Addressing Infant Mortality

By Brent Ewig, MHS

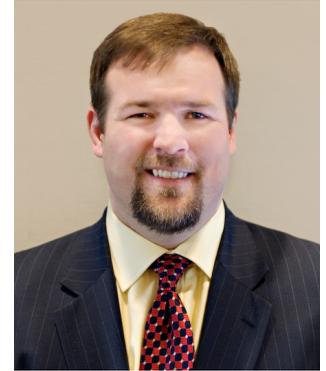
*Director of Policy & Government Affairs, AMCHP*

Infant mortality is one of the sentinel measures of how well any society is protecting and promoting the health of its women, children and families. Taking a long term view, the United States has made tremendous progress in reducing infant mortality rates. In fact, in 1999 the CDC included

## View from Washington CONT.

### Provisions of the Affordable Care Act

“healthier mothers and babies” among the [10 greatest public health achievements](#) of the 20th century, noting that from 1915 through 1997, the infant mortality rate declined greater than 90 percent and the maternal mortality rate declined almost 99 percent.



Today however we are painfully aware that this progress has essentially stalled. Moreover, significant disparities by race and ethnicity persist with the African American rate double and in some areas triple the rate for whites. Surprisingly - and despite AMCHP's aggressive advocacy - reducing infant mortality was not at the forefront of the debate over health reform. In fact the only direct mention of infant mortality in the entire 906 page law is in the section authorizing the new Maternal, Infant and Early Childhood Home Visiting Program.

Nevertheless, there are key provisions related to coverage, benefits and prevention investments that offer tremendous opportunities for us to accelerate progress. First, the law will extend affordable health insurance to the estimated one in five women of childbearing age who are currently uninsured. That means roughly 12 million women who would have a much better chance of receiving regular preventive services and early access to prenatal care if they were to become pregnant.

Second, reform provisions ensure that benefits packages have to include certain clinical preventive services with no cost-sharing; maternity and well child care services have to be included in any basic benefits package; and the practice of gender rating insurance premiums is prohibited. An additional provision calls for the development of Bright Futures guidelines for women. The Department of Health and Human Services recently contracted with the prestigious Institute of Medicine to begin formulating these recommendations. AMCHP has nominated two members to serve on this panel and in our view the key opportunity to assure that women are guaranteed access - with no cost sharing - to essential clinical preventive services.

But one thing we know from public health science is that health insurance - while fundamental and essential - is

## View from Washington Provisions of the Affordable Care Act

insufficient to improve population health outcomes. The preconception care movement also tells us that focusing on prenatal care alone might simply be too late. As one wise state MCH Director taught me, “We are realizing that seven or eight months of world class prenatal care simply cannot reverse a lifetime of unhealthy behaviors and environmental exposures that contribute to poor birth outcomes.”

Accordingly, throughout the health reform debate, AMCHP has advocated that our best opportunities to improve birth outcomes and prevent infant mortality likely come from focusing on upstream interventions across the lifespan that prevent or mitigate the chronic disease and other risk factors that might cause poor health and poor birth outcomes. In other words – and in what has become an AMCHP advocacy mantra on Capitol Hill – healthy kids start with healthy moms, healthy families, and healthy communities.

Fortunately, the Affordable Care Act includes several key provisions that could move preconception health recommendations into practice and have an impact on reducing infant mortality. Here are the highlights:

The creation of a **National Prevention and Wellness Strategy** and the **Public Health Investment Fund** will help reorient our health system toward prevention of disease and injuries.

- **National Prevention and Wellness Strategy:** The federal government does not currently have any mechanisms or plans that coordinate health policy across government to assess our public health status, establish national priorities, and identify health goals and objectives. The law calls for creation of a national strategy to accomplish these goals. AMCHP will advocate that improving our nation’s current ranking of 30 in the industrialized world in infant mortality rates has to be a national priority.
- **The Public Health Investment Fund:** Is a dedicated funding stream for public health and prevention that is needed to meet the many health threats we must face, including infant mortality and its contributing factors. The Fund will build upon what we know already works and to test new approaches. It will prioritize prevention and health, not just treatment. It will support core public health infrastructure to help state, local and tribal health departments meet their responsibilities and ensure

adequate levels of accountability. The Fund also boosts public health research and will provide public health practitioners and policymakers with the information we need to make the best decisions about preventive health.

Finally, the creation of the new \$1.5 billion **Maternal, Infant and Early Childhood Home Visiting Program**, offers states and communities the most direct opportunity to provide at-risk communities with the services and systems needed to move the needle on maternal and infant health indicators. For additional background information, see the June 2010 [Pulse](#) issue on home visiting.

None of these provisions are a silver bullet solution to the persistent and complex problem of infant mortality, but taken together they will go a long way to providing the commitment, leadership and resources we need to accelerate progress.

## Who’s New

On July 7, 2010, President Obama appointed **Donald Berwick, MD, MPP**, to serve as the Administrator of CMS through a recess appointment. Dr. Berwick is the first pediatrician to lead Centers for Medicare & Medicaid Services (CMS), and previously served as President and CEO of the Institute for Healthcare Improvement, a nonprofit organization dedicated to helping accelerate the pace of improvement of the health care systems in the U.S. and Canada. He was a practicing pediatrician at the Harvard Community Health Plan, an Associate in Pediatrics at the Children’s Hospital in Boston, and a Consultant in Pediatrics at Massachusetts General Hospital. He was also Associate Professor of Pediatrics at the Harvard Medical School, and Adjunct Associate Professor of Health Policy and Management at the Harvard School of Public Health. Dr. Berwick holds a BA degree from Harvard College, a MA of Public Policy degree from the John F. Kennedy School of Government, and a MD degree from Harvard Medical School.



## Who's New CONT.

On June 22, 2010, **Dr. Sherry Glied** was confirmed as the new HHS Assistant Secretary for Planning and Evaluation (ASPE). She previously served as professor and chair of the Department of Health Policy and Management at Columbia University where her principal areas of research were in health policy reform and mental healthcare policy. She served as a senior economist for healthcare and labor market policy to the President's Council of Economic Advisers, under both President Bush and President Clinton. In the latter part of her term, she was a participant in President Clinton's Health Care Task Force. She is an author of recently published articles and reports on managed care, women's health, child health, and health insurance expansions. She holds a PhD from Harvard University, MA from the University of Toronto, MA and BA from Yale University.



The U.S. Department of Health and Human Services also announced the appointment of **Marilyn J. Keefe, MPH**, as Deputy Assistant Secretary for Population Affairs (DASPA). As Deputy Assistant Secretary, she will manage operations and activities of the Office of Population Affairs (OPA) and its components, coordinate long-range planning; and guide program development. Ms. Keefe joins OPHS after having most recently served as the Director of Reproductive Health Programs for the National Partnership for Women & Families, an organization which promotes women's health issues, access to affordable health care, and workplace fairness. Previously, Ms. Keefe served for 13 years as Vice President for Public Policy at the National Family Planning and Reproductive Health Association (NFPRHA). Prior to joining NFPRHA, Ms. Keefe worked at HHS as a program analyst for four years, with special emphasis on the Medicare and Medicaid programs. Ms. Keefe earned a MPH degree with a concentration in population dynamics from Johns Hopkins University in 1993; a MA in Public Policy degree from the University of Chicago in 1986; and a BA in English from Columbia University in 1980.

## Get Involved Celebrating Title V at 75 Nationwide

Please join AMCHP and MCHB in a national webinar to celebrate the legacy of the Title V MCH Services Block Grant and share thoughts on its future on **September 27 at 3 p.m. EST.** The webcast is designed to "virtually" connect MCH leaders across the country at the same time and kick off this fall's commemoration of Title V in Washington, DC, and other state and local festivities. Plan an event in your agency around this important and informative webinar and join in the national celebration! Click here for activities to engage your state and local MCH leaders and helpful resources on Title V to help plan your own event.



To register for the webcast, visit [www.mchcom.com](http://www.mchcom.com). For more information, contact AMCHP at [info@amchp.org](mailto:info@amchp.org).

## Nominations for AMCHP Board Positions

AMCHP's Governance Committee is currently accepting nominations for 2011 AMCHP Board positions. These leadership positions guide, direct, inform and contribute to moving AMCHP's strategic directions and goals forward. Positions that will be open in the 2011 election include:

1. President-Elect
2. Director-At-Large
3. Family Representative
4. Region II
5. Region III
6. Region V
7. Region VII

Volunteer leadership is critical to AMCHP's success. We hope that you will consider participating in the nominations process. More information about these positions, necessary qualifications and the nominations process may be found on the AMCHP website or by clicking [here](#). We ask that all nominations be forwarded to the Governance Committee by September 30 to ensure ample time for the Committee to review all candidates' materials. Please note: Only named AMCHP delegates may be nominated to the Board. To verify your membership status, contact [Julio Arguello, Publications & Member Services Manager](#).

## Get Involved CONT.

### AMCHP–CityMatCH Health Reform Meeting

Register today! The AMCHP–CityMatCH Summit on MCH and Health Reform is quickly filling up. Attend

the one-day event on Thursday, October 21 to learn more about how recently enacted health reform legislation at the national level may impact state and local MCH practice. Registration is required and available [online](#). A block of rooms for Summit attendees, as well as those attending other events in Washington, DC the week of October 18, has been reserved at the Omni Shoreham Hotel. Hotel information is also available [here](#).



### AMCHP Board Meeting

AMCHP’s Board of Directors will be meeting in person in Washington, DC on Tuesday, October 19. Board meetings are open to the public and we are pleased to welcome visitors. If you plan to attend, please notify [Nora Lam](#), Executive Assistant or call (202) 266-3038. Agenda items include a discussion of health reform and policy implications for state MCH programs, a discussion of AMCHP policy on formal affiliations with other groups, and standard AMCHP business including finance and Board nominations.

### AMCHP & Family Voices National Conferences

Join us! Working Together to Improve Maternal and Child Health: The 2011 AMCHP and Family Voices National Conferences will be held in Washington, DC on February 12-15, 2011. Network, learn, and enjoy time with colleagues in our nation’s capital. More information is available [here](#). Registration information will be posted in early October. Please save the dates. See you there!



### AMCHP Membership Renewal Update

AMCHP is excited to announce the kick off of our membership renewal campaign for the 2011 membership year! Membership renewal packets have now been sent to all state and territorial program members, all organizational members and all individual associate members. If you or your program has not yet received your renewal packet or if any information listed on your invoice needs to be updated, please contact [Julio Arguello Jr.](#), Publications & Member Services Manager. Thank you for your support of AMCHP and we look forward to your active participation in the coming year!

### September is Infant Mortality Awareness Month

With the theme: *A Healthy Baby Begins with Two! Minority Fathers Fight Infant Mortality*, the Office of Minority Health is calling on communities across America to [get involved](#).



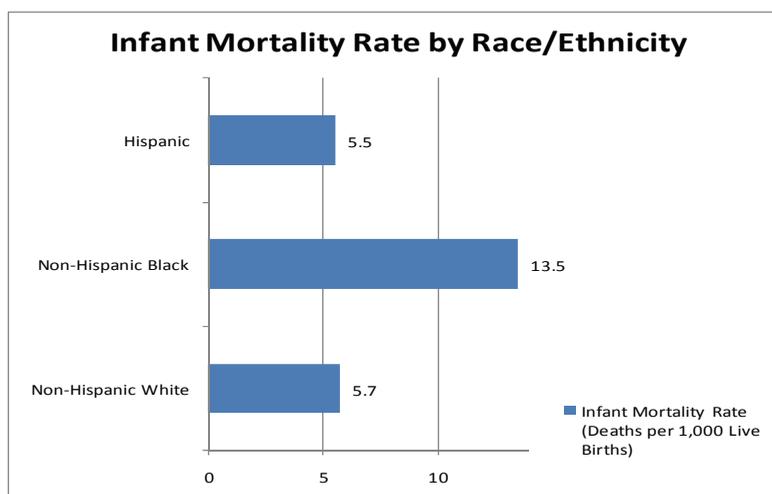
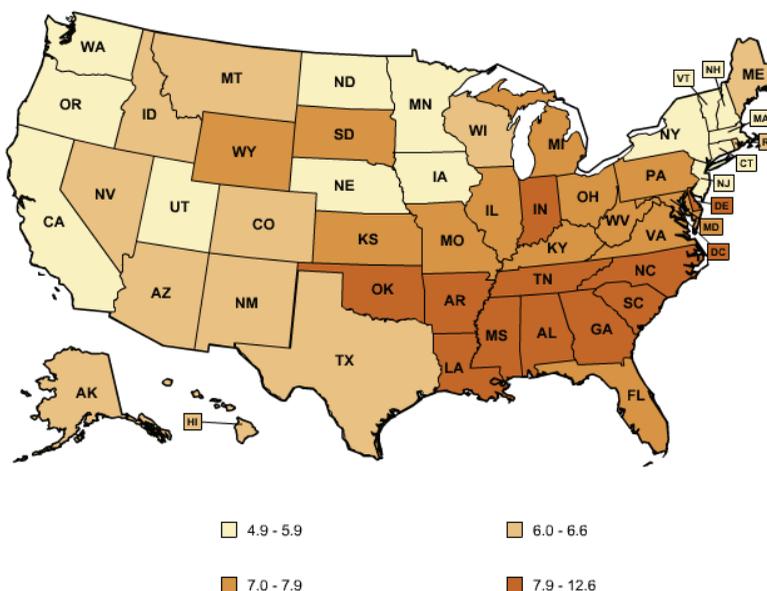
### AAP Webinar on Birth Defects Prevention and Intervention

The American Academy of Pediatrics (AAP) will host its first call in the Birth Defects Prevention and Identification CME Series “Medications Use During Pregnancy: What the Pediatrician Needs to Know” on September 23 at 12 p.m. EST. To register, visit [here](#).

## Data and Trends

	Infant Death Rate
<b>United States</b>	<b>6.8</b>
Alabama	9.1
Alaska	6.5
Arizona	6.6
Arkansas	8.2
California	5.2
Colorado	6.1
Connecticut	5.8
Delaware	8.6
District of Columbia	12.6
Florida	7.2
Georgia	8.2
Hawaii	6.1
Idaho	6.3
Illinois	7.4
Indiana	7.9
Iowa	5.2
Kansas	7.3
Kentucky	7.0
Louisiana	10.0
Maine	6.3
Maryland	7.9
Massachusetts	4.9
Michigan	7.6
Minnesota	5.0
Mississippi	10.6
Missouri	7.5
Montana	6.0
Nebraska	5.9
Nevada	6.2
New Hampshire	5.6
New Jersey	5.4
New Mexico	6.1
New York	5.9
North Carolina	8.5
North Dakota	5.9
Ohio	7.8
Oklahoma	8.0
Oregon	5.6
Pennsylvania	7.4
Rhode Island	6.0
South Carolina	9.0
South Dakota	7.3
Tennessee	8.7
Texas	6.3
Utah	5.0
Vermont	5.6
Virginia	7.3
Washington	5.1
West Virginia	7.6
Wisconsin	6.3
Wyoming	7.4
Guam	8.6
Puerto Rico	6.8
Virgin Islands	11.9

Infant Mortality Rate (Deaths per 1,000 Live Births),  
Linked Files, 2004-2006



Sources: Matthews, T.J., M.S., et. al. Infant Mortality Statistics from the 2006 Period Linked Birth/Infant Death Data Set. Division of Vital Statistics. National Vital Statistics Report, Vol 58, No. 17, April 30, 2010. Available at [http://www.cdc.gov/nchs/data/nvsr/nvsr58/nvsr58\\_17.pdf](http://www.cdc.gov/nchs/data/nvsr/nvsr58/nvsr58_17.pdf).

## Resources

[Association of Maternal & Child Health Programs \(AMCHP\)](#): Offers information and resources about its programs to help state public health agencies and communities address infant mortality.

[Association of SIDS and Infant Mortality Programs \(ASIP\)](#): Hosts information about the [National Sudden and Unexpected Infant/Child Death and Pregnancy Loss Project IMPACT](#), which is part of a national consortium of four centers supported by the [Maternal and Child Health Bureau \(MCHB\)](#) to address infant mortality and pregnancy loss.

[Centers for Disease Control and Prevention \(CDC\)](#): Offers resources and initiatives aimed at reducing infant mortality and pregnancy loss that include:

- [Division of Reproductive Health: Maternal and Infant Health \(CDC\)](#): Contains links to reports, data and other resources about promoting healthy pregnancy and infant health and preventing premature birth and infant illness and mortality, including [SIDS and SUID](#). Recent publications and initiatives include:
  - CDC's [Morbidity & Mortality Weekly Reports \(MMWR\)](#): Presents data based on weekly reports to CDC by state health departments. Recent reports about infant mortality and pregnancy loss include:
    - [QuickStats: Fetal Mortality Rates, by Period of Gestation—United States, 1990-2005](#) (2009): This graph shows fetal mortality rate trends from 1990 - 2005.
    - [QuickStats: Infant, Neonatal, and Postneonatal Annual Mortality Rates—United States, 1940-2006](#) (2009): This graph shows infant, neonatal and postneonatal annual mortality rate trends from 1940 - 2006.
- CDC's [National Center for Health Statistics \(NCHS\)](#): Includes national data about infant mortality and pregnancy loss. Recent publications include:
  - [Deaths: Final Data for 2006](#) (2009): This

report includes infant mortality rates and lists leading causes of infant death.

- [FASTATS: Infant Health \(rev. ed.\)](#) (2009): This fact sheet presents national infant mortality data statistics with links to full reports and data sets.
- [Fetal and Perinatal Mortality, United States, 2005](#) (2009)
- [Infant Mortality Statistics from the 2005 Period Linked Birth/Infant Death Data Set](#) (2008): This report presents data from the [linked birth/infant death data set](#).
- Also see the NCHS databases: [Data 2010, Health Data Interactive](#) and [VitalStats](#).
- CDC's [Racial and Ethnic Approaches to Community Health Across the U.S. \(REACH U.S.\)](#): Describes this initiative that supports community coalitions in designing, implementing and evaluating community-driven strategies to eliminate health disparities in eight priority areas, one of which is infant mortality.
- Also see CDC's [Pregnancy Risk Assessment Monitoring System \(PRAMS\)](#), the [National Center on Birth Defects and Developmental Disabilities \(NCBDDD\)](#), [publications and brochures](#) addressing folic acid, and diabetes and pregnancy, and NCBDDD's [brochure](#) for health professionals about stillbirths.

[CityMatCH](#): Contains tools and resources for implementing the Perinatal Periods of Risk (PPOR) approach for mobilizing communities to reduce fetto-infant mortality in U.S. cities.

[Eunice Kennedy Shriver National Institute of Child Health and Human Development \(NICHD\)](#): Contains research and grant information, publications and other resources for health professionals, researchers and families about pregnancy and infant and child health topics, including pregnancy loss, birth defects, prematurity, and infant mortality. [Reports](#) describe the research and training supported by NICHD's [Pregnancy and Perinatology Branch](#)

## Resources CONT.

to improve the outcomes of pregnancy, reduce infant mortality, and minimize maternal and infant morbidities.

[First Candle](#): Hosts information about the [National Sudden and Unexpected Infant/Child Death and Pregnancy Loss Program Support Center](#), which is part of a national consortium of four centers supported by the [Maternal and Child Health Bureau \(MCHB\)](#) to address infant mortality and pregnancy loss. Provides a hotline in English and Spanish for expectant and new parents on ways to help their infants survive and thrive, for parents who have experienced the death of an infant, and for professionals working with families. Also see First Candle's resources about [infant mortality risk reduction](#), [bereavement](#) and [safe sleep environments](#).

[Healthy People 2010](#): Offers information and publications about this national health-promotion and disease-prevention initiative that is coordinated by the [Office of Disease Prevention and Health Promotion \(ODPHP\)](#). View the maternal, infant, and child health [focus area](#) to learn about the objectives related to infant mortality and pregnancy loss. See [Data2010](#) for data about the objectives and the [HP2010 Information Access Project](#) for access to published literature related to the objectives. Also learn how to participate in the development of [Healthy People 2020](#).

[Joint Center for Political and Economic Studies: The Courage to Love Commission](#): Presents [papers](#), [PowerPoint presentations](#), and [fact sheets](#) from this initiative that analyzed racial and ethnic disparities in infant mortality. Papers include:

- [Race, Stress, and Social Support: Addressing the Crisis in Black Infant Mortality](#) (2007): This paper includes information on stress and coping, best practices and policy recommendations regarding black infant mortality.
- [Maternal Nutrition and Infant Mortality in the Context of Relationality](#) (2007): This paper covers infant mortality disparities, nutritional status and behaviors of pregnant women in the United States, prenatal nutrition interventions, relationality over the lifecycle and recommendations.

[March of Dimes \(MOD\)](#): Contains resources for health professionals and [expectant and new parents](#) in English and Spanish about preconceptional and prenatal care, [birth defects](#), [pregnancy loss](#), [prematurity](#), [bereavement](#), and how to get involved in improving infants' health by reducing the incidence of birth defects and infant mortality. Offers [perinatal statistics](#) (including infant mortality rates), continuing-education modules, medical reference information, and video and audio resources.

[Maternal and Child Health Bureau \(MCHB\)](#): Describes MCHB's projects and initiatives on behalf of America's women, infants, children, adolescents and their families. Initiatives include [Healthy Start](#), a program to address factors contributing to infant mortality, low birthweight, and other adverse perinatal outcomes in high-risk populations.

[Maternal and Child Health Library at Georgetown University Infant Mortality and Pregnancy Loss Knowledge Path](#): This document links to recent, high-quality resources about infant mortality and pregnancy loss and to factors that contribute to these public health problems, such as birth defects, injuries, prematurity and low birthweight. A section on sleep environment and the prevention of Sudden Infant Death Syndrome is included. A separate resource on these topics for [families](#) is also available.

The MCH Library [website](#) has been redesigned to provide a fresh look and feel and additional resources including pages focusing on professional, family, and school resources and resources on MCH professional education. An enhanced search feature allows users to select display formats and to create their own resource lists by checking off items from materials found in their searches. An updated sidebar and an A-Z Index guide visitors through the site, as well.

A new feature highlights the 75th Anniversary of Title V, and presents "75 Books for 75 Years," a book list of seminal and historical materials that are nominated by MCH Library visitors. An "In the News" page highlights significant developments related to public health and links to numerous federal and national public health news sources.

The site will continue to be developed with new features and new information, and user suggestions are always welcome. Please see [here](#) or contact the library at

## Resources CONT.

[mchgroup@georgetown.edu](mailto:mchgroup@georgetown.edu). To receive notices of new features and information, [subscribe](#) to the weekly MCH Alert.

[National Center for Child Death Review](#): Describes the child death review process for infants, children and adolescents from birth through age 18, offers tools for child death review teams, provides state program information and presents child mortality data by state.

[National Center for Cultural Competence \(NCCC\)](#): Hosts information about the [National Sudden and Unexpected Infant/Child Death and Pregnancy Loss Project](#), which is part of a national consortium of four centers supported by the [Maternal and Child Health Bureau \(MCHB\)](#) to address infant mortality and pregnancy loss. Provides technical assistance and develops resources on cultural and linguistic competence to help programs effectively address racial and ethnic disparities in perinatal, infant and child mortality and pregnancy loss.

[National Fetal and Infant Mortality Review Program \(NFIMR\)](#): Contains a wealth of resources for implementing the fetal and infant mortality review (FIMR) method, including a directory of state and community FIMR projects, program descriptions, data-abstraction forms, sample laws to implement and safeguard FIMR proceedings and an [online discussion group](#). NFIMR is a collaborative effort between the [American College of Obstetricians and Gynecologists \(ACOG\)](#) and the [Maternal and Child Health Bureau \(MCHB\)](#).

[National Healthy Start Association \(NHSA\)](#): Describes the Healthy Start program and provides general information about infant mortality, low-birthweight infants, and racial disparities in perinatal outcomes. Includes a directory of Healthy Start programs nationwide and a [newsletter](#). Funded by the [Maternal and Child Health Bureau \(MCHB\)](#), Healthy Start provides community-based, culturally competent, family-centered, comprehensive perinatal health services to women, infants and their families in communities with very high rates of infant mortality. Recent publications include:

- [National Infant Mortality Awareness Month Toolkit \(2010\)](#): This toolkit aims to help Healthy Start projects promote the effectiveness of programs

and efforts to reduce infant deaths, low birthweight, preterm births and disparities in perinatal outcomes.

[National Sudden and Unexpected Infant/Child Death and Pregnancy Loss Resource Center](#): Provides up-to-date information on the prevention of pregnancy loss, SIDS, and sudden unexpected infant and child death; and on bereavement support for families facing losses. Information on child care and SIDS, first responders, and a safe sleep environment is included, as are a training toolkit, statistics, and multimedia resources.

[Office of Minority Health: Infant Health](#): Contains statistics about infant mortality among racial and ethnic groups and a fact sheet and list of links to publications and websites about infant mortality. Initiatives include:

- [A Healthy Baby Begins with You](#): Presents information about this national print and radio campaign to raise awareness about infant mortality with an emphasis on the African-American community. Includes [campaign materials](#) and infant mortality disparities [fact sheets](#). Also presents information about another phase of the campaign, the [Preconception Peer Educators \(PPE\) Program](#), which is designed to educate the college-age population about preconception health and care and to train them to serve as ambassadors for their peers who are not attending college.

### Databases

The databases listed below are excellent tools for identifying [data](#), additional [literature and research](#), and [programs](#) addressing infant mortality and pregnancy loss.

[Community Health Status Indicators \(CHSI\)](#): Presents county-specific data on health status indicators obtained from a variety of federal agencies including the Department of Health and Human Services, the Environmental Protection Agency, the Census Bureau, and the Department of Labor. Use the indicators to compare a county with counties similar in population composition and selected demographics and to characterize the overall health of a county and its citizens to support health planning. Select a state and county and click on Display Data. Select Measures of Birth and Death to view birth

## Resources CONT.

measures and infant mortality rates. CHSI is a service of the [Department of Health and Human Services \(DHHS\)](#).

[Data2010 - The Healthy People 2010 Database](#): Contains the most recent monitoring data for tracking [Healthy People 2010](#). To obtain data about infant mortality and contributing factors, click on the field, Data by Focus Area. Under the field, Select a Focus Area, choose 16 - Maternal, Infant, and Child Health from the pop-up menu. Next, click on the button for Include Related Objectives From Other Focus Areas in the Table. Click on the Submit button. This data set is provided by the [National Center for Health Statistics \(NCHS\)](#) via [CDC Wonder](#).

[Health Data Interactive \(HDI\)](#): Presents interactive online data tables on pregnancy and birth, health conditions and risk factors, health care access and use, and mortality. Infant, neonatal, and postneonatal mortality data and data about preterm birth and low birthweight are presented. HDI is a service of the [National Center for Health Statistics \(NCHS\)](#).

[KIDS COUNT Data Center](#): Contains information about this national and state-by-state effort to track the status of children in the United States. Generate custom graphs, maps, ranked lists, and state-by-state profiles of birth outcomes, among other child health indicators. KIDS COUNT is a project of the [Annie E. Casey Foundation \(AECF\)](#).

[Linked Birth/Infant Death Data Set](#): Contains data about infant births/deaths occurring within the United States to U.S. residents. Data are available by county of mother's residence, infant's age, underlying cause of death, gender, birthweight, birth plurality, birth order, gestational age at birth, period of prenatal care, maternal race and ethnicity, maternal age, maternal education and marital status. This data set is provided by the [National Center for Health Statistics \(NCHS\)](#) via [CDC Wonder](#).

[PeriStats](#): Provides access to maternal and infant health-related data at the national, state, county and city level by aggregating data from several government agencies and organizations. Topics include the timing and frequency of prenatal care, preterm birth, low birthweight, infant mortality, tobacco use and health insurance coverage.

Over 60,000 graphs, maps and tables are available, and data are referenced to the relevant source. PeriStats is a service of the [March of Dimes](#).

[Pregnancy Risk Assessment Monitoring System \(PRAMS\)](#): Presents state-specific, population-based data on maternal attitudes and experiences before, during and immediately following pregnancy. PRAMS is a surveillance project of the [Centers for Disease Control and Prevention \(CDC\)](#) and state health departments.

[State Health Facts Online](#): Contains state-level data on more than 500 health topics. View individual state profiles, or compare data for all states by category. For infant mortality data, click on the Health Status category and select one of several subcategories under Infants. For data about low birthweight and prematurity, click on the Health Status category, and select one of several subcategories under Births. This system is provided by the [Kaiser Family Foundation](#).

[Title V Information System \(TVIS\)](#): Contains data from annual Title V Block Grant applications and reports submitted by all 59 U.S. states and jurisdictions. To identify state efforts to reduce infant mortality, conduct several searches: (1) Select [Program Data](#); scroll to Medicaid/ Non Medicaid Comparison and select Infants deaths per 1,000 live births; select a state and Annual Report Year; and click on Start Search. (2) Select [Measurement and Indicator Data](#); select National Outcome Measures; select Most Recent Year Available or Multi-Year Report; select a state and infant mortality measure; click on Start Search. (3) Select [Measurement and Indicator Data](#); scroll to State Data; select State Priority Needs Keyword Search; select Keyword: Morbidity/Mortality and Population: Infants; click on Start Search. (4) Select [Measurement and Indicator Data](#); scroll to State Data; select State Outcome Measures; select Search By Keyword/Population; select a state and Keyword: Morbidity/Mortality and Population: Infants; click on Start Search. (5) View [State Snapshots of Maternal and Child Health](#) for a summary of each state's infant mortality data. TVIS is a service of the [Maternal and Child Health Bureau \(MCHB\)](#).

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**Darlisha Williams, MPH**, Program Manager, Best Practices

## Calendar

### SPECIAL EVENTS

[Celebrating Title V at 75 Nationwide](#)

September 27  
Washington, DC

[MCHB 75th Anniversary of Title V Commemoration](#)

October 20  
Washington, DC

[Looking to the Future: What are the Opportunities and Challenges of Health Reform for Improving Maternal and Child Health?](#)

October 21  
Washington, DC

[AMCHP 2011 Annual Conference](#)

February 12-15  
Washington, DC

## Calendar CONT.

### MORE MCH EVENTS

[NIH Consensus Development Conference](#)

October 27-29  
Bethesda, MD

[15th Annual International Meeting of the Academy of Breastfeeding Medicine](#)

October 27-30  
San Francisco, CA

[Postpartum Support International Annual Conference](#)

October 27-30  
Pittsburgh, PA

[2010 AUCD Conference](#)

October 30-November 3  
Crystal City, VA

[ASIP/PLIDA International Conference on Perinatal and Infant Death](#)

November 4-7  
Alexandria, VA

[APHA 138th Annual Meeting and Exposition](#)

November 6-10  
Denver, CO

[25th Zero to Three National Training Institute](#)

December 9-11  
Phoenix, AZ

[16th Annual MCH EPI Pre-Conference Data Skill Trainings](#)

December 13-14  
San Antonio, TX

[16th Annual CDC MCH EPI Conference](#)

December 15-17  
San Antonio, TX

**Association of Maternal & Child Health Programs**

2030 M Street, NW, Suite 350  
Washington, DC 20036  
(202) 775-0436  
www.amchp.org