HEALTHY MOMS. STRONG BABIES.

2020 MARCH OF DIMES REPORT CARD

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POLICY ACTIONS
March of Dimes 2020 Report Card monitors progress on key indicators and actions to improve the health of moms and babies in the U.S. Overall, the rates of maternal death and preterm birth (the second leading contributor to infant death) are increasing. With approximately 10 percent of births nationwide occurring in counties with limited access to maternity care, action is needed now to help ensure that all women receive the care and support they need before, during and after pregnancy.

Policies should be rooted in addressing disparities in maternal and infant health outcomes. Policymakers must take swift action to better serve the women and children in our country. No single solution will address improved maternal and child health; however, focusing improvements in equity, access and prevention are key to making an impact. Recommendations are described below:

**EQUITY**

**ELIMINATE RACIAL DISPARITIES IN HEALTH OUTCOMES FOR MOMS AND BABIES**

Black, American Indian and Alaska Native women and their babies consistently have worse health outcomes than their white peers. Implicit bias training for health care providers and increasing access to and coverage for doula services are among the many strategies to fight unacceptable disparities. Addressing determinants of health caused by social, environmental, and economic factors is another strategy to reduce disparities to improve health equity through engaging in health system reform.

**REMOVE BARRIERS TO OBTAINING QUALITY CARE IN UNDERSERVED AND RURAL COMMUNITIES**

Each year in the U.S., approximately 150,000 babies are born to moms living in maternity care deserts or communities without a hospital offering obstetric care and without any obstetric providers. Women in these communities may have difficulty obtaining appropriate and quality care before, during and after pregnancy. Increasing access to inpatient obstetrical facilities and qualified obstetrical providers is critical to improving outcomes in these communities. Expanding access to midwifery care and further integrating midwives and their model of care into maternity care in all states can help improve access in under-resourced areas, reduce interventions that contribute to risk of maternal mortality and morbidity and improve the health of moms and babies. Reimbursement for doula care is another way to help improve birth outcomes and reduce higher rates of maternal morbidity and mortality. In some states coverage of doula services is provided under the full range of private and public insurance programs, including Medicaid, the Children’s Health Insurance Program (CHIP), TRICARE, and others. Payment levels should be sufficient to support the care provided. Efforts should be made to make the doula profession more accessible to people of diverse socio-economic and cultural backgrounds. Lastly, implementing perinatal regionalization would create a coordinated system of care within a geographic area that can help pregnant women to receive risk-appropriate care in a facility equipped with the proper resources and health care providers.

**LEGEND**

ACCESS

PROTECT COMPREHENSIVE HEALTH CARE COVERAGE FOR MOMS AND CHILDREN

Almost 90% of U.S. women will give birth during their reproductive years. They all need access to quality prenatal, labor and delivery and postpartum services to help prevent and manage complications. It is imperative that health plans continue to offer the ten categories of Essential Health Benefits, including maternity and newborn care, well-woman and well-child preventive care, prescription drugs and mental health services, which are critical to the health of both mom and baby. Lawmakers must also preserve existing consumer protections regarding pre-existing conditions and shield families from high premiums and out-of-pocket costs and lifetime or annual limits.

PROVIDE AFFORDABLE, QUALITY PUBLIC HEALTH INSURANCE PROGRAMS TO WOMEN BEFORE PREGNANCY, AN ESSENTIAL TIME TO INTERVENE TO ACHIEVE HEALTHY PREGNANCIES

Research shows one of the best opportunities to achieve healthy pregnancies is to improve the health of all women before they become pregnant. Medicaid expansion to cover individuals up to 138% of the federal poverty level can play an essential role in improving maternal and infant health. A growing number of studies indicate that Medicaid expansion has reduced the rate of women of childbearing age who are uninsured, improved health outcomes and helped to reduce disparities, including lower rates of preterm birth and low birthweight for Black infants in expansion states.

The uninsured rate for women of childbearing age is nearly twice as high in states that have not expanded Medicaid compared to those that have expanded Medicaid (16 percent vs. 9 percent).1

The latest data shows that one-third of all pregnancy-related deaths happen one week to one year after delivery. In too many states, Medicaid maternity coverage ends 60 days after giving birth, ending access to care at a time when risks of maternal complications and death persist. Comprehensive health care coverage in Medicaid should be extended to at least 12 months postpartum.

55% of moms who were insured by Medicaid for their delivery were uninsured six months after giving birth.5

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In order to implement strategies to prevent maternal death, we need to understand why moms are dying before, during and after pregnancy. Improving maternal mortality and morbidity data collection and surveillance will help us to understand trends and monitor progress. Maternal mortality review committees (MMRC) investigate every instance of maternal death in a state or community, and make recommendations to stop future tragedies. We must continue to support the work of state MMRCs to collect robust and standardized data to inform local and national policies to address the nation’s maternal mortality crisis.

March of Dimes supports increasing access to telehealth services for pregnant and postpartum women. There’s reason to focus specifically on telehealth in maternity care, as in recent years, telehealth has been incorporated into many aspects of women’s health care, including: virtual patient consultation with specialists, remote observation of ultrasound recordings by maternal-fetal medicine experts, postpartum blood pressure monitoring using Wi-Fi connected devices and fertility tracking with patient-generated data.

Studies demonstrate that group prenatal care can provide health benefits for both moms and babies, such as reducing preterm birth. Enhanced reimbursement models, including delivery and outcomes-based incentives, can encourage providers to offer it.

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Population-level improvements in maternal and infant health rely on a robust public health infrastructure to detect contributors to poor outcomes, identify opportunities to address those contributors and then mobilize providers, health systems, stakeholders and communities to take action. We must support efforts to improve data on maternal and infant health and bolster programs focused on implementing strategies that have shown to keep all moms and babies healthy.

These systems should strive to make benefits available to all workers while also distributing the responsibility for funding this system among employers.

The impact of COVID-19 on pregnant women is alarming. They have a greater likelihood of severe complications due to the virus, which is why we must include pregnant and/or lactating women in clinical trials and prioritize them when a vaccine is made available.

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2020 REPORT CARDS
In the 2020 Report Card, we highlight the latest key indicators to describe and improve maternal and infant health in the United States (U.S.). Preterm birth and its complications are the second largest contributor to infant death in the U.S., and preterm birth rates have been increasing for five years. Prematurity grades are assigned by comparing the 2019 preterm birth grade to March of Dimes’ goal of 8.1 percent by 2020.

Rates of maternal death and morbidity continue to be unacceptably high in the U.S. Maternal morbidity, social determinants of health, availability of state level health insurance policy and the availability of surveillance and research data affect the health and survival of both mom and baby. While we currently do not have enough to grade states or report on all maternal health indicators, we have highlighted measures with the best available data.

Puerto Rico is not included in the United States total.

Preterm is less than 37 completed weeks of gestation, based on obstetric estimate of gestational age.

Source: Preterm birth rates are from the National Center for Health Statistics, 2019 final natality data. Grades assigned by March of Dimes Perinatal Data Center.

Scan for details

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UNITED STATES MATERNAL AND INFANT HEALTH

SELECTED SOCIAL DETERMINANTS OF HEALTH

Many structural, systemic and environmental factors influence the health of moms and babies, especially for Black, American Indian and Alaska Native people. When looking at factors such as access to maternity care, financial stability and health insurance status, these disparities persist. Systemic racism and the wealth gap in the U.S. deepen many health inequities in our society. The onset of COVID-19 has further magnified preexisting health disparities. March of Dimes is collaborating with others to confront these drivers of health outcomes, while identifying solutions to achieve health equity for all.

ADOPTED in 39 STATES (INCLUDING D.C.)

MEDICAID EXPANSION

Medicaid expansion to cover individuals up to 138% of the federal poverty level can play an essential role in improving maternal and infant health. A growing number of studies indicate that Medicaid expansion has reduced the rate of women of childbearing age who are uninsured, improved health outcomes and helped to reduce disparities, including lower rates of premature birth and low birthweight for Black infants in expansion states.

RECENT ACTION ON MEDICAID EXTENSION

Recent action is determined if a state or territory has introduced the policy extension, enacted or is currently implemented to some degree. No states have extended the full benefits of Medicaid at this time. This policy, supported by clinical evidence, aims to extend healthcare coverage from 60 days postpartum, to a full year for women who are covered under Medicaid.

$65 THOUSAND

AVERAGE COST OF A PRETERM BIRTH

The estimated societal cost per preterm birth includes medical care for premature children, maternal delivery costs, early intervention services, special education services and lost productivity. State estimates reflect 2016 adjustments to underlying national estimates developed in 2005 (see technical notes for additional details).

25 STATES ARE SUPPORTED BY ERASE MM FUNDING

MATERNAL MORTALITY REVIEW COMMITTEE

These committees are organized at the state or city level to comprehensively review deaths that occur to women within one year of delivering a baby. The committees can be made up of representatives from public health, nursing, maternal-fetal medicine, obstetrics and gynecology, midwifery, patient advocacy groups and community-based organizations. States that have an MMRC are better equipped to prevent pregnancy-related deaths. ERASE MM indicates Enhancing Reviews and Surveillance to Eliminate Maternal Mortality.

13 STATES ARE SUPPORTED BY DIVISION OF REPRODUCTIVE HEALTH

PERINATAL QUALITY COLLABORATIVE

The focus of these state or multi-state collaboratives are to improve the quality of care for moms and babies, before, during and after pregnancy. The Perinatal Quality Collaborative (PQC) involves partnerships with families, key state agencies and organizations to identify and initiate programs or procedures that increase the quality of care in clinical settings.

To prevent maternal and infant deaths, we need to better understand the causes of severe maternal morbidity (SMM) and those most impacted by it, including racial and ethnic disparities. This starts by standardizing data collection and reporting for maternal and infant health across the U.S. These data will help us to examine factors contributing to SMM, preventable deaths and poor birth outcomes in order to develop evidence-based solutions. To this end, future Report Cards will assess overall rates and disparities of SMM, low-risk cesarean sections and measures of equity in maternal and infant health.

Additional details on these future measures can be found here.

MORE INFORMATION: MARCHOFDIMES.ORG/REPORTCARD

March of Dimes recommends state policy actions that are rooted in addressing disparities in maternal and infant health outcomes. For more detail visit Policy & Action. For details on data sources and calculations, see Technical Notes. To learn how we are working to reduce preterm birth visit www.marchofdimes.org. ©2020 March of Dimes
Aggregate 2016-2018 preterm birth rates are shown for each of the five bridged racial and ethnic groups. The racial/ethnic group with the highest rate is compared to the combined rate for all other racial/ethnic groups.

In the United States, the preterm birth rate among Black women is 50% higher than the rate among all other women.

RACE & ETHNICITY DISPARITY BY STATE

The March of Dimes disparity ratio measures and tracks progress towards the elimination of racial/ethnic disparities in preterm birth. It’s based on Healthy People 2020 methodology and compares the group with the lowest preterm birth rate to the average for all other groups. Progress is evaluated by comparing the current disparity ratio to a baseline disparity ratio. A lower disparity ratio is better, with a disparity ratio of 1 indicating no disparity.

U.S. disparity ratio

1.26

The U.S. Disparity Ratio has worsened from baseline

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INFANT MORTALITY

Infant mortality rates are an indication of overall health. Leading causes of infant death include birth defects, prematurity, low birth weight, maternal complications and sudden infant death syndrome.

INFANT MORTALITY RATE

5.7

RATE BY RACE AND ETHNICITY

2018 infant mortality rates per 1,000 live births are shown for each of the bridged racial and ethnic groups. The highest rate of infant mortality are seen for non-Hispanic Black women.

INFANT MORTALITY RATE BY STATE

March of Dimes recommends state policy actions that are rooted in addressing disparities in maternal and infant health outcomes. For more detail visit Policy & Action. For details on data sources and calculations, see Technical Notes. To learn how we are working to reduce preterm birth visit www.marchofdimes.org.

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The 2020 U.S. March of Dimes Report Card assigns grades to the 100 cities with the greatest number of live births in 2018. Premature Birth Report Card grades are assigned by comparing the 2018 preterm birth rate in a city to the March of Dimes goal of 8.1 percent by 2020.

Notes:
- Preterm is less than 37 weeks gestation based on obstetric estimate of gestational age.
- Cities represent those with the greatest number of live births out of all cities with a population of >100,000, as defined by the National Center for Health Statistics.
- *Data for Honolulu represent the combined city and county of Honolulu. Data are not comparable to past years.
- See the U.S. 2020 March of Dimes Report Card for more information.

PRETERM BIRTH: DEFINITION AND SOURCE

Preterm birth is a birth with less than 37 weeks gestation based on the obstetric estimate of gestational age. Data used in this report card came from the National Center for Health Statistics (NCHS) natality files, as compiled from data provided by the 57 vital statistics jurisdictions through the Vital Statistics Cooperative Program. This national data source was used so that data are comparable for each state and jurisdiction-specific report card. Data provided on the report card may differ from data obtained directly from state or local health departments and vital statistics agencies due to timing of data submission and handling of missing data. The preterm birth rates shown at the top of report card was calculated from the NCHS 2019 final natality data. Preterm birth rates in the trend graph are from the NCHS 2009-2019 final natality data. County and city preterm birth rates are from the NCHS 2018 final natality data. Preterm birth rates for bridged racial and ethnic categories were calculated from NCHS 2016-2018 final natality data. Preterm birth rates were calculated as the number of premature births divided by the number of live births with known gestational age multiplied by 100.

INFANT MORTALITY RATE

Infant mortality rates were calculated using the NCHS 2018 period linked infant birth and infant death data. Infant mortality rates were calculated as the number of infant deaths divided by the number of live births multiplied by 1,000. Infant mortality rate in the trend graph are from the NCHS 2008-2018 period linked infant birth and infant death files.

PRETERM BIRTH BY RACE/ETHNICITY OF THE MOTHER

Mother’s race and Hispanic ethnicity are reported separately on birth certificates. Rates for Hispanic women include all bridged racial categories (white, black, American Indian/Alaska Native and Asian/Pacific Islander). Rates for non-Hispanic women are classified according to race. The Asian/Pacific Islander category includes Native Hawaiian. To provide stable rates, racial and ethnic groups are shown on the report card if the group had 20 or more preterm births in each year from 2010-2018. To calculate preterm birth rates on the report card, three years of data were aggregated (2016-2018). Preterm birth rates for not stated/unknown race are not shown on the report card.

PRETERM BIRTH BY CITY

Report cards for states and jurisdictions, except District of Columbia, display the city with the greatest number of live births. Cities are not displayed for Delaware, Maine, Vermont, West Virginia and Wyoming due to limited availability of data. Grades were assigned based on the grading criteria described above. Change from previous year was calculated by comparing the 2018 city preterm birth rate to the 2017 rate.

PRETERM BIRTH DISPARITY MEASURES

The March of Dimes disparity ratio is based on Healthy People 2020 methodology and provides a measure of the differences, or disparities, in preterm birth rates across racial/ethnic groups within a geographic area. The disparity ratio compares the racial/ethnic group with the lowest preterm birth rate (comparison group) to the average of the preterm birth rate for all other groups.

To calculate the disparity ratio, the 2016-2018 preterm birth rates for all groups (excluding the comparison group) were averaged and divided by the 2016-2018 comparison group preterm birth rate. The comparison group is the racial/ethnic group with the lowest six-year aggregate preterm birth rate (2010-2015) among groups that had 20 or more preterm births in each year from 2010-2015. A disparity ratio was calculated for U.S. states, the District of Columbia, and the total U.S. A disparity ratio was not calculated for Maine, Vermont, and West Virginia. A lower disparity ratio is better, with a disparity ratio of 1 indicating no disparity.
PRETERM BIRTH DISPARITY MEASURES
Progress toward eliminating racial and ethnic disparities was evaluated by comparing the 2016-2018 disparity ratio to a baseline (2010-2012) disparity ratio. Change between time periods was assessed for statistical significance at the 0.05 level using the approach recommended by Healthy People 2020. If the disparity ratio significantly improved because the average preterm birth rate for all other groups got better, we displayed “Improved” on the report card. If the disparity ratio significantly worsened because the lowest group got better or the average of all other groups got worse, we displayed “Worsened” on the report card. If the disparity ratio did not significantly change, we displayed “No Improvement” on the report card.

The report card also provides the percent difference between the racial/ethnic group with the 2016-2018 highest preterm birth rate compared to the combined 2016-2018 preterm birth rate among women in all other racial/ethnic groups. This percent difference was calculated using only the racial/ethnic groups displayed on the state or jurisdiction-specific report card. This difference was calculated for each U.S. state with adequate numbers and the District of Columbia.

SELECTED SOCIAL DETERMINANTS OF HEALTH
March of Dimes recognizes the importance of certain risk factors that are associated with preterm birth. Three of these contributing factors are highlighted for each state. We reference target goals for these three measures from Healthy People 2030. These risk factors are poverty in women (age 15-44 years), lack of health insurance in women (15-44 years) and inadequacy of prenatal care.

A woman was considered uninsured if she was not covered by any type of health insurance. The uninsured percent is calculated among women ages 15-44 in 2018. Persons in poverty are defined as those who make less than 100% of the poverty threshold established by the US Census Bureau. The Federal poverty threshold for a family of three was $20,598 in 2019. Poverty is reported for women 15-44 years in 2017-2019.

Inadequacy of prenatal care is measured using the Adequacy of Prenatal Care Utilization Index, which classifies prenatal care received into 1 of 4 categories (inadequate, intermediate, adequate and adequate plus) by combining information about the timing of prenatal care, the number of visits and the infant’s gestational age. Inadequate prenatal care is defined as a woman who received less than 50% of her expected visits.

MATERNAL AND CHILD HEALTH INDICATORS
MEDIACID EXPANSION — A growing number of studies indicate that Medicaid expansion has reduced the rate of women of childbearing age who are uninsured, improved health outcomes and helped to reduce disparities, including lower rates of premature birth and low birthweight for Black infants in expansion states.

Medicaid Expansion is provided from the Kaiser Family Foundation as adopted or not adopted. Medicaid expansion has reduced the rates of uninsured. Increased access and utilization of health care are significantly associated with Medicaid expansion.

MEDIACID EXTENSION — Advocacy for Medicaid extension by the Equitable Maternal Health Coalition (EMHC) supports that adoption of the policy allows women to avoid disruption to healthcare during the postpartum period and by maintaining access to healthcare, improves both maternal and child health outcomes. Extending this coverage typically requires both state legislation and an appropriation in addition to a Section 1115 waiver in order to receive federal match. Medicaid extension status is provided by the American College of Obstetricians and Gynecologists as adopted and/or in development or not adopted and/or not developing. States who have had the following actions the policy extension introduced, enacted or is currently implemented to some degree, are categorized as having recent action.

PRETERM BIRTH COST — Updated average preterm birth cost (2016) for state and District of Columbia utilized the 2007 Institute of Medicine’s (IOM) study. Preterm Birth: Causes, Consequences and Prevention served as the foundation for updating costs to 2016 and for providing separate estimates for each state and the District of Columbia. Costs were updated adjusting for price changes over time and for variation in prices of services between states. Changes in the rate of preterm birth, the distribution of preterm birth by gestational age (GA), and the rate of infant mortality by GA at the national and state levels were also incorporated. This cost of preterm birth estimates are the most comprehensive national estimates to date, and provide the first profile of such costs by state for every state and the District of Columbia. Measure is provided as either above or below the calculated U.S. average.

MATERNAL MORTALITY REVIEW COMMITTEE — The committees can be made up of representatives from public health, nursing, maternal-fetal medicine, obstetrics and gynecology, midwifery, patient advocacy groups and community-based organizations. The majority of pregnancy-related deaths are preventable.

States that have an MMRC are better equipped to prevent pregnancy-related deaths by having a better understanding of what is causing them in their state or city. The measure is provided by the CDC at: https://www.cdc.gov/reproductivehealth/maternal_mortality/erase_mm/index.html. Maternal mortality rates are categorized as having or developing the committee, having the committee with funding from CDC, or not having or developing the committee.

PERINATAL QUALITY COLLABORATIVE — The PQC involves partnerships with families, key state agencies and organizations in order to identify and initiate programs or procedures that increase the quality of care in clinical settings. PQC’s work focus on collaborative learning among healthcare providers and the PQC. Data is provided by the CDC at: https://www.cdc.gov/reproductivehealth/maternalinfanthealth/pqc-states.html and the measure is reported as either having or developing the collaborative, having the collaborative with funding from CDC, or not having or developing the collaborative.

March of Dimes recommends state policy actions that are rooted in addressing disparities in maternal and infant health outcomes. For more detail visit Policy & Action. For details on data sources and calculations, see Technical Notes. To learn how we are working to reduce preterm birth visit www.marchofdimes.org.
CALCULATIONS
All natality calculations were conducted by the March of Dimes Perinatal Data Center. Calculations for the cost of premature birth were conducted by the University of Utah.

REFERENCES
1 National Center for Health Statistics, final natality data 2016-2019.
3 US Department of Health and Human Services, Healthy People 2030. Available at: https://health.gov/healthypeople
6 Kotelchuck M. An evaluation of the Kessner Adequacy of Prenatal Care Index and a Proposed Adequacy of Prenatal Care Utilization Index. Am J Public Health 1994;84(9):1414-1420.
15 Center for Disease Control (CDC), Perinatal Quality Collaboratives. Available at: https://www.cdc.gov/reproductivehealth/maternalinfanthealth/pqc.htm

MORE INFORMATION  MARCHEODIMES.ORG/REPORTCARD

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Rates of maternal death and morbidity continue to be unacceptably high in the U.S. Maternal morbidity, social determinants of health, availability of state level health insurance policy and the availability of surveillance and research data affect the health and survival of both mom and baby. While we currently do not have enough to grade states or report on all maternal health indicators, we have highlighted measures with the best available data.

**ALABAMA**

**PRETERM BIRTH GRADE**

F

**PRETERM BIRTH RATE**

12.5%

**INFANT MORTALITY RATE**

6.9

**PRETERM BIRTH RATE BY RACE AND ETHNICITY**

The March of Dimes disparity ratio measures and tracks progress towards the elimination of racial/ethnic disparities in preterm birth. It’s based on Healthy People 2020 methodology and compares the group with the lowest preterm birth rate to the average for all other groups. Progress is evaluated by comparing the current disparity ratio to a baseline disparity ratio. A lower disparity ratio is better, with a disparity ratio of 1 indicating no disparity.

In Alabama, the preterm birth rate among Black women is 51% higher than the rate among all other women.

**DISPARITY RATIO:**

1.28

**CHANGE FROM BASELINE:**

No Improvement

**PRETERM BIRTH RATE BY CITY**

<table>
<thead>
<tr>
<th>CITY</th>
<th>GRADE</th>
<th>PRETERM BIRTH RATE</th>
<th>CHANGE IN RATE FROM LAST YEAR</th>
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<tr>
<td>Birmingham</td>
<td>F</td>
<td>13.9%</td>
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ALABAMA MATERNAL AND INFANT HEALTH

SELECTED SOCIAL DETERMINANTS OF HEALTH

Many structural, systemic and environmental factors influence the health of moms and babies, especially for Black, American Indian and Alaska Native people. When looking at factors such as access to maternity care, financial stability and health insurance status, these disparities persist. Systemic racism and the wealth gap in the U.S. deepen many health inequities in our society. The onset of COVID-19 has further magnified preexisting health disparities. March of Dimes is collaborating with others to confront these drivers of health outcomes, while identifying solutions to achieve health equity for all.

To prevent maternal and infant deaths, we need to better understand the causes of severe maternal morbidity (SMM) and those most impacted by it, including racial and ethnic disparities. This starts by standardizing data collection and reporting for maternal and infant health across the U.S. These data will help us to examine factors contributing to SMM, preventable deaths and poor birth outcomes in order to develop evidence-based solutions. To this end, future Report Cards will assess overall rates and disparities of SMM, low-risk cesarean sections and measures of equity in maternal and infant health.

Additional details on these future measures can be found here.
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ALASKA

PRETERM BIRTH GRADE

C

PRETERM BIRTH RATE

9.7%

Infant mortality rates are an indication of overall health. Leading causes of infant death include birth defects, prematurity, low birth weight, maternal complications and sudden infant death syndrome.

INFANT MORTALITY

Rate per 1,000 live births

2008 2018

6.0 6.9 3.6 3.8 5.1 5.8 6.7 6.9 5.2 5.7 6.3

INFANT MORTALITY RATE

6.3

PRETERM BIRTH RATE BY RACE AND ETHNICITY

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In Alaska, the preterm birth rate among American Indian/Alaska Native women is 42% higher than the rate among all other women.

DISPARITY RATIO: 1.40

CHANGE FROM BASELINE: No Improvement

PRETERM BIRTH RATE BY CITY

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<th>CHANGE IN RATE FROM LAST YEAR</th>
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<tr>
<td>Anchorage</td>
<td>C</td>
<td>9.8%</td>
<td>Worsened</td>
</tr>
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</table>
ALASKA MATERNAL AND INFANT HEALTH

SELECTED SOCIAL DETERMINANTS OF HEALTH

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![Bar charts showing uninsured, inadequate prenatal care, and poverty among women in Alaska compared to the United States.]

Legend

- ▶ State has or is developing the indicated organization/policy
- ✭ State has the indicated organization and is CDC funded
- ✗ State does not have or is not developing the indicated organization/policy
- ↑ State is above estimated U.S. cost
- ↓ State is below estimated U.S. cost

MEDICAID EXPANSION
States who have adopted this policy allow women greater access to preventative care during pregnancy.

MEDICAID EXTENSION
State has recent action to extend coverage for women beyond 60 days postpartum.

AVERAGE PRETERM BIRTH COST
Estimated societal cost includes care for babies, delivery costs, early intervention services, special education and lost productivity.

MATERNAL MORTALITY REVIEW COMMITTEE
These committees are essential to understanding and addressing the causes of maternal death.

PERINATAL QUALITY COLLABORATIVE
These teams work to identify and improve quality care issues in maternal and infant health care.

To prevent maternal and infant deaths, we need to better understand the causes of severe maternal morbidity (SMM) and those most impacted by it, including racial and ethnic disparities. This starts by standardizing data collection and reporting for maternal and infant health across the U.S. These data will help us to examine factors contributing to SMM, preventable deaths and poor birth outcomes in order to develop evidence-based solutions. To this end, future Report Cards will assess overall rates and disparities of SMM, low-risk cesarean sections and measures of equity in maternal and infant health.

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**ARIZONA**

**PRETERM BIRTH GRADE**

C+

**PRETERM BIRTH RATE**

9.4%

**INFANT MORTALITY**

Infant mortality rates are an indication of overall health. Leading causes of infant death include birth defects, prematurity, low birth weight, maternal complications and sudden infant death syndrome.

**INFANT MORTALITY RATE**

5.7

**PRETERM BIRTH RATE BY RACE AND ETHNICITY**

The March of Dimes disparity ratio measures and tracks progress towards the elimination of racial/ethnic disparities in preterm birth. It’s based on Healthy People 2020 methodology and compares the group with the lowest preterm birth rate to the average for all other groups. Progress is evaluated by comparing the current disparity ratio to a baseline disparity ratio. A lower disparity ratio is better, with a disparity ratio of 1 indicating no disparity.

<table>
<thead>
<tr>
<th>RACE/ETHNICITY</th>
<th>Percentage of live births in 2016-2018 (average) born preterm</th>
</tr>
</thead>
<tbody>
<tr>
<td>Asian/Pacific Islander</td>
<td>9.1</td>
</tr>
<tr>
<td>American Indian/Alaska Native</td>
<td>10.5</td>
</tr>
<tr>
<td>Black</td>
<td>12.5</td>
</tr>
<tr>
<td>White</td>
<td>8.6</td>
</tr>
<tr>
<td>Hispanic</td>
<td>9.4</td>
</tr>
</tbody>
</table>

**DISPARITY RATIO:**

1.21

**CHANGE FROM BASELINE:**

No Improvement

In Arizona, the preterm birth rate among Black women is 37% higher than the rate among all other women.

**PRETERM BIRTH RATE BY CITY**

<table>
<thead>
<tr>
<th>CITY</th>
<th>GRADE</th>
<th>PRETERM BIRTH RATE</th>
<th>CHANGE IN RATE FROM LAST YEAR</th>
</tr>
</thead>
<tbody>
<tr>
<td>Phoenix</td>
<td>C</td>
<td>9.9%</td>
<td>Better</td>
</tr>
</tbody>
</table>

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ARIZONA MATERNAL AND INFANT HEALTH

SELECTED SOCIAL DETERMINANTS OF HEALTH

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<table>
<thead>
<tr>
<th>State</th>
<th>Uninsured among women (15-44)</th>
<th>Inadequate prenatal care</th>
<th>Poverty among women (15-44)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Arizona</td>
<td>7.9%</td>
<td>14.6%</td>
<td>14.6%</td>
</tr>
<tr>
<td>United States</td>
<td>11.9%</td>
<td>19.5%</td>
<td>19.6%</td>
</tr>
<tr>
<td>HP 2030</td>
<td>14.6%</td>
<td>14.9%</td>
<td>16.2%</td>
</tr>
<tr>
<td>Arizona</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

State has or is developing the indicated organization/policy
State has the indicated organization and is CDC funded
State does not have or is not developing the indicated organization/policy
State is above estimated U.S. cost
State is below estimated U.S. cost

Legend

MEDICAID EXPANSION
States who have adopted this policy allow women greater access to preventative care during pregnancy.

MEDICAID EXTENSION
State has recent action to extend coverage for women beyond 60 days postpartum.

MATERNAL MORTALITY REVIEW COMMITTEE
These committees are essential to understanding and addressing the causes of maternal death.

PERINATAL QUALITY COLLABORATIVE
These teams work to identify and improve quality care issues in maternal and infant health care.

AVERAGE PRETERM BIRTH COST
Estimated societal cost includes care for babies, delivery costs, early intervention services, special education and lost productivity.

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MORE INFORMATION MARCHEOFDIMES.ORG/REPORTCARD

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ARKANSAS

PRETERM BIRTH GRADE
F

PRETERM BIRTH RATE
11.9%

INFANT MORTALITY
Infant mortality rates are an indication of overall health. Leading causes of infant death include birth defects, prematurity, low birth weight, maternal complications and sudden infant death syndrome.

INFANT MORTALITY RATE
7.5

PRETERM BIRTH RATE BY RACE AND ETHNICITY
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<table>
<thead>
<tr>
<th>RACE/ETHNICITY</th>
<th>DISPARITY RATIO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Asian/Pacific Islander</td>
<td>10.2</td>
</tr>
<tr>
<td>American Indian/Alaska Native</td>
<td>10.8</td>
</tr>
<tr>
<td>Black</td>
<td>15.3</td>
</tr>
<tr>
<td>White</td>
<td>10.4</td>
</tr>
<tr>
<td>Hispanic</td>
<td>9.4</td>
</tr>
</tbody>
</table>

In Arkansas, the preterm birth rate among Black women is 49% higher than the rate among all other women.

DISPARITY RATIO: 1.25
CHANGE FROM BASELINE: No Improvement

PRETERM BIRTH RATE BY CITY

<table>
<thead>
<tr>
<th>CITY</th>
<th>GRADE</th>
<th>PRETERM BIRTH RATE</th>
<th>CHANGE IN RATE FROM LAST YEAR</th>
</tr>
</thead>
<tbody>
<tr>
<td>Little Rock</td>
<td>F</td>
<td>12.7%</td>
<td>Worsened</td>
</tr>
</tbody>
</table>

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CALIFORNIA

PRETERM BIRTH GRADE

B-

PRETERM BIRTH RATE

9.0%

INFANT MORTALITY

Infant mortality rates are an indication of overall health. Leading causes of infant death include birth defects, prematurity, low birth weight, maternal complications and sudden infant death syndrome.

INFANT MORTALITY RATE

4.2

PRETERM BIRTH RATE BY RACE AND ETHNICITY

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<td>8.1</td>
</tr>
<tr>
<td>American Indian/Alaska Native</td>
<td>11.3</td>
</tr>
<tr>
<td>Black</td>
<td>12.0</td>
</tr>
<tr>
<td>White</td>
<td>7.7</td>
</tr>
<tr>
<td>Hispanic</td>
<td>8.9</td>
</tr>
</tbody>
</table>

In California, the preterm birth rate among Black women is 43% higher than the rate among all other women.

DISPARITY RATIO: 1.31

CHANGE FROM BASELINE: Worsened

PRETERM BIRTH RATE BY CITY

<table>
<thead>
<tr>
<th>CITY</th>
<th>GRADE</th>
<th>PRETERM BIRTH RATE</th>
<th>CHANGE IN RATE FROM LAST YEAR</th>
</tr>
</thead>
<tbody>
<tr>
<td>Los Angeles</td>
<td>C+</td>
<td>9.5%</td>
<td>Better</td>
</tr>
</tbody>
</table>

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CALIFORNIA MATERNAL AND INFANT HEALTH

SELECTED SOCIAL DETERMINANTS OF HEALTH

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MEDICAID EXPANSION
States who have adopted this policy allow women greater access to preventative care during pregnancy.

MEDICAID EXTENSION
State has recent action to extend coverage for women beyond 60 days postpartum.

AVERAGE PRETERM BIRTH COST
Estimated societal cost includes care for babies, delivery costs, early intervention services, special education and lost productivity.

PERINATAL QUALITY COLLABORATIVE
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**COLORADO**

**PRETERM BIRTH GRADE**

C+

**PRETERM BIRTH RATE**

9.6%

**INFANT MORTALITY**

Infant mortality rates are an indication of overall health. Leading causes of infant death include birth defects, prematurity, low birth weight, maternal complications and sudden infant death syndrome.

**INFANT MORTALITY RATE**

4.8

**PRETERM BIRTH RATE BY RACE AND ETHNICITY**

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<table>
<thead>
<tr>
<th>RACE/ETHNICITY</th>
<th>Percentage of live births in 2016-2018 (average) born preterm</th>
</tr>
</thead>
<tbody>
<tr>
<td>Asian/Pacific Islander</td>
<td>9.1</td>
</tr>
<tr>
<td>American Indian/Alaska Native</td>
<td>11.2</td>
</tr>
<tr>
<td>Black</td>
<td>11.2</td>
</tr>
<tr>
<td>White</td>
<td>8.4</td>
</tr>
<tr>
<td>Hispanic</td>
<td>9.4</td>
</tr>
</tbody>
</table>

In Colorado, the preterm birth rate among American Indian/Alaska Native women is 26% higher than the rate among all other women.

**DISPARITY RATIO:**

1.22

**CHANGE FROM BASELINE:**

No Improvement

**PRETERM BIRTH RATE BY CITY**

<table>
<thead>
<tr>
<th>CITY</th>
<th>GRADE</th>
<th>PRETERM BIRTH RATE</th>
<th>CHANGE IN RATE FROM LAST YEAR</th>
</tr>
</thead>
<tbody>
<tr>
<td>Denver</td>
<td>B</td>
<td>8.9%</td>
<td>Worsened</td>
</tr>
</tbody>
</table>

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COLORADO MATERNAL AND INFANT HEALTH

**SELECTED SOCIAL DETERMINANTS OF HEALTH**

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<table>
<thead>
<tr>
<th>Indicator</th>
<th>Colorado</th>
<th>United States</th>
<th>HP 2030</th>
</tr>
</thead>
<tbody>
<tr>
<td>Uninsured among women (15-44)</td>
<td>7.9</td>
<td>11.9</td>
<td>8.9</td>
</tr>
<tr>
<td>Inadequate prenatal care</td>
<td>14.9</td>
<td>14.7</td>
<td>19.5</td>
</tr>
<tr>
<td>Poverty among women (15-44)</td>
<td>8.0</td>
<td>14.7</td>
<td>10.0</td>
</tr>
</tbody>
</table>

**LEGEND**

- ✔️ State has or is developing the indicated organization/policy
- ✖️ State does not have or is not developing the indicated organization/policy
- ✯ State has the indicated organization and is CDC funded
- ↑ State is above estimated U.S. cost
- ↓ State is below estimated U.S. cost

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2020 MARCH OF DIMES REPORT CARD

CONNETICUT

PRETERM BIRTH GRADE

C+

PRETERM BIRTH RATE

9.4%

INFANT MORTALITY

Infant mortality rates are an indication of overall health. Leading causes of infant death include birth defects, prematurity, low birth weight, maternal complications and sudden infant death syndrome.

INFANT MORTALITY RATE

4.2

PRETERM BIRTH RATE BY RACE AND ETHNICITY

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In Connecticut, the preterm birth rate among Black women is 43% higher than the rate among all other women.

DISPARITY RATIO:

1.20

CHANGE FROM BASELINE:

No Improvement

PRETERM BIRTH RATE BY CITY

<table>
<thead>
<tr>
<th>CITY</th>
<th>GRADE</th>
<th>PRETERM BIRTH RATE</th>
<th>CHANGE IN RATE FROM LAST YEAR</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bridgeport</td>
<td>D+</td>
<td>10.6%</td>
<td>Worsened</td>
</tr>
</tbody>
</table>

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## DELAWARE

### PRETERM BIRTH GRADE

**D+**

### PRETERM BIRTH RATE

**10.7%**

### INFANT MORTALITY RATE

**5.9**

**Rate per 1,000 live births**

<table>
<thead>
<tr>
<th>Year</th>
<th>Rate per 1,000 live births</th>
</tr>
</thead>
<tbody>
<tr>
<td>2008</td>
<td>8.4, 8.0, 7.5, 8.9, 7.6, 7.1, 6.3, 5.9</td>
</tr>
<tr>
<td>2018</td>
<td>9.9, 10.1, 10.2, 9.6, 10.7</td>
</tr>
</tbody>
</table>

### PRETERM BIRTH RATE BY RACE AND ETHNICITY

- **Asian/Pacific Islander**: 7.5
- **Black**: 13.1
- **White**: 8.8
- **Hispanic**: 9.0

**Disparity Ratio**: 1.38

**Change from Baseline**: No Improvement

In Delaware, the preterm birth rate among Black women is 51% higher than the rate among all other women.

---

**MORE INFORMATION**  [MARCHOFDIMES.ORG/REPORTCARD](http://MARCHOFDIMES.ORG/REPORTCARD)

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**DISTRICT OF COLUMBIA**

**PRETERM BIRTH GRADE**

D+

**PRETERM BIRTH RATE**

10.4%

**INFANT MORTALITY**

Infant mortality rates are an indication of overall health. Leading causes of infant death include birth defects, prematurity, low birth weight, maternal complications and sudden infant death syndrome.

**INFANT MORTALITY RATE**

7.4

**PRETERM BIRTH RATE BY RACE AND ETHNICITY**

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- **Asian/Pacific Islander**: 7.2
- **Black**: 13.4
- **White**: 7.0
- **Hispanic**: 9.6

**DISPARITY RATIO**: 1.39

**CHANGE FROM BASELINE**: No Improvement

In District of Columbia, the preterm birth rate among Black women is 74% higher than the rate among all other women.

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SELECTED SOCIAL DETERMINANTS OF HEALTH

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MEDICAID EXPANSION
States who have adopted this policy allow women greater access to preventative care during pregnancy.

MEDICAID EXTENSION
State has recent action to extend coverage for women beyond 60 days postpartum.

MATERNAL MORTALITY REVIEW COMMITTEE
These committees are essential to understanding and addressing the causes of maternal death.

PERINATAL QUALITY COLLABORATIVE
These teams work to identify and improve quality care issues in maternal and infant health care.

AVERAGE PRETERM BIRTH COST
Estimated societal cost includes care for babies, delivery costs, early intervention services, special education and lost productivity.

Legend
✓ State has or is developing the indicated organization/policy
❄ State has the indicated organization and is CDC funded
✗ State does not have or is not developing the indicated organization/policy
⬆️ State is above estimated U.S. cost
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**FLORIDA**

**PRETERM BIRTH GRADE**

D+

**PRETERM BIRTH RATE**

10.6%

**INFANT MORTALITY**

Infant mortality rates are an indication of overall health. Leading causes of infant death include birth defects, prematurity, low birth weight, maternal complications and sudden infant death syndrome.

**INFANT MORTALITY RATE**

6.0

**PRETERM BIRTH RATE BY RACE AND ETHNICITY**

The March of Dimes disparity ratio measures and tracks progress towards the elimination of racial/ethnic disparities in preterm birth. It’s based on Healthy People 2020 methodology and compares the group with the lowest preterm birth rate to the average for all other groups. Progress is evaluated by comparing the current disparity ratio to a baseline disparity ratio. A lower disparity ratio is better, with a disparity ratio of 1 indicating no disparity.

In Florida, the preterm birth rate among Black women is 53% higher than the rate among all other women.

**DISPARITY RATIO:**

1.17

**CHANGE FROM BASELINE:**

No Improvement

**PRETERM BIRTH RATE BY CITY**

<table>
<thead>
<tr>
<th>CITY</th>
<th>GRADE</th>
<th>PRETERM BIRTH RATE</th>
<th>CHANGE IN RATE FROM LAST YEAR</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jacksonville</td>
<td>D-</td>
<td>11.4%</td>
<td>Better</td>
</tr>
</tbody>
</table>

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### GEORGIA

#### PRETERM BIRTH GRADE

**F**

**PRETERM BIRTH RATE**

11.7%

#### INFANT MORTALITY

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**INFANT MORTALITY RATE**

7.1

#### PRETERM BIRTH RATE BY RACE AND ETHNICITY

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**RACE/ETHNICITY**

- **Asian/Pacific Islander**: 8.7
- **Black**: 14.2
- **White**: 10.0
- **Hispanic**: 9.7

**DISPARITY RATIO**: 1.30

**CHANGE FROM BASELINE**: No Improvement

In Georgia, the preterm birth rate among Black women is 45% higher than the rate among all other women.

#### PRETERM BIRTH RATE BY CITY

<table>
<thead>
<tr>
<th>CITY</th>
<th>GRADE</th>
<th>PRETERM BIRTH RATE</th>
<th>CHANGE IN RATE FROM LAST YEAR</th>
</tr>
</thead>
<tbody>
<tr>
<td>Atlanta</td>
<td>D-</td>
<td>11.4%</td>
<td>Better</td>
</tr>
</tbody>
</table>

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Scan for details
SELECTED SOCIAL DETERMINANTS OF HEALTH

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<table>
<thead>
<tr>
<th></th>
<th>Georgia</th>
<th>United States</th>
<th>CDC Funded</th>
</tr>
</thead>
<tbody>
<tr>
<td>Uninsured among women (15-44)</td>
<td>7.9</td>
<td>11.9</td>
<td>19.4</td>
</tr>
<tr>
<td>Inadequate prenatal care</td>
<td>8.0</td>
<td>14.9</td>
<td>17.8</td>
</tr>
<tr>
<td>Poverty among women (15-44)</td>
<td>8.0</td>
<td>14.7</td>
<td>15.2</td>
</tr>
</tbody>
</table>

**MEDICAID EXPANSION**
States who have adopted this policy allow women greater access to preventative care during pregnancy.

**MEDICAID EXTENSION**
State has recent action to extend coverage for women beyond 60 days postpartum.

**AVERAGE PRETERM BIRTH COST**
Estimated societal cost includes care for babies, delivery costs, early intervention services, special education and lost productivity.

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HAWAII

PRETERM BIRTH GRADE
D+

PRETERM BIRTH RATE
10.6%

INFANT MORTALITY
Infant mortality rates are an indication of overall health. Leading causes of infant death include birth defects, prematurity, low birth weight, maternal complications and sudden infant death syndrome.

INFANT MORTALITY RATE
6.8

PRETERM BIRTH RATE BY RACE AND ETHNICITY
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In Hawaii, the preterm birth rate among Black women is 24% higher than the rate among all other women.

DISPARITY RATIO:
1.44

CHANGE FROM BASELINE:
No Improvement

PRETERM BIRTH RATE BY CITY

<table>
<thead>
<tr>
<th>CITY</th>
<th>GRADE</th>
<th>PRETERM BIRTH RATE</th>
<th>CHANGE IN RATE FROM LAST YEAR</th>
</tr>
</thead>
<tbody>
<tr>
<td>Honolulu, City and County</td>
<td>D+</td>
<td>10.5%</td>
<td>Better</td>
</tr>
</tbody>
</table>

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<table>
<thead>
<tr>
<th>State</th>
<th>Uninsured among women (15-44)</th>
<th>Inadequate prenatal care</th>
<th>Poverty among women (15-44)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hawaii</td>
<td>7.9%</td>
<td>19.5%</td>
<td>10.0%</td>
</tr>
<tr>
<td>HP 2030</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>United States</td>
<td>4.8%</td>
<td>14.9%</td>
<td>14.7%</td>
</tr>
<tr>
<td>Hawaii</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
</tr>
</tbody>
</table>

MEDICAID EXPANSION

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MEDICAID EXTENSION

State has recent action to extend coverage for women beyond 60 days postpartum.

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AVERAGE PRETERM BIRTH COST

Estimated societal cost includes care for babies, delivery costs, early intervention services, special education and lost productivity.

Legend

✔ State has or is developing the indicated organization/policy

❄ State has the indicated organization and is CDC funded

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IDAHO

PRETERM BIRTH GRADE

B

PRETERM BIRTH RATE

8.8%

INFANT MORTALITY

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INFANT MORTALITY RATE

5.1

PRETERM BIRTH RATE BY RACE AND ETHNICITY

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In Idaho, the preterm birth rate among American Indian/Alaska Native women is 25% higher than the rate among all other women.

DISPARITY RATIO:

1.19

CHANGE FROM BASELINE:

No Improvement

PRETERM BIRTH RATE BY CITY

<table>
<thead>
<tr>
<th>CITY</th>
<th>GRADE</th>
<th>PRETERM BIRTH RATE</th>
<th>CHANGE IN RATE FROM LAST YEAR</th>
</tr>
</thead>
<tbody>
<tr>
<td>Boise City</td>
<td>D+</td>
<td>10.5%</td>
<td>Worsened</td>
</tr>
</tbody>
</table>

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IDAHO MATERNAL AND INFANT HEALTH

SELECTED SOCIAL DETERMINANTS OF HEALTH

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ILLINOIS

PRETERM BIRTH GRADE

**D+**

PRETERM BIRTH RATE

**10.7%**

INFANT MORTALITY

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INFANT MORTALITY RATE

**6.6**

PRETERM BIRTH RATE BY RACE AND ETHNICITY

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<table>
<thead>
<tr>
<th>RACE/ETHNICITY</th>
<th>Percentage of live births in 2016-2018 (average) born preterm</th>
</tr>
</thead>
<tbody>
<tr>
<td>Asian/Pacific Islander</td>
<td>9.4</td>
</tr>
<tr>
<td>Black</td>
<td>14.5</td>
</tr>
<tr>
<td>White</td>
<td>9.5</td>
</tr>
<tr>
<td>Hispanic</td>
<td>9.9</td>
</tr>
</tbody>
</table>

In Illinois, the preterm birth rate among Black women is 51% higher than the rate among all other women.

DISPARITY RATIO: **1.12**

CHANGE FROM BASELINE: **Improved**

PRETERM BIRTH RATE BY CITY

<table>
<thead>
<tr>
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<th>PRETERM BIRTH RATE</th>
<th>CHANGE IN RATE FROM LAST YEAR</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chicago</td>
<td>D</td>
<td>11.1%</td>
<td>Worsened</td>
</tr>
</tbody>
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ILLINOIS MATERNAL AND INFANT HEALTH

SELECTED SOCIAL DETERMINANTS OF HEALTH

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AVERAGE PRETERM BIRTH COST

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Legend

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INDIANA

PRETERM BIRTH GRADE
C-

PRETERM BIRTH RATE
10.2%

INFANT MORTALITY
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INFANT MORTALITY RATE
6.7

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<table>
<thead>
<tr>
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<th>GRADE</th>
<th>PRETERM BIRTH RATE</th>
<th>CHANGE IN RATE FROM LAST YEAR</th>
</tr>
</thead>
<tbody>
<tr>
<td>Indianapolis</td>
<td>D-</td>
<td>11.2%</td>
<td>Better</td>
</tr>
</tbody>
</table>

In Indiana, the preterm birth rate among Black women is 44% higher than the rate among all other women.

DISPARITY RATIO: 1.27
CHANGE FROM BASELINE: No Improvement

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**IOWA**

**PRETERM BIRTH GRADE**

C+

**PRETERM BIRTH RATE**

9.5%

**INFANT MORTALITY**

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**INFANT MORTALITY RATE**

5.0

**PRETERM BIRTH RATE BY RACE AND ETHNICITY**

The March of Dimes disparity ratio measures and tracks progress towards the elimination of racial/ethnic disparities in preterm birth. It’s based on Healthy People 2020 methodology and compares the group with the lowest preterm birth rate to the average for all other groups. Progress is evaluated by comparing the current disparity ratio to a baseline disparity ratio. A lower disparity ratio is better, with a disparity ratio of 1 indicating no disparity.

<table>
<thead>
<tr>
<th>RACE/ETHNICITY</th>
<th>Percentage of live births in 2016-2018 (average) born preterm</th>
</tr>
</thead>
<tbody>
<tr>
<td>Asian/Pacific Islander</td>
<td>9.7</td>
</tr>
<tr>
<td>Black</td>
<td>12.2</td>
</tr>
<tr>
<td>White</td>
<td>9.1</td>
</tr>
<tr>
<td>Hispanic</td>
<td>9.9</td>
</tr>
</tbody>
</table>

**DISPARITY RATIO:**

1.05

**CHANGE FROM BASELINE:**

No Improvement

*In Iowa, the preterm birth rate among Black women is 33% higher than the rate among all other women.*

**PRETERM BIRTH RATE BY CITY**

<table>
<thead>
<tr>
<th>CITY</th>
<th>GRADE</th>
<th>PRETERM BIRTH RATE</th>
<th>CHANGE IN RATE FROM LAST YEAR</th>
</tr>
</thead>
<tbody>
<tr>
<td>Des Moines</td>
<td>F</td>
<td>11.5%</td>
<td>Worsened</td>
</tr>
</tbody>
</table>

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**SELECTED SOCIAL DETERMINANTS OF HEALTH**

Many structural, systemic and environmental factors influence the health of moms and babies, especially for Black, American Indian and Alaska Native people. When looking at factors such as access to maternity care, financial stability and health insurance status, these disparities persist. Systemic racism and the wealth gap in the U.S. deepen many health inequities in our society. The onset of COVID-19 has further magnified preexisting health disparities. March of Dimes is collaborating with others to confront these drivers of health outcomes, while identifying solutions to achieve health equity for all.

### MEDICAID EXPANSION
States who have adopted this policy allow women greater access to preventative care during pregnancy.

### MEDICAID EXTENSION
State has recent action to extend coverage for women beyond 60 days postpartum.

### AVERAGE PRETERM BIRTH COST
Estimated societal cost includes care for babies, delivery costs, early intervention services, special education and lost productivity.

### MATERNAL MORTALITY REVIEW COMMITTEE
These committees are essential to understanding and addressing the causes of maternal death.

### PERINATAL QUALITY COLLABORATIVE
These teams work to identify and improve quality care issues in maternal and infant health care.

To prevent maternal and infant deaths, we need to better understand the causes of severe maternal morbidity (SMM) and those most impacted by it, including racial and ethnic disparities. This starts by standardizing data collection and reporting for maternal and infant health across the U.S. These data will help us to examine factors contributing to SMM, preventable deaths and poor birth outcomes in order to develop evidence-based solutions. To this end, future Report Cards will assess overall rates and disparities of SMM, low-risk cesarean sections and measures of equity in maternal and infant health.

Additional details on these future measures can be found [here](#).

---

**MORE INFORMATION**
MARCHOFDIMES.ORG/REPORTCARD

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Rates of maternal death and morbidity continue to be unacceptably high in the U.S. Maternal morbidity, social determinants of health, availability of state level health insurance policy and the availability of surveillance and research data affect the health and survival of both mom and baby. While we currently do not have enough to grade states or report on all maternal health indicators, we have highlighted measures with the best available data.

**KANSAS**

**PRETERM BIRTH GRADE**

C-

**PRETERM BIRTH RATE**

10.1%

**INFANT MORTALITY**

Infant mortality rates are an indication of overall health. Leading causes of infant death include birth defects, prematurity, low birth weight, maternal complications and sudden infant death syndrome.

**INFANT MORTALITY RATE**

6.4%

**PRETERM BIRTH RATE BY RACE AND ETHNICITY**

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- **Asian/Pacific Islander**: 8.7
- **American Indian/Alaska Native**: 10.3
- **Black**: 13.6
- **White**: 9.1
- **Hispanic**: 8.9

In Kansas, the preterm birth rate among Black women is 51% higher than the rate among all other women.

**DISPARITY RATIO**: 1.17

**CHANGE FROM BASELINE**: No Improvement

**PRETERM BIRTH RATE BY CITY**

<table>
<thead>
<tr>
<th>CITY</th>
<th>GRADE</th>
<th>PRETERM BIRTH RATE</th>
<th>CHANGE IN RATE FROM LAST YEAR</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wichita</td>
<td>C-</td>
<td>10.1%</td>
<td>Better</td>
</tr>
</tbody>
</table>

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---

**MEDICAID EXPANSION**
States who have adopted this policy allow women greater access to preventative care during pregnancy.

**MEDICAID EXTENSION**
State has recent action to extend coverage for women beyond 60 days postpartum.

**AVERAGE PRETERM BIRTH COST**
Estimated societal cost includes care for babies, delivery costs, early intervention services, special education and lost productivity.

**PERINATAL QUALITY COLLABORATIVE**
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**MATERNAL MORTALITY REVIEW COMMITTEE**
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KENTUCKY

PRETERM BIRTH GRADE
D-

PRETERM BIRTH RATE
11.3%

INFANT MORTALITY
Infant mortality rates are an indication of overall health. Leading causes of infant death include birth defects, prematurity, low birth weight, maternal complications and sudden infant death syndrome.

INFANT MORTALITY RATE
6.1

PRETERM BIRTH RATE BY RACE AND ETHNICITY
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In Kentucky, the preterm birth rate among Black women is 30% higher than the rate among all other women.

DISPARITY RATIO:
1.28
CHANGE FROM BASELINE:
No Improvement

PRETERM BIRTH RATE BY CITY

<table>
<thead>
<tr>
<th>CITY</th>
<th>GRADE</th>
<th>PRETERM BIRTH RATE</th>
<th>CHANGE IN RATE FROM LAST YEAR</th>
</tr>
</thead>
<tbody>
<tr>
<td>Louisville</td>
<td>D</td>
<td>11.0%</td>
<td>Worsened</td>
</tr>
</tbody>
</table>
KENTUCKY MATERNAL AND INFANT HEALTH

SELECTED SOCIAL DETERMINANTS OF HEALTH

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<table>
<thead>
<tr>
<th>State has or is developing the indicated organization/policy</th>
<th>State has the indicated organization and is CDC funded</th>
<th>State does not have or is not developing the indicated organization/policy</th>
<th>State is above estimated U.S. cost</th>
<th>State is below estimated U.S. cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kentucky</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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**MEDICAID EXPANSION**

States who have adopted this policy allow women greater access to preventative care during pregnancy.

**MEDICAID EXTENSION**

State has recent action to extend coverage for women beyond 60 days postpartum.

**AVERAGE PRETERM BIRTH COST**

Estimated societal cost includes care for babies, delivery costs, early intervention services, special education and lost productivity.

Legend

- ✓ State has or is developing the indicated organization/policy
- ✭ State has the indicated organization and is CDC funded
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- ↓ State is below estimated U.S. cost

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LOUISIANA

PRETERM BIRTH GRADE

F

PRETERM BIRTH RATE

13.1%

INFANT MORTALITY

Infant mortality rates are an indication of overall health. Leading causes of infant death include birth defects, prematurity, low birth weight, maternal complications and sudden infant death syndrome.

INFANT MORTALITY RATE

7.7

PRETERM BIRTH RATE BY RACE AND ETHNICITY

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In Louisiana, the preterm birth rate among Black women is 55% higher than the rate among all other women.

DISPARITY RATIO:

1.32

CHANGE FROM BASELINE:

No Improvement

PRETERM BIRTH RATE BY CITY

<table>
<thead>
<tr>
<th>CITY</th>
<th>GRADE</th>
<th>PRETERM BIRTH RATE</th>
<th>CHANGE IN RATE FROM LAST YEAR</th>
</tr>
</thead>
<tbody>
<tr>
<td>Baton Rouge</td>
<td>F</td>
<td>13.2%</td>
<td>Worsened</td>
</tr>
</tbody>
</table>

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LOUISIANA MATERNAL AND INFANT HEALTH

SELECTED SOCIAL DETERMINANTS OF HEALTH

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- **Uninsured among women (15-44)**
  - Louisiana: 7.9%
  - United States: 11.9%
  - CDC: 9.8%

- **Inadequate prenatal care**
  - Louisiana: 19.5%
  - United States: 14.9%
  - CDC: 15.2%

- **Poverty among women (15-44)**
  - Louisiana: 8.0%
  - United States: 14.7%
  - CDC: 24.5%

Legend:
- ✔️ State has or is developing the indicated organization/policy
- ✗ State does not have or is not developing the indicated organization/policy
- ⬆️ State is above estimated U.S. cost
- ⬇️ State is below estimated U.S. cost

MEDICAID EXPANSION
States who have adopted this policy allow women greater access to preventative care during pregnancy.

MEDICAID EXTENSION
State has recent action to extend coverage for women beyond 60 days postpartum.

AVERAGE PRETERM BIRTH COST
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**MAINE**

**PRETERM BIRTH GRADE**

**B-**

**PRETERM BIRTH RATE**

9.0%

**INFANT MORTALITY RATE**

5.5

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<table>
<thead>
<tr>
<th>Race/Ethnicity</th>
<th>Percentage of live births born preterm (2016-2018 average)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Black</td>
<td>9.1</td>
</tr>
<tr>
<td>White</td>
<td>8.6</td>
</tr>
</tbody>
</table>

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MAINE MATERNAL AND INFANT HEALTH

SELECTED SOCIAL DETERMINANTS OF HEALTH

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<table>
<thead>
<tr>
<th>Category</th>
<th>Maine</th>
<th>United States</th>
<th>HP 2030</th>
</tr>
</thead>
<tbody>
<tr>
<td>Uninsured among women (15-44)</td>
<td>7.9</td>
<td>11.9</td>
<td>9.9</td>
</tr>
<tr>
<td>Inadequate prenatal care</td>
<td></td>
<td>14.9</td>
<td>9.9</td>
</tr>
<tr>
<td>Poverty among women (15-44)</td>
<td>8.0</td>
<td>14.7</td>
<td>18.5</td>
</tr>
</tbody>
</table>

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AVG. PRETERM BIRTH COST
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Legend
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**MARYLAND**

**PRETERM BIRTH GRADE**

C-

**PRETERM BIRTH RATE**

10.3%

**INFANT MORTALITY RATE**

6.0

**PRETERM BIRTH RATE BY RACE AND ETHNICITY**

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In Maryland, the preterm birth rate among Black women is 44% higher than the rate among all other women.

**DISPARITY RATIO:**

1.18

**CHANGE FROM BASELINE:**

No Improvement

**PRETERM BIRTH RATE BY CITY**

<table>
<thead>
<tr>
<th>CITY</th>
<th>GRADE</th>
<th>PRETERM BIRTH RATE</th>
<th>CHANGE IN RATE FROM LAST YEAR</th>
</tr>
</thead>
<tbody>
<tr>
<td>Baltimore</td>
<td>F</td>
<td>12.3%</td>
<td>Better</td>
</tr>
</tbody>
</table>
MARYLAND MATERNAL AND INFANT HEALTH

SELECTED SOCIAL DETERMINANTS OF HEALTH

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Legend

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To learn how we are working to reduce preterm birth visit www.marchofdimes.org.
2020 MARCH OF DIMES REPORT CARD

MASSACHUSETTS

PRETERM BIRTH GRADE

B-

PRETERM BIRTH RATE

9.0%

INFANT MORTALITY

Infant mortality rates are an indication of overall health. Leading causes of infant death include birth defects, prematurity, low birth weight, maternal complications and sudden infant death syndrome.

INFANT MORTALITY RATE

4.2

PRETERM BIRTH RATE BY RACE AND ETHNICITY

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In Massachusetts, the preterm birth rate among Black women is 31% higher than the rate among all other women.

DISPARITY RATIO: 1.23

CHANGE FROM BASELINE: Worsened

PRETERM BIRTH RATE BY CITY

<table>
<thead>
<tr>
<th>CITY</th>
<th>GRADE</th>
<th>PRETERM BIRTH RATE</th>
<th>CHANGE IN RATE FROM LAST YEAR</th>
</tr>
</thead>
<tbody>
<tr>
<td>Boston</td>
<td>C-</td>
<td>10.1%</td>
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| State has or is developing the indicated organization/policy | 7.9 |
| State has the indicated organization and is CDC funded | 11.9 |
| State does not have or is not developing the indicated organization/policy | 3.1 |
| State is above estimated U.S. cost | 14.9 |
| State is below estimated U.S. cost | 10.9 |
| Estimated societal cost includes care for babies, delivery costs, early intervention services, special education and lost productivity. | 14.7 |
| State has recent action to extend coverage for women beyond 60 days postpartum. | 8.0 |
| States who have adopted this policy allow women greater access to preventative care during pregnancy. | 13.2 |

MEDICAID EXPANSION

States who have adopted this policy allow women greater access to preventative care during pregnancy.

PERINATAL QUALITY COLLABORATIVE

These teams work to identify and improve quality care issues in maternal and infant health care.

MATERNAL MORTALITY REVIEW COMMITTEE

These committees are essential to understanding and addressing the causes of maternal death.

AVERAGE PRETERM BIRTH COST

Estimated societal cost includes care for babies, delivery costs, early intervention services, special education and lost productivity.

Legend

- ✔ State has or is developing the indicated organization/policy
- ✭ State has the indicated organization and is CDC funded
- ✗ State does not have or is not developing the indicated organization/policy
- ↑ State is above estimated U.S. cost
- ↓ State is below estimated U.S. cost

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MORE INFORMATION

MARCHOFDIMES.ORG/REPORTCARD

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**MICHIGAN**

**PRETERM BIRTH GRADE**

**C-**

**PRETERM BIRTH RATE**

10.3%

**INFANT MORTALITY RATE**

6.2%

**PRETERM BIRTH RATE BY RACE AND ETHNICITY**

The March of Dimes disparity ratio measures and tracks progress towards the elimination of racial/ethnic disparities in preterm birth. It’s based on Healthy People 2020 methodology and compares the group with the lowest preterm birth rate to the average for all other groups. Progress is evaluated by comparing the current disparity ratio to a baseline disparity ratio. A lower disparity ratio is better, with a disparity ratio of 1 indicating no disparity.

- Asian/Pacific Islander: 8.4
- American Indian/Alaska Native: 10.5
- Black: 14.6
- White: 9.0
- Hispanic: 9.7

In Michigan, the preterm birth rate among Black women is 60% higher than the rate among all other women.

**DISPARITY RATIO:** 1.19

**CHANGE FROM BASELINE:** No Improvement

**PRETERM BIRTH RATE BY CITY**

<table>
<thead>
<tr>
<th>CITY</th>
<th>GRADE</th>
<th>PRETERM BIRTH RATE</th>
<th>CHANGE IN RATE FROM LAST YEAR</th>
</tr>
</thead>
<tbody>
<tr>
<td>Detroit</td>
<td>F</td>
<td>15.2%</td>
<td>Worsened</td>
</tr>
</tbody>
</table>

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MICHIGAN MATERNAL AND INFANT HEALTH

SELECTED SOCIAL DETERMINANTS OF HEALTH

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MEDICAID EXPANSION
States who have adopted this policy allow women greater access to preventative care during pregnancy.

MEDICAID EXTENSION
State has recent action to extend coverage for women beyond 60 days postpartum.

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These committees are essential to understanding and addressing the causes of maternal death.

PERINATAL QUALITY COLLABORATIVE
These teams work to identify and improve quality care issues in maternal and infant health care.

AVERAGE PRETERM BIRTH COST
Estimated societal cost includes care for babies, delivery costs, early intervention services, special education and lost productivity.

Legend
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✗ State does not have or is not developing the indicated organization/policy
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↓ State is below estimated U.S. cost

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**MINNESOTA**

**PRETERM BIRTH GRADE**

C+

**PRETERM BIRTH RATE**

9.3%

**INFANT MORTALITY**

Infant mortality rates are an indication of overall health. Leading causes of infant death include birth defects, prematurity, low birth weight, maternal complications and sudden infant death syndrome.

**INFANT MORTALITY RATE**

5.1

**PRETERM BIRTH RATE BY RACE AND ETHNICITY**

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In Minnesota, the preterm birth rate among American Indian/Alaska Native women is 64% higher than the rate among all other women.

**DISPARITY RATIO:**

1.22

**CHANGE FROM BASELINE:**

No Improvement

**PRETERM BIRTH RATE BY CITY**

<table>
<thead>
<tr>
<th>CITY</th>
<th>GRADE</th>
<th>PRETERM BIRTH RATE</th>
<th>CHANGE IN RATE FROM LAST YEAR</th>
</tr>
</thead>
<tbody>
<tr>
<td>Minneapolis</td>
<td>C+</td>
<td>9.4%</td>
<td>Better</td>
</tr>
</tbody>
</table>

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These committees are essential to understanding and addressing the causes of maternal death.

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**MISSISSIPPI**

**PRETERM BIRTH GRADE**

F

**PRETERM BIRTH RATE**

14.6%

**INFANT MORTALITY RATE**

8.4

**PRETERM BIRTH RATE BY RACE AND ETHNICITY**

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In Mississippi, the preterm birth rate among Black women is 43% higher than the rate among all other women.

**DISPARITY RATIO:**

1.26

**CHANGE FROM BASELINE:**

No Improvement

**PRETERM BIRTH RATE BY CITY**

<table>
<thead>
<tr>
<th>CITY</th>
<th>GRADE</th>
<th>PRETERM BIRTH RATE</th>
<th>CHANGE IN RATE FROM LAST YEAR</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jackson</td>
<td>F</td>
<td>16.5%</td>
<td>Better</td>
</tr>
</tbody>
</table>

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MISSISSIPPI MATERNAL AND INFANT HEALTH

SELECTED SOCIAL DETERMINANTS OF HEALTH

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<table>
<thead>
<tr>
<th>Parameter</th>
<th>Unit</th>
<th>Mississippi</th>
<th>United States</th>
<th>HP 2030</th>
</tr>
</thead>
<tbody>
<tr>
<td>Uninsured among women (15-44)</td>
<td></td>
<td>7.9</td>
<td>11.9</td>
<td>17.7</td>
</tr>
<tr>
<td>Inadequate prenatal care</td>
<td></td>
<td>14.9</td>
<td>13.6</td>
<td>19.5</td>
</tr>
<tr>
<td>Poverty among women (15-44)</td>
<td></td>
<td>8.0</td>
<td>14.7</td>
<td>23.5</td>
</tr>
</tbody>
</table>

Legend

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- ✭ State has the indicated organization and is CDC funded
- ✗ State does not have or is not developing the indicated organization/policy
- 📈 State is above estimated U.S. cost
- ⬇️ State is below estimated U.S. cost

Medicaid Expansion

States who have adopted this policy allow women greater access to preventative care during pregnancy.

Medicaid Extension

State has recent action to extend coverage for women beyond 60 days postpartum.

Average Preterm Birth Cost

Estimated societal cost includes care for babies, delivery costs, early intervention services, special education and lost productivity.

Maternal Mortality Review Committee

These committees are essential to understanding and addressing the causes of maternal death.

Perinatal Quality Collaborative

These teams work to identify and improve quality care issues in maternal and infant health care.

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MISSOURI

**PRETERM BIRTH GRADE**

D

**PRETERM BIRTH RATE**

10.9%

**INFANT MORTALITY RATE**

6.4

**PRETERM BIRTH RATE BY RACE AND ETHNICITY**

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<table>
<thead>
<tr>
<th>RACE/ETHNICITY</th>
<th>DISPARITY RATIO</th>
<th>CHANGE FROM BASELINE:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Asian/Pacific Islander</td>
<td>10.1</td>
<td>No Improvement</td>
</tr>
<tr>
<td>American Indian/Alaska Native</td>
<td>11.3</td>
<td></td>
</tr>
<tr>
<td>Black</td>
<td>14.6</td>
<td></td>
</tr>
<tr>
<td>White</td>
<td>9.7</td>
<td></td>
</tr>
<tr>
<td>Hispanic</td>
<td>9.8</td>
<td></td>
</tr>
</tbody>
</table>

**PRETERM BIRTH RATE BY CITY**

<table>
<thead>
<tr>
<th>CITY</th>
<th>GRADE</th>
<th>PRETERM BIRTH RATE</th>
<th>CHANGE IN RATE FROM LAST YEAR</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kansas City</td>
<td>D+</td>
<td>10.6%</td>
<td>Better</td>
</tr>
</tbody>
</table>

In Missouri, the preterm birth rate among Black women is 51% higher than the rate among all other women.

PRETERM BIRTH GRADE

D

PRETERM BIRTH RATE

10.9%

INFANT MORTALITY RATE

6.4

PRETERM BIRTH RATE BY RACE AND ETHNICITY

In Missouri, the preterm birth rate among Black women is 51% higher than the rate among all other women.

DISPARITY RATIO: 1.13

CHANGE FROM BASELINE: No Improvement

PRETERM BIRTH RATE BY CITY

<table>
<thead>
<tr>
<th>CITY</th>
<th>GRADE</th>
<th>PRETERM BIRTH RATE</th>
<th>CHANGE IN RATE FROM LAST YEAR</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kansas City</td>
<td>D+</td>
<td>10.6%</td>
<td>Better</td>
</tr>
</tbody>
</table>
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---

**MEDICAID EXPANSION**
States who have adopted this policy allow women greater access to preventative care during pregnancy.

**MEDICAID EXTENSION**
State has recent action to extend coverage for women beyond 60 days postpartum.

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These committees are essential to understanding and addressing the causes of maternal death.

**PERINATAL QUALITY COLLABORATIVE**
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MONTANA

PRETERM BIRTH GRADE

C+

PRETERM BIRTH RATE

9.6%

In Montana, the preterm birth rate among American Indian/Alaska Native women is 61% higher than the rate among all other women.

DISPARITY RATIO: 1.39

CHANGE FROM BASELINE: No Improvement

INFANT MORTALITY

Infant mortality rates are an indication of overall health. Leading causes of infant death include birth defects, prematurity, low birth weight, maternal complications and sudden infant death syndrome.

INFANT MORTALITY RATE

4.8

PRETERM BIRTH RATE BY RACE AND ETHNICITY

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<table>
<thead>
<tr>
<th>CITY</th>
<th>GRADE</th>
<th>PRETERM BIRTH RATE</th>
<th>CHANGE IN RATE FROM LAST YEAR</th>
</tr>
</thead>
<tbody>
<tr>
<td>Billings</td>
<td>C+</td>
<td>9.3%</td>
<td>Better</td>
</tr>
</tbody>
</table>

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# Montana Maternal and Infant Health

## Selected Social Determinants of Health

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<table>
<thead>
<tr>
<th>State</th>
<th>Insured among women (15-44)</th>
<th>Inadequate prenatal care</th>
<th>Poverty among women (15-44)</th>
</tr>
</thead>
<tbody>
<tr>
<td>0%</td>
<td>10%</td>
<td>20%</td>
<td>30%</td>
</tr>
<tr>
<td>HP 2030</td>
<td>United States</td>
<td>Montana</td>
<td>HP 2030</td>
</tr>
<tr>
<td>7.9</td>
<td>11.9</td>
<td>14.9</td>
<td>8.0</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Status</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>✓</td>
<td>Medicaid Expansion</td>
</tr>
<tr>
<td></td>
<td>States who have adopted this policy allow women greater access to preventative care during pregnancy.</td>
</tr>
<tr>
<td>✗</td>
<td>Medicaid Extension</td>
</tr>
<tr>
<td></td>
<td>State has recent action to extend coverage for women beyond 60 days postpartum.</td>
</tr>
<tr>
<td>✓</td>
<td>Maternal Mortality Review Committee</td>
</tr>
<tr>
<td></td>
<td>These committees are essential to understanding and addressing the causes of maternal death.</td>
</tr>
<tr>
<td>✓</td>
<td>Perinatal Quality Collaborative</td>
</tr>
<tr>
<td></td>
<td>These teams work to identify and improve quality care issues in maternal and infant health care.</td>
</tr>
</tbody>
</table>

## Average Preterm Birth Cost

States have recent action to extend coverage for women beyond 60 days postpartum.

**Legend**

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Scan for details
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### NEBRASKA

#### PRETERM BIRTH GRADE

**D+**

#### PRETERM BIRTH RATE

**10.5%**

#### INFANT MORTALITY RATE

**5.8**

#### PRETERM BIRTH RATE BY RACE AND ETHNICITY

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<table>
<thead>
<tr>
<th>RACE/ETHNICITY</th>
<th>2016-2018 Percentage of live births born preterm</th>
</tr>
</thead>
<tbody>
<tr>
<td>Asian/Pacific Islander</td>
<td>9.7</td>
</tr>
<tr>
<td>American Indian/Alaska Native</td>
<td>14.3</td>
</tr>
<tr>
<td>Black</td>
<td>13.3</td>
</tr>
<tr>
<td>White</td>
<td>9.6</td>
</tr>
<tr>
<td>Hispanic</td>
<td>9.8</td>
</tr>
</tbody>
</table>

In Nebraska, the preterm birth rate among American Indian/Alaska Native women is 44% higher than the rate among all other women.

**DISPARITY RATIO:**

1.21

**CHANGE FROM BASELINE:**

No Improvement

#### PRETERM BIRTH RATE BY CITY

<table>
<thead>
<tr>
<th>CITY</th>
<th>GRADE</th>
<th>PRETERM BIRTH RATE</th>
<th>CHANGE IN RATE FROM LAST YEAR</th>
</tr>
</thead>
<tbody>
<tr>
<td>Omaha</td>
<td>F</td>
<td>11.7%</td>
<td>Worsened</td>
</tr>
</tbody>
</table>

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NEBRASKA MATERNAL AND INFANT HEALTH

SELECTED SOCIAL DETERMINANTS OF HEALTH

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![Uninsured among women (15-44)](chart)
- Nebraska: 7.9%
- United States: 11.9%
- HP 2030: 12.3%

![Inadequate prenatal care](chart)
- Nebraska: 8.0%
- United States: 14.7%
- HP 2030: 14.9%

![Poverty among women (15-44)](chart)
- Nebraska: 8.0%
- United States: 11.9%
- HP 2030: 12.6%

Legend
- ✓ State has or is developing the indicated organization/policy
- ✗ State does not have or is not developing the indicated organization/policy
- ↑ State is above estimated U.S. cost
- ↓ State is below estimated U.S. cost

MEDICAID EXPANSION
States who have adopted this policy allow women greater access to preventative care during pregnancy.

MEDICAID EXTENSION
State has recent action to extend coverage for women beyond 60 days postpartum.

MATERNAL MORTALITY REVIEW COMMITTEE
These committees are essential to understanding and addressing the causes of maternal death.

PERINATAL QUALITY COLLABORATIVE
These teams work to identify and improve quality care issues in maternal and infant health care.

AVERAGE PRETERM BIRTH COST
Estimated societal cost includes care for babies, delivery costs, early intervention services, special education and lost productivity.

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MORE INFORMATION MARCHOFDIMES.ORG/REPORTCARD
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Rates of maternal death and morbidity continue to be unacceptably high in the U.S. Maternal morbidity, social determinants of health, availability of state level health insurance policy and the availability of surveillance and research data affect the health and survival of both mom and baby. While we currently do not have enough to grade states or report on all maternal health indicators, we have highlighted measures with the best available data.

**NEVADA**

**PRETERM BIRTH GRADE**

D+

**PRETERM BIRTH RATE**

10.7%

**INFANT MORTALITY**

Infant mortality rates are an indication of overall health. Leading causes of infant death include birth defects, prematurity, low birth weight, maternal complications and sudden infant death syndrome.

**INFANT MORTALITY RATE**

6.1

**PRETERM BIRTH RATE BY RACE AND ETHNICITY**

The March of Dimes disparity ratio measures and tracks progress towards the elimination of racial/ethnic disparities in preterm birth. It’s based on Healthy People 2020 methodology and compares the group with the lowest preterm birth rate to the average for all other groups. Progress is evaluated by comparing the current disparity ratio to a baseline disparity ratio. A lower disparity ratio is better, with a disparity ratio of 1 indicating no disparity.

In Nevada, the preterm birth rate among Black women is 38% higher than the rate among all other women.

**DISPARITY RATIO:**

1.10

**CHANGE FROM BASELINE:**

No Improvement

**PRETERM BIRTH RATE BY CITY**

<table>
<thead>
<tr>
<th>CITY</th>
<th>GRADE</th>
<th>PRETERM BIRTH RATE</th>
<th>CHANGE IN RATE FROM LAST YEAR</th>
</tr>
</thead>
<tbody>
<tr>
<td>Las Vegas</td>
<td>C-</td>
<td>10.3%</td>
<td>Better</td>
</tr>
</tbody>
</table>

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NEVADA MATERNAL AND INFANT HEALTH

SELECTED SOCIAL DETERMINANTS OF HEALTH

Many structural, systemic and environmental factors influence the health of moms and babies, especially for Black, American Indian and Alaska Native people. When looking at factors such as access to maternity care, financial stability and health insurance status, these disparities persist. Systemic racism and the wealth gap in the U.S. deepen many health inequities in our society. The onset of COVID-19 has further magnified preexisting health disparities. March of Dimes is collaborating with others to confront these drivers of health outcomes, while identifying solutions to achieve health equity for all.

- **Uninsured among women (15-44)**
  - Nevada: 7.9%
  - United States: 11.9%
  - HP 2030: 15.2%

- **Inadequate prenatal care**
  - Nevada: 14.9%
  - United States: 17.3%
  - HP 2030: 19.5%

- **Poverty among women (15-44)**
  - Nevada: 8.0%
  - United States: 14.7%
  - HP 2030: 13.8%

**Legend**
- ✔️ State has or is developing the indicated organization/policy
- ✖️ State has the indicated organization and is CDC funded
- ☑️ State does not have or is not developing the indicated organization/policy
- ⬆️ State is above estimated U.S. cost
- ⬇️ State is below estimated U.S. cost

- **MEDICAID EXPANSION**
  States who have adopted this policy allow women greater access to preventative care during pregnancy.

- **MEDICAID EXTENSION**
  State has recent action to extend coverage for women beyond 60 days postpartum.

- **MATERNAL MORTALITY REVIEW COMMITTEE**
  These committees are essential to understanding and addressing the causes of maternal death.

- **PERINATAL QUALITY COLLABORATIVE**
  These teams work to identify and improve quality care issues in maternal and infant health care.

- **AVERAGE PRETERM BIRTH COST**
  Estimated societal cost includes care for babies, delivery costs, early intervention services, special education and lost productivity.

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NEW HAMPSHIRE

PRETERM BIRTH GRADE

B+

PRETERM BIRTH RATE

8.2%

INFANT MORTALITY

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INFANT MORTALITY RATE

3.5

PRETERM BIRTH RATE BY RACE AND ETHNICITY

The March of Dimes disparity ratio measures and tracks progress towards the elimination of racial/ethnic disparities in preterm birth. It’s based on Healthy People 2020 methodology and compares the group with the lowest preterm birth rate to the average for all other groups. Progress is evaluated by comparing the current disparity ratio to a baseline disparity ratio. A lower disparity ratio is better, with a disparity ratio of 1 indicating no disparity.

PRETERM BIRTH RATE BY CITY

<table>
<thead>
<tr>
<th>CITY</th>
<th>GRADE</th>
<th>PRETERM BIRTH RATE</th>
<th>CHANGE IN RATE FROM LAST YEAR</th>
</tr>
</thead>
<tbody>
<tr>
<td>Manchester</td>
<td>C+</td>
<td>9.5%</td>
<td>Worsened</td>
</tr>
</tbody>
</table>

In New Hampshire, the preterm birth rate among Asian/Pacific Islander and Hispanic women is 8% higher than the rate among all other women.

DISPARITY RATIO: 1.04

CHANGE FROM BASELINE: No Improvement
NEW HAMPSHIRE MATERNAL AND INFANT HEALTH

SELECTED SOCIAL DETERMINANTS OF HEALTH

Many structural, systemic and environmental factors influence the health of moms and babies, especially for Black, American Indian and Alaska Native people. When looking at factors such as access to maternity care, financial stability and health insurance status, these disparities persist. Systemic racism and the wealth gap in the U.S. deepen many health inequities in our society. The onset of COVID-19 has further magnified preexisting health disparities. March of Dimes is collaborating with others to confront these drivers of health outcomes, while identifying solutions to achieve health equity for all.

MEDICAID EXPANSION
States who have adopted this policy allow women greater access to preventative care during pregnancy.

MEDICAID EXTENSION
State has recent action to extend coverage for women beyond 60 days postpartum.

AVERAGE PRETERM BIRTH COST
Estimated societal cost includes care for babies, delivery costs, early intervention services, special education and lost productivity.

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### NEW JERSEY

#### PRETERM BIRTH GRADE

<table>
<thead>
<tr>
<th>CITY</th>
<th>GRADE</th>
<th>PRETERM BIRTH RATE</th>
<th>CHANGE IN RATE FROM LAST YEAR</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jersey City</td>
<td>D</td>
<td>10.8%</td>
<td>Worsened</td>
</tr>
</tbody>
</table>

#### PRETERM BIRTH RATE

- **Preterm Birth Rate**: 9.6%
- **Change in Rate from Last Year**: Worsened

#### INFANT MORTALITY

- **Infant Mortality Rate**: 3.8%

#### PRETERM BIRTH RATE BY RACE AND ETHNICITY

- **Asian/Pacific Islander**: 8.8%
- **Black**: 13.3%
- **White**: 8.5%
- **Hispanic**: 10.0%

**Disparity Ratio**: 1.19

**Change from Baseline**: No Improvement

*In New Jersey, the preterm birth rate among Black women is 48% higher than the rate among all other women.*

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NEW JERSEY MATERNAL AND INFANT HEALTH

SELECTED SOCIAL DETERMINANTS OF HEALTH

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MEDICAID EXPANSION
States who have adopted this policy allow women greater access to preventative care during pregnancy.

MEDICAID EXTENSION
State has recent action to extend coverage for women beyond 60 days postpartum.

PERINATAL QUALITY COLLABORATIVE
These teams work to identify and improve quality care issues in maternal and infant health care.

MATERNAL MORTALITY REVIEW COMMITTEE
These committees are essential to understanding and addressing the causes of maternal death.

AVERAGE PRETERM BIRTH COST
Estimated societal cost includes care for babies, delivery costs, early intervention services, special education and lost productivity.

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### New Mexico

**Preterm Birth Grade**

C-  

10.1%

**Preterm Birth Rate**

**Infant Mortality Rate**

5.7

**Preterm Birth Rate by Race and Ethnicity**

<table>
<thead>
<tr>
<th>Race/Ethnicity</th>
<th>Preterm Birth Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Asian/Pacific Islander</td>
<td>10.0</td>
</tr>
<tr>
<td>American Indian/Alaska Native</td>
<td>10.2</td>
</tr>
<tr>
<td>Black</td>
<td>12.8</td>
</tr>
<tr>
<td>White</td>
<td>9.6</td>
</tr>
<tr>
<td>Hispanic</td>
<td>10.1</td>
</tr>
</tbody>
</table>

In New Mexico, the preterm birth rate among Black women is 29% higher than the rate among all other women.

**Disparity Ratio:**

1.04

**Change from Baseline:**

No Improvement

**Preterm Birth Rate by City**

<table>
<thead>
<tr>
<th>City</th>
<th>Grade</th>
<th>Preterm Birth Rate</th>
<th>Change in Rate from Last Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Albuquerque</td>
<td>D</td>
<td>10.8%</td>
<td>Worsened</td>
</tr>
</tbody>
</table>

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NEW MEXICO MATERNAL AND INFANT HEALTH

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![Diagram of social determinants]

- **Uninsured among women (15-44)**
  - HP 2030: 7.9%
  - United States: 11.9%
  - New Mexico: 12.3%

- **Inadequate prenatal care**
  - HP 2030: 14.9%
  - United States: 19.5%
  - New Mexico: 22.2%

- **Poverty among women (15-44)**
  - HP 2030: 8.0%
  - United States: 14.7%
  - New Mexico: 22.0%

---

**MEDICAID EXPANSION**
States who have adopted this policy allow women greater access to preventative care during pregnancy.

**MEDICAID EXTENSION**
State has recent action to extend coverage for women beyond 60 days postpartum.

**AVerage Preterm Birth Cost**
Estimated societal cost includes care for babies, delivery costs, early intervention services, special education and lost productivity.

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NEW YORK

PRETERM BIRTH GRADE

B-

PRETERM BIRTH RATE

9.2%

INFANT MORTALITY

Infant mortality rates are an indication of overall health. Leading causes of infant death include birth defects, prematurity, low birth weight, maternal complications and sudden infant death syndrome.

INFANT MORTALITY RATE

4.3

PRETERM BIRTH RATE BY RACE AND ETHNICITY

The March of Dimes disparity ratio measures and tracks progress towards the elimination of racial/ethnic disparities in preterm birth. It’s based on Healthy People 2020 methodology and compares the group with the lowest preterm birth rate to the average for all other groups. Progress is evaluated by comparing the current disparity ratio to a baseline disparity ratio. A lower disparity ratio is better, with a disparity ratio of 1 indicating no disparity.

In New York, the preterm birth rate among Black women is 51% higher than the rate among all other women.

DISPARITY RATIO:

1.26

CHANGE FROM BASELINE:

No Improvement

PRETERM BIRTH RATE BY CITY

<table>
<thead>
<tr>
<th>CITY</th>
<th>GRADE</th>
<th>PRETERM BIRTH RATE</th>
<th>CHANGE IN RATE FROM LAST YEAR</th>
</tr>
</thead>
<tbody>
<tr>
<td>New York</td>
<td>B-</td>
<td>9.0%</td>
<td>Worsened</td>
</tr>
</tbody>
</table>

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NEW YORK MATERNAL AND INFANT HEALTH

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**MEDICAID EXPANSION**
States who have adopted this policy allow women greater access to preventative care during pregnancy.

**MEDICAID EXTENSION**
State has recent action to extend coverage for women beyond 60 days postpartum.

**AVERAGE PRETERM BIRTH COST**
Estimated societal cost includes care for babies, delivery costs, early intervention services, special education and lost productivity.

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NORTH CAROLINA

PRETERM BIRTH GRADE

D+

PRETERM BIRTH RATE

10.7%

INFANT MORTALITY

Infant mortality rates are an indication of overall health. Leading causes of infant death include birth defects, prematurity, low birth weight, maternal complications and sudden infant death syndrome.

INFANT MORTALITY RATE

6.8

PRETERM BIRTH RATE BY RACE AND ETHNICITY

The March of Dimes disparity ratio measures and tracks progress towards the elimination of racial/ethnic disparities in preterm birth. It’s based on Healthy People 2020 methodology and compares the group with the lowest preterm birth rate to the average for all other groups. Progress is evaluated by comparing the current disparity ratio to a baseline disparity ratio. A lower disparity ratio is better, with a disparity ratio of 1 indicating no disparity.

<table>
<thead>
<tr>
<th>RACE/ETHNICITY</th>
<th>2018 Percentage of live births born preterm</th>
</tr>
</thead>
<tbody>
<tr>
<td>Asian/Pacific Islander</td>
<td>8.6</td>
</tr>
<tr>
<td>American Indian/Alaska Native</td>
<td>12.1</td>
</tr>
<tr>
<td>Black</td>
<td>13.7</td>
</tr>
<tr>
<td>White</td>
<td>9.5</td>
</tr>
<tr>
<td>Hispanic</td>
<td>9.1</td>
</tr>
</tbody>
</table>

In North Carolina, the preterm birth rate among Black women is 46% higher than the rate among all other women.

DISPARITY RATIO: 1.29

CHANGE FROM BASELINE: No Improvement

PRETERM BIRTH RATE BY CITY

<table>
<thead>
<tr>
<th>CITY</th>
<th>GRADE</th>
<th>PRETERM BIRTH RATE</th>
<th>CHANGE IN RATE FROM LAST YEAR</th>
</tr>
</thead>
<tbody>
<tr>
<td>Charlotte</td>
<td>D+</td>
<td>10.5%</td>
<td>Better</td>
</tr>
</tbody>
</table>

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NORTH CAROLINA MATERNAL AND INFANT HEALTH

SELECTED SOCIAL DETERMINANTS OF HEALTH

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- **Uninsured among women (15-44)**
  - North Carolina: 7.9%
  - United States: 11.9%
  - HP 2030: 14.8%

- **Inadequate prenatal care**
  - North Carolina: 14.9%
  - United States: 16.4%
  - HP 2030: 19.5%

- **Poverty among women (15-44)**
  - North Carolina: 8.0%
  - United States: 14.7%
  - HP 2030: 17.8%

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**MEDICAID EXPANSION**

States who have adopted this policy allow women greater access to preventative care during pregnancy.

---

**MEDICAID EXTENSION**

State has recent action to extend coverage for women beyond 60 days postpartum.

---

**PERINATAL QUALITY COLLABORATIVE**

These teams work to identify and improve quality care issues in maternal and infant health care.

---

**MATERNAL MORTALITY REVIEW COMMITTEE**

These committees are essential to understanding and addressing the causes of maternal death.

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**AVERAGE PRETERM BIRTH COST**

Estimated societal cost includes care for babies, delivery costs, early intervention services, special education and lost productivity.

**Legend**

- ✔️ State has or is developing the indicated organization/policy
- ✭ State has the indicated organization and is CDC funded
- ✗ State does not have or is not developing the indicated organization/policy
- 🔽 State is above estimated U.S. cost
- 🔼 State is below estimated U.S. cost

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MORE INFORMATION

MARCHOFDIMES.ORG/REPORTCARD

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Scan for details
In North Dakota, the preterm birth rate among American Indian/Alaska Native women is 56% higher than the rate among all other women.

**DISPARITY RATIO:** 1.35

**CHANGE FROM BASELINE:** No Improvement

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Rates of maternal death and morbidity continue to be unacceptably high in the U.S. Maternal morbidity, social determinants of health, availability of state level health insurance policy and the availability of surveillance and research data affect the health and survival of both mom and baby. While we currently do not have enough to grade states or report on all maternal health indicators, we have highlighted measures with the best available data.
NORTH DAKOTA MATERNAL AND INFANT HEALTH

SELECTED SOCIAL DETERMINANTS OF HEALTH

Many structural, systemic and environmental factors influence the health of moms and babies, especially for Black, American Indian and Alaska Native people. When looking at factors such as access to maternity care, financial stability and health insurance status, these disparities persist. Systemic racism and the wealth gap in the U.S. deepen many health inequities in our society. The onset of COVID-19 has further magnified preexisting health disparities. March of Dimes is collaborating with others to confront these drivers of health outcomes, while identifying solutions to achieve health equity for all.

MEDICAID EXPANSION
States who have adopted this policy allow women greater access to preventative care during pregnancy.

MEDICAID EXTENSION
State has recent action to extend coverage for women beyond 60 days postpartum.

AVERAGE PRETERM BIRTH COST
Estimated societal cost includes care for babies, delivery costs, early intervention services, special education and lost productivity.

MATERNAL MORTALITY REVIEW COMMITTEE
These committees are essential to understanding and addressing the causes of maternal death.

PERINATAL QUALITY COLLABORATIVE
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### Ohio

#### Preterm Birth Grade

**D+**

#### Preterm Birth Rate

**10.5%**

#### Infant Mortality Rate

**6.9**

#### Preterm Birth Rate by Race and Ethnicity

- **Asian/Pacific Islander**: 8.8
- **Black**: 14.1
- **White**: 9.5
- **Hispanic**: 10.5

In Ohio, the preterm birth rate among Black women is 48% higher than the rate among all other women.

**Disparity Ratio:** 1.30

**Change from baseline:** No Improvement

#### Preterm Birth Rate by City

<table>
<thead>
<tr>
<th>CITY</th>
<th>GRADE</th>
<th>PRETERM BIRTH RATE</th>
<th>CHANGE IN RATE FROM LAST YEAR</th>
</tr>
</thead>
<tbody>
<tr>
<td>Columbus</td>
<td>F</td>
<td>11.6%</td>
<td>Worsened</td>
</tr>
</tbody>
</table>

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MEDICAID EXTENSION
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AVERAGE PRETERM BIRTH COST
Estimated societal cost includes care for babies, delivery costs, early intervention services, special education and lost productivity.

Legend
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### OKLAHOMA

#### Preterm Birth Grade

**F**

**Preterm Birth Rate**

11.5%

#### Infant Mortality Rate

7.1

In Oklahoma, the preterm birth rate among Black women is 36% higher than the rate among all other women.

#### Preterm Birth Rate by Race and Ethnicity

<table>
<thead>
<tr>
<th>Race/Ethnicity</th>
<th>Percentage of live births in 2016-2018 (average) born preterm</th>
</tr>
</thead>
<tbody>
<tr>
<td>Asian/Pacific Islander</td>
<td>8.9</td>
</tr>
<tr>
<td>American Indian/Alaska Native</td>
<td>11.0</td>
</tr>
<tr>
<td>Black</td>
<td>14.6</td>
</tr>
<tr>
<td>White</td>
<td>10.8</td>
</tr>
<tr>
<td>Hispanic</td>
<td>10.3</td>
</tr>
</tbody>
</table>

#### Change from Baseline:

Improved

Disparity Ratio: 1.10

### Preterm Birth Rate by City

<table>
<thead>
<tr>
<th>City</th>
<th>Grade</th>
<th>Preterm Birth Rate</th>
<th>Change in Rate from Last Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oklahoma City</td>
<td>F</td>
<td>12.0%</td>
<td>Better</td>
</tr>
</tbody>
</table>

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OKLAHOMA MATERNAL AND INFANT HEALTH

SELECTED SOCIAL DETERMINANTS OF HEALTH

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![Graph showing social determinants of health](image)

- **Uninsured among women (15-44)**
  - State has or is developing: 7.9%
  - State has: 11.9%
  - State does not have or is not developing: 19.6%

- **Inadequate prenatal care**
  - State has or is developing: 14.9%
  - State has: 16.2%
  - State does not have or is not developing: 19.5%

- **Poverty among women (15-44)**
  - State has or is developing: 8.0%
  - State has: 14.7%
  - State does not have or is not developing: 15.4%

**Legend**

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**MEDICAID EXPANSION**
States who have adopted this policy allow women greater access to preventative care during pregnancy.

**MEDICAID EXTENSION**
State has recent action to extend coverage for women beyond 60 days postpartum.

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**AVERAGE PRETERM BIRTH COST**
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OREGON

PRETERM BIRTH GRADE

B+

PRETERM BIRTH RATE

8.3%

INFANT MORTALITY

Infant mortality rates are an indication of overall health. Leading causes of infant death include birth defects, prematurity, low birth weight, maternal complications and sudden infant death syndrome.

INFANT MORTALITY RATE

4.2

PRETERM BIRTH RATE BY RACE AND ETHNICITY

The March of Dimes disparity ratio measures and tracks progress towards the elimination of racial/ethnic disparities in preterm birth. It’s based on Healthy People 2020 methodology and compares the group with the lowest preterm birth rate to the average for all other groups. Progress is evaluated by comparing the current disparity ratio to a baseline disparity ratio. A lower disparity ratio is better, with a disparity ratio of 1 indicating no disparity.

In Oregon, the preterm birth rate among American Indian/Alaska Native women is 40% higher than the rate among all other women.

DISPARITY RATIO:

1.24

CHANGE FROM BASELINE: No Improvement

PRETERM BIRTH RATE BY CITY

<table>
<thead>
<tr>
<th>CITY</th>
<th>GRADE</th>
<th>PRETERM BIRTH RATE</th>
<th>CHANGE IN RATE FROM LAST YEAR</th>
</tr>
</thead>
<tbody>
<tr>
<td>Portland</td>
<td>A</td>
<td>7.7%</td>
<td>Better</td>
</tr>
</tbody>
</table>

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OREGON MATERNAL AND INFANT HEALTH

SELECTED SOCIAL DETERMINANTS OF HEALTH

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State has or is developing the indicated organization/policy
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State does not have or is not developing the indicated organization/policy
State is above estimated U.S. cost
State is below estimated U.S. cost

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MEDICAID EXPANSION
States who have adopted this policy allow women greater access to preventative care during pregnancy.

MEDICAID EXTENSION
State has recent action to extend coverage for women beyond 60 days postpartum.

AVERAGE PRETERM BIRTH COST
Estimated societal cost includes care for babies, delivery costs, early intervention services, special education and lost productivity.

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PENNSYLVANIA

PRETERM BIRTH GRADE

C

PRETERM BIRTH RATE

9.9%

INFANT MORTALITY

Infant mortality rates are an indication of overall health. Leading causes of infant death include birth defects, prematurity, low birth weight, maternal complications and sudden infant death syndrome.

INFANT MORTALITY RATE

5.9

PRETERM BIRTH RATE BY RACE AND ETHNICITY

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<table>
<thead>
<tr>
<th>RACE/ETHNICITY</th>
<th>PRETERM BIRTH RATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Asian/Pacific Islander</td>
<td>8.1</td>
</tr>
<tr>
<td>Black</td>
<td>13.1</td>
</tr>
<tr>
<td>White</td>
<td>8.6</td>
</tr>
<tr>
<td>Hispanic</td>
<td>10.0</td>
</tr>
</tbody>
</table>

In Pennsylvania, the preterm birth rate among Black women is 49% higher than the rate among all other women.

DISPARITY RATIO: 1.30

CHANGE FROM BASELINE: No Improvement

PRETERM BIRTH RATE BY CITY

<table>
<thead>
<tr>
<th>CITY</th>
<th>GRADE</th>
<th>PRETERM BIRTH RATE</th>
<th>CHANGE IN RATE FROM LAST YEAR</th>
</tr>
</thead>
<tbody>
<tr>
<td>Philadelphia</td>
<td>D</td>
<td>11.1%</td>
<td>Worsened</td>
</tr>
</tbody>
</table>

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Rhode Island

Preterm Birth Grade

C+

Preterm Birth Rate

9.5%

Infant Mortality Rate

5.0

Preterm Birth Rate by Race and Ethnicity

In Rhode Island, the preterm birth rate among Black women is 40% higher than the rate among all other women.

Disparity Ratio: 1.18

Change from baseline: No Improvement

Preterm Birth Rate by City

<table>
<thead>
<tr>
<th>City</th>
<th>Grade</th>
<th>Preterm Birth Rate</th>
<th>Change in Rate from Last Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Providence</td>
<td>C</td>
<td>9.8%</td>
<td>Worsened</td>
</tr>
</tbody>
</table>

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**RHODE ISLAND MATERNAL AND INFANT HEALTH**

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<table>
<thead>
<tr>
<th>Health Indicator</th>
<th>Rhode Island</th>
<th>United States</th>
<th>HP 2030</th>
</tr>
</thead>
<tbody>
<tr>
<td>Uninsured among women (15-44)</td>
<td>7.9%</td>
<td>11.9%</td>
<td>5.7%</td>
</tr>
<tr>
<td>Inadequate prenatal care</td>
<td>14.9%</td>
<td>6.8%</td>
<td>19.5%</td>
</tr>
<tr>
<td>Poverty among women (15-44)</td>
<td>14.7%</td>
<td>8.0%</td>
<td>11.7%</td>
</tr>
</tbody>
</table>

---

**MEDICAID EXPANSION**

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**MEDICAID EXTENSION**

State has recent action to extend coverage for women beyond 60 days postpartum.

**PERINATAL QUALITY COLLABORATIVE**

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**MATERNAL MORTALITY REVIEW COMMITTEE**

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**AVERAGE PRETERM BIRTH COST**

Estimated societal cost includes care for babies, delivery costs, early intervention services, special education and lost productivity.

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SOUTH CAROLINA

PRETERM BIRTH GRADE

F

PRETERM BIRTH RATE

11.5%

INFANT MORTALITY

Infant mortality rates are an indication of overall health. Leading causes of infant death include birth defects, prematurity, low birth weight, maternal complications and sudden infant death syndrome.

INFANT MORTALITY RATE

7.1

PRETERM BIRTH RATE BY RACE AND ETHNICITY

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<table>
<thead>
<tr>
<th>RACE/ETHNICITY</th>
<th>2016-2018 (average)</th>
<th>2019</th>
</tr>
</thead>
<tbody>
<tr>
<td>Asian/Pacific Islander</td>
<td>10.3</td>
<td></td>
</tr>
<tr>
<td>Black</td>
<td>14.9</td>
<td></td>
</tr>
<tr>
<td>White</td>
<td>9.6</td>
<td></td>
</tr>
<tr>
<td>Hispanic</td>
<td>9.5</td>
<td></td>
</tr>
</tbody>
</table>

In South Carolina, the preterm birth rate among Black women is 55% higher than the rate among all other women.

DISPARITY RATIO: 1.23

CHANGE FROM BASELINE: No Improvement

PRETERM BIRTH RATE BY CITY

<table>
<thead>
<tr>
<th>CITY</th>
<th>GRADE</th>
<th>PRETERM BIRTH RATE</th>
<th>CHANGE IN RATE FROM LAST YEAR</th>
</tr>
</thead>
<tbody>
<tr>
<td>Columbia</td>
<td>F</td>
<td>12.8%</td>
<td>Better</td>
</tr>
</tbody>
</table>
SOUTH CAROLINA MATERNAL AND INFANT HEALTH

SELECTED SOCIAL DETERMINANTS OF HEALTH

Many structural, systemic and environmental factors influence the health of moms and babies, especially for Black, American Indian and Alaska Native people. When looking at factors such as access to maternity care, financial stability and health insurance status, these disparities persist. Systemic racism and the wealth gap in the U.S. deepen many health inequities in our society. The onset of COVID-19 has further magnified preexisting health disparities. March of Dimes is collaborating with others to confront these drivers of health outcomes, while identifying solutions to achieve health equity for all.

<table>
<thead>
<tr>
<th>Uninsured among women (15-44)</th>
<th>0%</th>
<th>10%</th>
<th>20%</th>
<th>30%</th>
</tr>
</thead>
<tbody>
<tr>
<td>South Carolina</td>
<td>7.9</td>
<td>11.9</td>
<td>14.0</td>
<td>18.0</td>
</tr>
<tr>
<td>United States</td>
<td>11.9</td>
<td>14.0</td>
<td>17.1</td>
<td>20.0</td>
</tr>
<tr>
<td>HP 2030</td>
<td>14.0</td>
<td>17.1</td>
<td>20.0</td>
<td>23.0</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Inadequate prenatal care</th>
<th>0%</th>
<th>10%</th>
<th>20%</th>
<th>30%</th>
</tr>
</thead>
<tbody>
<tr>
<td>South Carolina</td>
<td>14.9</td>
<td>17.1</td>
<td>20.0</td>
<td>23.0</td>
</tr>
<tr>
<td>United States</td>
<td>17.1</td>
<td>20.0</td>
<td>23.0</td>
<td>26.0</td>
</tr>
<tr>
<td>HP 2030</td>
<td>19.5</td>
<td>22.5</td>
<td>25.5</td>
<td>28.5</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Poverty among women (15-44)</th>
<th>0%</th>
<th>10%</th>
<th>20%</th>
<th>30%</th>
</tr>
</thead>
<tbody>
<tr>
<td>South Carolina</td>
<td>8.0</td>
<td>11.7</td>
<td>15.4</td>
<td>19.1</td>
</tr>
<tr>
<td>United States</td>
<td>10.0</td>
<td>14.9</td>
<td>19.8</td>
<td>24.7</td>
</tr>
<tr>
<td>HP 2030</td>
<td>17.1</td>
<td>20.5</td>
<td>24.0</td>
<td>27.5</td>
</tr>
</tbody>
</table>

MEDICAID EXPANSION
States who have adopted this policy allow women greater access to preventative care during pregnancy.

MEDICAID EXTENSION
State has recent action to extend coverage for women beyond 60 days postpartum.

AVERAGE PRETERM BIRTH COST
Estimated societal cost includes care for babies, delivery costs, early intervention services, special education and lost productivity.

MATERNAL MORTALITY REVIEW COMMITTEE
These committees are essential to understanding and addressing the causes of maternal death.

PERINATAL QUALITY COLLABORATIVE
These teams work to identify and improve quality care issues in maternal and infant health care.

To prevent maternal and infant deaths, we need to better understand the causes of severe maternal morbidity (SMM) and those most impacted by it, including racial and ethnic disparities. This starts by standardizing data collection and reporting for maternal and infant health across the U.S. These data will help us to examine factors contributing to SMM, preventable deaths and poor birth outcomes in order to develop evidence-based solutions. To this end, future Report Cards will assess overall rates and disparities of SMM, low-risk cesarean sections and measures of equity in maternal and infant health.

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**SOUTH DAKOTA**

**PRETERM BIRTH GRADE**  
C+

**PRETERM BIRTH RATE**  
9.6%

**INFANT MORTALITY RATE**  
5.9

**PRETERM BIRTH RATE BY RACE AND ETHNICITY**

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<table>
<thead>
<tr>
<th>RACE/ETHNICITY</th>
<th>Percentage of live births born preterm</th>
</tr>
</thead>
<tbody>
<tr>
<td>American Indian/Alaska Native</td>
<td>12.7</td>
</tr>
<tr>
<td>Black</td>
<td>8.6</td>
</tr>
<tr>
<td>White</td>
<td>8.4</td>
</tr>
<tr>
<td>Hispanic</td>
<td>10.7</td>
</tr>
</tbody>
</table>

In South Dakota, the preterm birth rate among American Indian/Alaska Native women is 49% higher than the rate among all other women.

**DISPARITY RATIO:**  
1.27

**CHANGE FROM BASELINE:**  
No Improvement

**PRETERM BIRTH RATE BY CITY**

<table>
<thead>
<tr>
<th>CITY</th>
<th>GRADE</th>
<th>PRETERM BIRTH RATE</th>
<th>CHANGE IN RATE FROM LAST YEAR</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sioux Falls</td>
<td>C+</td>
<td>9.6%</td>
<td>Worsened</td>
</tr>
</tbody>
</table>

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Estimated societal cost includes care for babies, delivery costs, early intervention services, special education and lost productivity.

Legend
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**TENNESSEE**

**PRETERM BIRTH GRADE**

D-

**PRETERM BIRTH RATE**

11.2%

**INFANT MORTALITY RATE**

6.9

**PRETERM BIRTH RATE BY RACE AND ETHNICITY**

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% of live births in 2016-2018 (average) born preterm

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<thead>
<tr>
<th>RACE/ETHNICITY</th>
<th>Percentage of live births born preterm</th>
</tr>
</thead>
<tbody>
<tr>
<td>Asian/Pacific Islander</td>
<td>9.5</td>
</tr>
<tr>
<td>Black</td>
<td>14.7</td>
</tr>
<tr>
<td>White</td>
<td>10.3</td>
</tr>
<tr>
<td>Hispanic</td>
<td>9.6</td>
</tr>
</tbody>
</table>

In Tennessee, the preterm birth rate among Black women is 44% higher than the rate among all other women.

DISPARITY RATIO: 1.22

CHANGE FROM BASELINE: Improved

**PRETERM BIRTH RATE BY CITY**

<table>
<thead>
<tr>
<th>CITY</th>
<th>GRADE</th>
<th>PRETERM BIRTH RATE</th>
<th>CHANGE IN RATE FROM LAST YEAR</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nashville-Davidson</td>
<td>D+</td>
<td>10.4%</td>
<td>Better</td>
</tr>
</tbody>
</table>

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TENNESSEE MATERNAL AND INFANT HEALTH

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**Legend**

- ![X](image1.png)
  - **MEDICAID EXPANSION**
  - States who have adopted this policy allow women greater access to preventative care during pregnancy.

- ![✓](image2.png)
  - **MEDICAID EXTENSION**
  - State has recent action to extend coverage for women beyond 60 days postpartum.

- ![−](image3.png)
  - **AVG. PRETERM BIRTH COST**
  - Estimated societal cost includes care for babies, delivery costs, early intervention services, special education and lost productivity.

- ![∗](image4.png)
  - **MATERNAL MORTALITY REVIEW COMMITTEE**
  - These committees are essential to understanding and addressing the causes of maternal death.

- ![✓](image5.png)
  - **PERINATAL QUALITY COLLABORATIVE**
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**TEXAS**

**PRETERM BIRTH GRADE**

D

**PRETERM BIRTH RATE**

11.0%

**INFANT MORTALITY**

Infant mortality rates are an indication of overall health. Leading causes of infant death include birth defects, prematurity, low birth weight, maternal complications and sudden infant death syndrome.

**INFANT MORTALITY RATE**

5.5

**PRETERM BIRTH RATE BY RACE AND ETHNICITY**

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<table>
<thead>
<tr>
<th>RACE/ETHNICITY</th>
<th>PRETERM BIRTH RATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Asian/Pacific Islander</td>
<td>9.2</td>
</tr>
<tr>
<td>American Indian/Alaska Native</td>
<td>11.0</td>
</tr>
<tr>
<td>Black</td>
<td>14.0</td>
</tr>
<tr>
<td>White</td>
<td>9.6</td>
</tr>
<tr>
<td>Hispanic</td>
<td>10.6</td>
</tr>
</tbody>
</table>

In Texas, the preterm birth rate among Black women is 39% higher than the rate among all other women.

**DISPARITY RATIO:**

1.02

**CHANGE FROM BASELINE:**

No Improvement

**PRETERM BIRTH RATE BY CITY**

<table>
<thead>
<tr>
<th>CITY</th>
<th>GRADE</th>
<th>PRETERM BIRTH RATE</th>
<th>CHANGE IN RATE FROM LAST YEAR</th>
</tr>
</thead>
<tbody>
<tr>
<td>Houston</td>
<td>F</td>
<td>11.9%</td>
<td>Worsened</td>
</tr>
</tbody>
</table>

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THREE MATERNAL AND INFANT HEALTH

SELECTED SOCIAL DETERMINANTS OF HEALTH

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<table>
<thead>
<tr>
<th></th>
<th>Texas</th>
<th>United States</th>
<th>HP 2030</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Uninsured among women</strong></td>
<td>7.9%</td>
<td>11.9%</td>
<td>24.7%</td>
</tr>
<tr>
<td><strong>Inadequate prenatal care</strong></td>
<td>14.9%</td>
<td>20.6%</td>
<td></td>
</tr>
<tr>
<td><strong>Poverty among women</strong></td>
<td>8.0%</td>
<td>14.7%</td>
<td>15.8%</td>
</tr>
</tbody>
</table>

**MEDICAID EXPANSION**
States who have adopted this policy allow women greater access to preventative care during pregnancy.

**MEDICAID EXTENSION**
State has recent action to extend coverage for women beyond 60 days postpartum.

**AVERAGE PRETERM BIRTH COST**
Estimated societal cost includes care for babies, delivery costs, early intervention services, special education and lost productivity.

**MATERNAL MORTALITY REVIEW COMMITTEE**
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Scan for details
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**UTAH**

**PRETERM BIRTH GRADE**

C

**PRETERM BIRTH RATE**

9.7%

**INFANT MORTALITY**

Infant mortality rates are an indicator of overall health. Leading causes of infant death include birth defects, prematurity, low birth weight, maternal complications and sudden infant death syndrome.

**INFANT MORTALITY RATE**

5.5

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In Utah, the preterm birth rate among Asian/Pacific Islander women is 22% higher than the rate among all other women.

**DISPARITY RATIO:**

1.17

**CHANGE FROM BASELINE:**

No Improvement

**PRETERM BIRTH RATE BY CITY**

<table>
<thead>
<tr>
<th>CITY</th>
<th>GRADE</th>
<th>PRETERM BIRTH RATE</th>
<th>CHANGE IN RATE FROM LAST YEAR</th>
</tr>
</thead>
<tbody>
<tr>
<td>Salt Lake City</td>
<td>B-</td>
<td>9.1%</td>
<td>Better</td>
</tr>
</tbody>
</table>

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UTAH MATERNAL AND INFANT HEALTH

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**VERMONT**

**PRETERM BIRTH GRADE**

*Grade: B+

**PRETERM BIRTH RATE**

*Rate: 8.4%

**INFANT MORTALITY**

Infant mortality rates are an indication of overall health. Leading causes of infant death include birth defects, prematurity, low birth weight, maternal complications and sudden infant death syndrome.

**INFANT MORTALITY RATE**

*Rate: 6.4
VERMONT MATERNAL AND INFANT HEALTH

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Uninsured among women (15-44)

- Vermont: 4.6%
- United States: 11.9%
- 2030: 7.9%

Inadequate prenatal care

- Vermont: 5.3%
- United States: 14.9%
- 2030: 19.5%

Poverty among women (15-44)

- Vermont: 8.0%
- United States: 14.7%
- 2030: 12.7%

0% 10% 20% 30%

MEDICAID EXPANSION

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MEDICAID EXTENSION

State has recent action to extend coverage for women beyond 60 days postpartum.

AVERAGE PRETERM BIRTH COST

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Legend

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Rates of maternal death and morbidity continue to be unacceptably high in the U.S. Maternal morbidity, social determinants of health, availability of state level health insurance policy and the availability of surveillance and research data affect the health and survival of both mom and baby. While we currently do not have enough to grade states or report on all maternal health indicators, we have highlighted measures with the best available data.

**VIRGINIA**

**PRETERM BIRTH GRADE**

C

**PRETERM BIRTH RATE**

9.9%

**INFANT MORTALITY**

Infant mortality rates are an indication of overall health. Leading causes of infant death include birth defects, prematurity, low birth weight, maternal complications and sudden infant death syndrome.

**INFANT MORTALITY RATE**

5.6

**PRETERM BIRTH RATE BY RACE AND ETHNICITY**

The March of Dimes disparity ratio measures and tracks progress towards the elimination of racial/ethnic disparities in preterm birth. It’s based on Healthy People 2020 methodology and compares the group with the lowest preterm birth rate to the average for all other groups. Progress is evaluated by comparing the current disparity ratio to a baseline disparity ratio. A lower disparity ratio is better, with a disparity ratio of 1 indicating no disparity.

In Virginia, the preterm birth rate among Black women is 54% higher than the rate among all other women.

**DISPARITY RATIO:**

1.14

**CHANGE FROM BASELINE:**

No Improvement

**PRETERM BIRTH RATE BY CITY**

<table>
<thead>
<tr>
<th>CITY</th>
<th>GRADE</th>
<th>PRETERM BIRTH RATE</th>
<th>CHANGE IN RATE FROM LAST YEAR</th>
</tr>
</thead>
<tbody>
<tr>
<td>Virginia Beach</td>
<td>D+</td>
<td>10.4%</td>
<td>Worsened</td>
</tr>
</tbody>
</table>

March of Dimes recommends state policy actions that are rooted in addressing disparities in maternal and infant health outcomes. For more detail visit Policy & Action. For details on data sources and calculations, see Technical Notes. To learn how we are working to reduce preterm birth visit www.marchofdimes.org.

©2020 March of Dimes
Many structural, systemic and environmental factors influence the health of moms and babies, especially for Black, American Indian and Alaska Native people. When looking at factors such as access to maternity care, financial stability and health insurance status, these disparities persist. Systemic racism and the wealth gap in the U.S. deepen many health inequities in our society. The onset of COVID-19 has further magnified preexisting health disparities. March of Dimes is collaborating with others to confront these drivers of health outcomes, while identifying solutions to achieve health equity for all.

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## Washington

### Preterm Birth Grade

**B+**

### Preterm Birth Rate

**8.5%**

### Infant Mortality Rate

**4.7**

### Preterm Birth Rate by Race and Ethnicity

The March of Dimes disparity ratio measures and tracks progress towards the elimination of racial/ethnic disparities in preterm birth. It’s based on Healthy People 2020 methodology and compares the group with the lowest preterm birth rate to the average for all other groups. Progress is evaluated by comparing the current disparity ratio to a baseline disparity ratio. A lower disparity ratio is better, with a disparity ratio of 1 indicating no disparity.

In Washington, the preterm birth rate among American Indian/Alaska Native women is 52% higher than the rate among all other women.

**Disparity Ratio:** 1.28

**Change from baseline:** No Improvement

### Preterm Birth Rate by City

<table>
<thead>
<tr>
<th>City</th>
<th>Grade</th>
<th>Preterm Birth Rate</th>
<th>Change in Rate from Last Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Seattle</td>
<td>A</td>
<td>7.7%</td>
<td>Better</td>
</tr>
</tbody>
</table>

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©2020 March of Dimes
WASHINGTON MATERNAL AND INFANT HEALTH

SELECTED SOCIAL DETERMINANTS OF HEALTH

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<table>
<thead>
<tr>
<th>Indicator</th>
<th>Washington</th>
<th>United States</th>
<th>HP 2030</th>
</tr>
</thead>
<tbody>
<tr>
<td>Uninsured among women (15-44)</td>
<td>11.9%</td>
<td>14.9%</td>
<td>14.7%</td>
</tr>
<tr>
<td>Inadequate prenatal care</td>
<td>19.5%</td>
<td>14.4%</td>
<td>14.9%</td>
</tr>
<tr>
<td>Poverty among women (15-44)</td>
<td>14.7%</td>
<td>14.4%</td>
<td>14.9%</td>
</tr>
</tbody>
</table>

MEDICAID EXPANSION
States who have adopted this policy allow women greater access to preventative care during pregnancy.

MEDICAID EXTENSION
State has recent action to extend coverage for women beyond 60 days postpartum.

AVG. PRETERM BIRTH COST
Estimated societal cost includes care for babies, delivery costs, early intervention services, special education and lost productivity.

PERINATAL QUALITY COLLABORATIVE
These teams work to identify and improve quality care issues in maternal and infant health care.

MATERNAL MORTALITY REVIEW COMMITTEE
These committees are essential to understanding and addressing the causes of maternal death.

To prevent maternal and infant deaths, we need to better understand the causes of severe maternal morbidity (SMM) and those most impacted by it, including racial and ethnic disparities. This starts by standardizing data collection and reporting for maternal and infant health across the U.S. These data will help us to examine factors contributing to SMM, preventable deaths and poor birth outcomes in order to develop evidence-based solutions. To this end, future Report Cards will assess overall rates and disparities of SMM, low-risk cesarean sections and measures of equity in maternal and infant health.

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MORE INFORMATION MARCHOFDIMES.ORG/REPORTCARD

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WEST VIRGINIA

PRETERM BIRTH GRADE

F

PRETERM BIRTH RATE

12.6%

INFANT MORTALITY

Infant mortality rates are an indication of overall health. Leading causes of infant death include birth defects, prematurity, low birth weight, maternal complications and sudden infant death syndrome.

INFANT MORTALITY RATE

7.0

PRETERM BIRTH RATE BY RACE AND ETHNICITY

The March of Dimes disparity ratio measures and tracks progress towards the elimination of racial/ethnic disparities in preterm birth. It’s based on Healthy People 2020 methodology and compares the group with the lowest preterm birth rate to the average for all other groups. Progress is evaluated by comparing the current disparity ratio to a baseline disparity ratio. A lower disparity ratio is better, with a disparity ratio of 1 indicating no disparity.

In West Virginia, the preterm birth rate among Black women is 15% higher than the rate among all other women.

MORE INFORMATION

MARCHOFDIMES.ORG/REPORTCARD

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Selected Social Determinants of Health

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Legend
- ✓ State has or is developing the indicated organization/policy
- ✭ State has the indicated organization and is CDC funded
- ✗ State does not have or is not developing the indicated organization/policy
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To prevent maternal and infant deaths, we need to better understand the causes of severe maternal morbidity (SMM) and those most impacted by it, including racial and ethnic disparities. This starts by standardizing data collection and reporting for maternal and infant health across the U.S. These data will help us to examine factors contributing to SMM, preventable deaths and poor birth outcomes in order to develop evidence-based solutions. To this end, future Report Cards will assess overall rates and disparities of SMM, low-risk cesarean sections and measures of equity in maternal and infant health.

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### Wisconsin

**Preterm Birth Grade**

C-

**Preterm Birth Rate**

10.1%

**Infant Mortality Rate**

6.1

**Preterm Birth Rate by Race and Ethnicity**

<table>
<thead>
<tr>
<th>Race/Ethnicity</th>
<th>Percentage of live births born preterm</th>
</tr>
</thead>
<tbody>
<tr>
<td>Asian/Pacific Islander</td>
<td>8.7</td>
</tr>
<tr>
<td>American Indian/Alaska Native</td>
<td>11.6</td>
</tr>
<tr>
<td>Black</td>
<td>14.8</td>
</tr>
<tr>
<td>White</td>
<td>9.0</td>
</tr>
<tr>
<td>Hispanic</td>
<td>9.8</td>
</tr>
</tbody>
</table>

In Wisconsin, the preterm birth rate among Black women is 63% higher than the rate among all other women.

**Disparity Ratio:** 1.30

**Change from Baseline:** No Improvement

**Preterm Birth Rate by City**

<table>
<thead>
<tr>
<th>City</th>
<th>Grade</th>
<th>Preterm Birth Rate</th>
<th>Change in Rate from Last Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Milwaukee</td>
<td>F</td>
<td>12.9%</td>
<td>Worsened</td>
</tr>
</tbody>
</table>

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SELECTED SOCIAL DETERMINANTS OF HEALTH

Many structural, systemic and environmental factors influence the health of moms and babies, especially for Black, American Indian and Alaska Native people. When looking at factors such as access to maternity care, financial stability and health insurance status, these disparities persist. Systemic racism and the wealth gap in the U.S. deepen many health inequities in our society. The onset of COVID-19 has further magnified preexisting health disparities. March of Dimes is collaborating with others to confront these drivers of health outcomes, while identifying solutions to achieve health equity for all.

STATE HAS OR IS DEVELOPING THE INDICATED ORGANIZATION/_POLICY
- Uninsured among women (15-44)
- Inadequate prenatal care
- Poverty among women (15-44)

LEGEND
- HP 2030
- United States
- Wisconsin

PERINATAL QUALITY COLLABORATIVE
These teams work to identify and improve quality care issues in maternal and infant health care.

MATERNAL MORTALITY REVIEW COMMITTEE
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MEDICAID EXPANSION
States who have adopted this policy allow women greater access to preventative care during pregnancy.

MEDICAID EXTENSION
State has recent action to extend coverage for women beyond 60 days postpartum.

AVERAGE PRETERM BIRTH COST
Estimated societal cost includes care for babies, delivery costs, early intervention services, special education and lost productivity.

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**WYOMING**

**PRETERM BIRTH GRADE**

C

**PRETERM BIRTH RATE**

9.9%

**INFANT MORTALITY RATE**

5.3

**PRETERM BIRTH RATE BY RACE AND ETHNICITY**

The March of Dimes disparity ratio measures and tracks progress towards the elimination of racial/ethnic disparities in preterm birth. It’s based on Healthy People 2020 methodology and compares the group with the lowest preterm birth rate to the average for all other groups. Progress is evaluated by comparing the current disparity ratio to a baseline disparity ratio. A lower disparity ratio is better, with a disparity ratio of 1 indicating no disparity.

In Wyoming, the preterm birth rate among American Indian/Alaska Native women is 48% higher than the rate among all other women.

**DISPARITY RATIO:**

1.23

**CHANGE FROM BASELINE:**

No Improvement

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**MEDICAID EXTENSION**
State has recent action to extend coverage for women beyond 60 days postpartum.

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**PUERTO RICO**

**PRETERM BIRTH GRADE**

**F**

**PRETERM BIRTH RATE**

**11.8%**

**INFANT MORTALITY RATE**

**6.6%**

**PRETERM BIRTH RATE BY RACE AND ETHNICITY**

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In Puerto Rico, the preterm birth rate among White women is 14% higher than the rate among all other women.

**DISPARITY RATIO:**

**1.14**

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©2020 March of Dimes
SELECTED SOCIAL DETERMINANTS OF HEALTH

Many structural, systemic and environmental factors influence the health of moms and babies, especially for Black, American Indian and Alaska Native people. When looking at factors such as access to maternity care, financial stability and health insurance status, these disparities persist. Systemic racism and the wealth gap in the U.S. deepen many health inequities in our society. The onset of COVID-19 has further magnified preexisting health disparities. March of Dimes is collaborating with others to confront these drivers of health outcomes, while identifying solutions to achieve health equity for all.

Puerto Rico
United States
HP 2030
Poverty among women (15-44) 11.9
Inadequate prenatal care 14.9
Poverty among women (15-44) 14.7

Legend
☑ State has or is developing the indicated organization/policy
☒ State has the indicated organization and is CDC funded
☒ State does not have or is not developing the indicated organization/policy
☒ State is above estimated U.S. cost
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Additional details on these future measures can be found here.
PRETERM BIRTH: DEFINITION AND SOURCE

Preterm birth is a birth with less than 37 weeks gestation based on the obstetric estimate of gestational age. Data used in this report card came from the Puerto Rico Department of Health, Demographic Registry and Vital Statistics. The preterm birth rates shown at the top of report card was calculated from the 2019 Birth Certificate, Demographic Registry and Vital Statistics data. Preterm birth rates in the trend graph are from the Demographic registry and Vital Statistics 2009-2019 data. Preterm birth rates for bridged racial and ethnic categories were calculated from the 2016-2018 Demographic Registry and Vital Statistic data. Preterm birth rates were calculated as the number of premature births divided by the number of live births with known gestational age multiplied by 100.

GRADING METHODOLOGY

Expanded grade ranges were introduced in 2019. Grade ranges remain based on standard deviations of final 2014 state and District of Columbia preterm birth rates away from the March of Dimes goal of 8.1 percent by 2020. Grades were determined using the following scoring formula: (preterm birth rate of each jurisdiction – 8.1 percent) / standard deviation of final 2014 state and District of Columbia preterm birth rates. Each score within a grade was divided into thirds to create +/-intervals. The resulting scores were rounded to one decimal place and assigned a grade. See the table for details.

INFANT MORTALITY RATE

Infant mortality rates were calculated using the 2019 Death and Birth Certificate, Demographic Registry and Vital Statistics data period linked infant birth and infant death data. Infant mortality rates were calculated as the number of infant deaths divided by the number of live births multiplied by 1,000. Infant mortality rate in the trend graph is from the 2008-2018 Demographic Registry and Vital Statistics provided by the Puerto Rico Department of Health.

PRETERM BIRTH BY RACE/ETHNICITY OF THE MOTHER

Mother’s race and Hispanic ethnicity are reported separately on birth certificates. Rates for Hispanic women include all bridged racial categories (white, black, American Indian/Alaska Native and Asian/Pacific Islander). Rates for non-Hispanic women are classified according to race. The Asian/Pacific Islander category includes Native Hawaiian. To provide stable rates, racial and ethnic groups are shown on the report card if the group had 20 or more preterm births in each year from 2016-2018. To calculate preterm birth rates on the report card, three years of data were aggregated (2016-2018). Preterm birth rates for not stated/unknown race are not shown on the report card.

SELECTED SOCIAL DETERMINANTS OF HEALTH

March of Dimes recognizes the importance of certain risk factors that are associated with preterm birth. Three of these contributing factors are highlighted for each state and are taken from Healthy People 2030. These risk factors are poverty in women (age 15-44 years), lack of health insurance in women (15-44 years) and inadequacy of prenatal care.

A woman was considered uninsured if she was not covered by any type of health insurance. The uninsured percent is calculated among women ages 15-44. Persons in poverty are defined as those who make less than 100% of the poverty threshold established by the US Census Bureau. The Federal poverty threshold for a family of three was $20,598 in 2019. Poverty is reported for women 15-44 years. Adequacy of prenatal care is measured using the Adequacy of Prenatal Care Utilization Index, which classifies prenatal care received into 1 of 4 categories (inadequate, intermediate, adequate and adequate plus) by combining information about the timing of prenatal care, the number of visits and the infant’s gestational age.

### Table: Preterm Birth Rate Range and Scoring Criteria

<table>
<thead>
<tr>
<th>GRADE</th>
<th>PRETERM BIRTH RATE RANGE</th>
<th>SCORING CRITERIA</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>Preterm birth rate less than or equal to 7.7%</td>
<td></td>
</tr>
<tr>
<td>A-</td>
<td>Preterm birth rate of 7.8 to 8.1%</td>
<td></td>
</tr>
<tr>
<td>B+</td>
<td>Preterm birth rate of 8.2 to 8.5%</td>
<td></td>
</tr>
<tr>
<td>B</td>
<td>Preterm birth rate of 8.6 to 8.9%</td>
<td></td>
</tr>
<tr>
<td>B-</td>
<td>Preterm birth rate of 9.0 to 9.2%</td>
<td></td>
</tr>
<tr>
<td>C+</td>
<td>Preterm birth rate of 9.3 to 9.6%</td>
<td></td>
</tr>
<tr>
<td>C</td>
<td>Preterm birth rate of 9.7 to 10.0%</td>
<td></td>
</tr>
<tr>
<td>C-</td>
<td>Preterm birth rate of 10.1 to 10.3%</td>
<td></td>
</tr>
<tr>
<td>D+</td>
<td>Preterm birth rate of 10.4 to 10.7%</td>
<td></td>
</tr>
<tr>
<td>D</td>
<td>Preterm birth rate of 10.8 to 11.1%</td>
<td></td>
</tr>
<tr>
<td>D-</td>
<td>Preterm birth rate of 11.2 to 11.4%</td>
<td></td>
</tr>
<tr>
<td>F</td>
<td>Preterm birth rate greater than or equal to 11.5%</td>
<td></td>
</tr>
</tbody>
</table>
MATERNAL AND CHILD HEALTH INDICATORS

MATERNAL MORTALITY REVIEW COMMITTEE — The committees can be made up of representatives from public health, nursing, maternal-fetal medicine, obstetrics and gynecology, midwifery, patient advocacy groups and community-based organizations. States that have an MMRC are better equipped to prevent pregnancy-related deaths by having a better understanding of what is causing them in their state or city. The measure is provided by the CDC ERASE MM Program (https://www.cdc.gov/reproductivehealth/maternal-mortality/erase-mm/index.html) and is categorized as having and/or developing the committee, having the committee with funding from CDC, or not having or developing the committee.

PERINATAL QUALITY COLLABORATIVE — The PQC involves partnerships with families, key state agencies and organizations in order to identify and initiate programs or procedures that increase the quality of care in clinical settings. PQC’s work focus on collaborative learning among healthcare providers and the PQC. Data is provided by the CDC at: https://www.cdc.gov/reproductivehealth/maternalinfanthealth/pqc-states.html and the measure is reported as either having and/or developing the collaborative, having the collaborative with funding from CDC, or not having and/or developing the collaborative.

CALCULATIONS

All birth certificate and death certificate calculations were conducted by the Puerto Rico Department of Health.

REFERENCES

2 US Department of Health and Human Services, Healthy People 2030. Available at: https://health.gov/healthypeople
4 Kotelchuck M. An evaluation of the Kessner Adequacy of Prenatal Care Index and a Proposed Adequacy of Prenatal Care Utilization Index. Am J Public Health 1994;84(9):1414-1420.
7 Center for Disease Control (CDC), Perinatal Quality Collaboratives. Available at: https://www.cdc.gov/reproductivehealth/maternalinfanthealth/pqc.htm
STATE SPOTLIGHTS
SUMMARY STATEMENT

The Alabama Department of Public Health, Bureau of Family Health Services has implemented evidence-based, comprehensive programs to ensure positive maternal health and birth outcomes for women and infants across the state. In 2016, the top three contributors to infant death were chromosomal malformations, disorders related to preterm births and low birth weight, and sudden infant death syndrome. Additionally, 20 percent of women of childbearing age were uninsured. These issues are marked by significant racial and ethnic disparities. Initiatives have been enacted to address these adverse health events and disparities through program implementation, evaluation and quality improvement of services, and engagement and collaboration with various stakeholders.

ACTIVITIES AND RESULTS

In 2018, the State of Alabama Infant Mortality Reduction Plan (IMR-Plan) was adopted and launched in collaboration with multiple partner agencies. This seven-part initiative utilizes cutting edge strategies to reverse the current trend of infant deaths in Alabama over a course of five years in three pilot counties. One of the strategies within the initiative is focused on preconception and interconception health of women. Led by a multidisciplinary team of nurses and nurse practitioners, social workers, and peer supporters, women receive education on healthy lifestyles and optimal nutrition, as well as services for chronic disease management (e.g., hypertension). Other strategies for the IMR-Plan include: increasing the utilization of alpha hydroxyprogesterone caproate; increasing awareness, outreach, and education for best safe sleep and breastfeeding practices; ensuring women are delivering at a hospital that is most appropriate for the needed level of care; expansion of home visitations, using the Nurse-Family Partnership model; and increasing screenings for women who may suffer from substance abuse, depression, and domestic violence.

In addition, the IMR-Plan includes efforts beyond the pilot counties to reduce infant mortality. The Fetal and Infant Mortality Review program has been expanded to ensure that 100 percent of infant deaths are reviewed. In this way, multifactorial determinants of infant deaths, including social, economic, environmental, and health factors, can be determined and used to improve community resources and systems of care for maternal and infant health. To further support infant mortality reduction, long-acting reversible contraceptives (LARC) are provided in birthing hospitals for immediate placement after delivery. The Health Services Initiative includes an ALL Babies program, which provides low-cost healthcare coverage for pregnant women who meet eligibility requirements. Benefits include a plethora of services – maternity, hospital, preventive, and emergency care; mental health and substance abuse services; care coordination; and pharmacy, dental, and vision services. Program enrollment strategies which alleviate the burden of traditional enrollment procedures allow more women to be reached (e.g., citizenship documentation is not required, no age limit, no premiums for coverage). The use and expansion of telemedicine allows women in rural areas access to appropriate clinical services, particularly for those in need of high-risk obstetrical care. Telehealth access is available in sixty-five of the sixty-six counties throughout the state and can readily support a range of services, including but not limited to maternal-fetal medicine, nephrology, neurology, cardiology, and behavioral health.

The work of various partner organizations compliments the bureau’s efforts to address factors which impact birth outcomes. The Alabama Perinatal Quality Collaborative advances health quality and equality for mothers and babies. In 2019 and 2020, efforts were focused on work to improve/address birth certificate accuracy, neonatal opioid withdrawal syndrome, and maternal hypertension. Within Jefferson County, one of Alabama’s largest metropolitan areas, the Birmingham Healthy Start Plus program focuses specifically on health outcomes for African American women before, during, and after pregnancy. Thus, the program aims to address and reduce disparities in perinatal health among a group most heavily affected.

The University of Alabama’s University Medical Center’s Interventions to Minimize Preterm and Low birth weight Infants through Continuous Improvement Techniques (IMPLICIT) Program is a family medicine network that looks at modified risk and works to improve the health of pregnant women before pregnancy. The modified risks identified by
IMPLICIT are smoking, depression, family planning and multivitamin use. The program’s goal is to talk to women of childbearing age at primary care physician visits. Mothers with children aged zero to twenty-four months are assessed and screened to identify any of the modifiable risks. Those who screen positive are linked to appropriate resources. Lastly, the bureau initiated the Alabama Maternal Mortality Review Program (MMRP) and committee (AL-MMRC) in 2018. The AL-MMRC convened to determine the scope of maternal mortality and key considerations, such as causes of deaths, contributing factors, and preventability. Through these comprehensive reviews, the committee will put forth actionable recommendations and preventative strategies to combat maternal mortality and morbidity. The combined work of both the bureau and partners is a hallmark of the goal we all strive for in positively impacting maternal and child health.

Through the aforementioned programs and many others, Alabama is well on its way to reverse the narrative of disparate maternal health and birth outcomes, which have far too long affected mothers and babies. In 2016, the infant mortality rate was 9.1 deaths per 1,000 live births. In 2018, the lowest rate in Alabama’s history was recorded at 7.0 deaths per 1,000 live births. Though this decline may not be directly attributable to the programs described, it is the collective efforts geared towards this issue which have and will continue to improve maternal health and birth outcomes.
SUMMARY STATEMENT

Arizona’s Department of Health Services (ADHS), in collaboration with numerous statewide partners including the March of Dimes, is leading, supporting, and implementing a variety of programs and activities to promote equitable and optimal care and protective factors for mothers and infants before, during, and after pregnancy.

ACTIVITIES AND RESULTS

IT BEGINS AT HOME

Arizona’s home visiting programs are a pillar of our work to care for our state’s mothers and to address health disparities and prevent preterm birth. Home visiting programs (Health Start and High Risk Perinatal programs as well as the Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV), funded Healthy Families (through Arizona Department of Child Safety), Nurse-Family Partnership (through Maricopa County Department of Public Health, Pima County Health Department, and First Things First), Family Spirit (through Coconino County and San Carlos Apache Tribe) and Parents as Teachers (through four Native American tribes: Cocopah, Gila River, Hualapai, and Navajo Nation)) connect families to essential preventive and primary care. In 2019, Arizona’s home visiting programs provided 48,112 home visits statewide. Two recent assessments, the 2020 Title V Maternal and Child Health Needs Assessment and the Prenatal-to-3 Policy Impact Center’s State Roadmap, identified Arizona’s home visiting programs as a major strength in the area of Maternal and Child Health.

Arizona is a large state with a shortage of medical providers, particularly in sparsely populated rural areas of the state. Programs like the High-Risk Perinatal Program (HRPP) provide critical linkages to community nursing services and transportation to specialized care, when required, and assure that high-risk pregnant women and critically ill newborns receive timely access to appropriate medical care — without regard to geographic location or ability to pay. In 2019, HRPP transported 777 critically ill pregnant women and 813 critically ill newborns to a higher level of care hospital (and/or transported them back home for continuing care).

Additionally, Arizona’s home visiting programs work to increase awareness on postpartum warning signs, using the Association of Women’s Health, Obstetric and Neonatal Nurses’ Post-Birth Warning Signs Education. This is supplemented with Arizona-specific training providing further insight on what maternal mortality and morbidity look like in Arizona and why knowing postpartum warning signs is important.

EFFORTS TO ADDRESS MATERNAL MORBIDITY AND MORTALITY

Under Senate Bill 1040 (2019), ADHS established and led the Advisory Committee on Maternal Fatalities and Morbidity, which provided recommendations for enhancing data collection and reporting for the Arizona Maternal Mortality Review process. To reduce preventable maternal deaths and morbidities, ADHS launched a multidisciplinary Maternal Health Task Force (MHTF), which aims to improve health outcomes for birthing individuals before, during, and after pregnancy and ensure that they have access to quality maternal healthcare. The task force includes a Tribal Maternal Health Task Force specifically dedicated to improving maternal health and birth outcomes for indigenous women in Arizona.

In partnership with the Arizona Perinatal Trust and the March of Dimes, the MHTF engaged over 36 stakeholders representing the state agencies, maternal health experts, healthcare systems, and organizations, including the Governor’s Office, to develop a maternal mortality action plan. This laid the foundation for the Governor’s Goal Council Maternal Mortality Action Plan when the Governor’s Goal Council identified Maternal Mortality as a Breakthrough Project in 2019. Initiatives assigned this designation are provided with technical support and monitoring by the Governor’s Office to ensure their successful implementation.
The Maternal Mortality Action Plan identified five key goals to address maternal mortality and outlined activities to work towards those goals, based on inputs and recommendations from the MHTF: 1) increase pregnant and postpartum women’s awareness of postpartum warning signs; 2) improve access to care; 3) support workforce and workforce capacity; 4) improve surveillance; and 5) support systems of care.

In 2019 ADHS was awarded one of nine national awards for the Health Resources & Services Administration (HRSA)-funded State Maternal Health Innovation Program (MHIP). That same year we also received the five-year Preventing Maternal Deaths: Supporting Maternal Mortality Reviews grant from the Centers for Disease Control (CDC). These federally-funded grants have allowed ADHS to increase staff time and activities for the Maternal Mortality Review Program, apply innovative strategies to address the disparate maternal morbidity burden for Black and American Indian women, and incorporate telemedicine as a strategy to increase access to care for underserved and rural populations.

With the support and direction of the MHTF, Arizona became a member state of the Alliance for Innovation on Maternal Health (AIM). The AIM Steering Committee chose to address severe hypertension in pregnancy, a cause of preterm labor, as their first quality improvement initiative.

**COVID RELATED WORK**

In order to ensure ongoing access to care during the COVID-19 public health emergency, the Bureau of Women’s and Children’s Health (BWCH) within the Arizona Department of Health Services (ADHS) led the Telehealth Task Force to facilitate the expansion of telemedicine in Arizona in response to Governor Doug Ducey’s Executive Order 2020-15. The Telehealth Task Force engaged with stakeholders from the public and private sector to identify barriers to adopting telemedicine to deliver health services during the pandemic. Specifically, for pregnant women, the use of telemedicine provides access to continuity of prenatal services and monitoring while minimizing or eliminating exposure to COVID-19.

The Telehealth Task Force identified a number of clinician and patient-related barriers, which include: an overall lack or limited knowledge of telemedicine technology, limited understanding of telehealth requirements and regulations (i.e., reimbursements, coding, HIPAA regulations, etc.), lack of awareness of where telemedicine services could be accessed in Arizona, and broadband and connectivity issues. The Telehealth Task Force, through stakeholders’ engagement, compiled a list of short and long-term strategies that were submitted to the ADHS Health Emergency Operations Center for consideration. Among the short-term strategies identified were: providing training and technical assistance focused on telemedicine; developing telemedicine informational materials for providers and patients; increasing outreach and information about telemedicine availability through public service announcements, website, and social media; and supporting broadband/connectivity software.

To assist patients in locating telemedicine sites in Arizona that offer services based on a Sliding Fee Scale, the Telehealth Task Force implemented an interactive Sliding Fee Scale telemedicine site mapper. The Telehealth Task Force initiated discussions with Arizona Health Care Cost Containment System (AHCCCS), Arizona’s Medicaid agency, on reimbursement parity for telehealth services. In addition, the Telehealth Task Force is in the process of establishing an Interservice Agency Agreement with the University of Arizona Telemedicine Program to assist with training and technical assistance on telehealth and to help develop materials for patients and clinicians to assist their efforts in accessing or fully adopting telemedicine.

The COVID-19 pandemic also prompted ADHS to reach out to home visiting contractors to provide guidance and technical assistance. MIECHV, Health Start, and HRPP home visiting programs released guidance requesting that contractors continue to implement home visiting programs as outlined in program guidelines, following model developer guidance, with fidelity. Each of the home visiting models successfully adjusted home visits to continue reaching families via alternative methods, such as virtual visits or phone calls, to ensure that families continue to
receive the services they need at the same high-quality level that they would receive in-person. In 2021, MIECHV, Health Start, and HRPP home visiting programs will continue to monitor the impacts of COVID-19 and work collaboratively with federal and state partners, contractors, and subcontractors to support virtual home visits and monitor emerging trends and guidance to adapt services as needed.

In addition to the general COVID-19 dashboard hosted on the ADHS website, the Maternal Health page has COVID-19-related resources and information that are specific to maternal health.
SUMMARY STATEMENT

Through collaboration and partnerships, the California Department of Public Health; Maternal, Child and Adolescent Health Division (CDPH/MCAH) continues to work to decrease the state’s preterm birth rate. In addition to current programs, CDPH/MCAH has expanded efforts to reduce disparities in preterm births. In 2018, the preterm birth rate among births to non-Hispanic Black mothers was more than 1.5 times the preterm birth rate among non-Hispanic White mothers (12.2% vs. 7.6%).

ACTIVITIES AND RESULTS

CDPH/MCAH continues to focus on the impact of racism on Black birthing people to develop and revise strategies to improve Black birth outcomes. Data from the Maternal and Infant Health Assessment (MIHA) survey reveal a sharp increase in chronic worry about racial discrimination among Black women. In 2018, nearly seven in ten Black women worried often about experiencing racial discrimination for themselves or a loved one, and three-quarters of Black women had experienced incidents of racial discrimination. Worry about racial discrimination has been linked to preterm birth, maternal hypertension and symptoms of maternal depression.

To address the health and wellbeing of Black women and their babies, CDPH/MCAH funds 14 Local Health Jurisdictions to implement the Black Infant Health Program (BIH). BIH currently uses a group-based approach with complementary life-planning services to help pregnant and parenting Black women develop life skills, set and attain health goals, learn strategies for managing stress, and build social support and empowerment. New funding granted to the BIH program in 2018 allowed the program to expand beyond the group model and provide case management to birthing people to meet their needs. An evaluation of the BIH Program was conducted covering three state fiscal years (July 1, 2015 – June 30, 2018), focusing primarily on implementation of the prenatal group component. The goal of the evaluation was to examine implementation and participants’ outcomes of the program. The evaluation covered five focus areas: population served; services received by participants and participants’ perceptions of the program; services provided by staff and staffs’ perceptions of the program; implementation fidelity and contextual factors supportive of fidelity; and participants’ intermediate health and health-related outcomes. Dissemination of the evaluation results is forthcoming.

In addition, CDPH/MCAH also funds 11 counties to implement the Perinatal Equity Initiative (PEI). PEI requires each county to utilize a community advisory board to determine which of five interventions to implement in order to complement the BIH program and further support Black families. Counties have chosen to implement fatherhood or partner interventions, implicit bias trainings, group prenatal care, personal support models, connecting birthing people to doulas/midwives, home visiting models, and preconception/interconception care models. Each county is also developing a public awareness campaign that focuses racism as a risk factor for preterm birth. PEI is utilizing the Results Based Accountability (RBA) framework to monitor local implementation and outcomes.

In 2018-21, CDPH/MCAH, with the March of Dimes and other preconception health leaders, is participating in the California Preconception CoIIN to pilot clinical practices to improve health before pregnancy with a particular focus on supporting low-income women and women of color.
COVID RELATED WORK

COVID-19 has affected all MCAH programs and populations. Some examples of what CDPH/MCAH is doing to support the response are:

- Developing and updating guidance for people who are pregnant and breastfeeding
- Providing funding flexibilities to support program participants and the MCAH population with meeting their basic needs, e.g., with baby items, food/food services, clothing, hygiene items, mental health support, technology and school supplies
- Adapting program implementation to use virtual platforms and allow participants to safely receive services and maintain continuity of support and connection. As an example, through collaboration with the California Department of Health Care Services, the California Perinatal Services Program (CPSP) released guidance on telehealth for delivering Medi-Cal-covered services during the pandemic.
- Adapting the MIHA survey questionnaire and protocol to monitor secondary impacts of the COVID-19 pandemic related to topics including income, employment, childcare, food security, intimate partner violence, mental health, substance use, healthcare access and program participation

CDPH/MCAH recognizes that the COVID-19 pandemic is likely to cause severe long-term impacts on health and well-being, and will continue to assess, adapt, and strive to meet the needs of babies and families in California.
SUMMARY STATEMENT

The goal of Every Woman Connecticut Learning Collaborative (EWCTLC) is to increase the expertise and self-efficacy of healthcare workers, to implement routine pregnancy intention screening and appropriate care, education, and services to improve birth spacing and increase pregnancy intentionality and discussions around health before and between conceptions. Overall, 326 providers from 39 cities/towns and 9 statewide programs have been involved.

Collaborative members receive access to implement One Key Question (OKQ) screening in their respective sites and programs, by asking women, “Would you like to become pregnant in the next year?” The screening tool is used by community-based teams of clinicians and partners in communities with high volume/burden of poor birth outcomes who demonstrate readiness for this program. The Connecticut Department of Public Health is incorporating One Key Question screening into several Department of Mental Health and Addiction Services sponsored programs that provide “whole person care” to women and men of childbearing ages who are suffering from mental health illness, substance use disorders, and other chronic comorbidities within a behavioral health medical home framework.

ACTIVITIES AND RESULTS

This work will be done under the auspices of the Connecticut Women’s Consortium. Consulting services will continue to be provided by Marijane Carey of Carey Consulting. Carey Consulting will manage the Advisory Committee, expand partnerships, respond to evaluation recommendations and engage members of Every Woman Connecticut (EWCT) to increase provider knowledge and self-efficacy. Carey Consulting will help providers deliver promising and evidence-based education, care, and services related to pregnancy intentionality, optimal birth spacing, and pre-/interconception health.

Based on the evaluation report prepared for the Advisory Committee by Dr. Megan Smith through Elevate, a policy lab at Yale School of Medicine, beginning this year evaluation recommendations will be addressed. The recommendations are: 1) clarifying EWCT’s mission and objectives; 2) clarifying the role of Advisory Committee members and other involved in EWCT’s work; 3) sustainability planning and 4) measuring impact. Internal work will also include updating the OKQ manual to include information and guidance on providing care during a pandemic. It also includes information on how federal and state legislation, (The Child Abuse Prevention and Treatment Act (CAPTA) and the Comprehensive Addiction Recovery Act (CARA)), impacts women who deliver an infant believed to have been substance exposed. The manual update will be informed by the information and resources presented in the two EWCT-sponsored workshops on CAPTA and CARA.

Externally EWCT is strategically planning to maximize its reach by establishing relationships with other organizations and entities. The specific groups are:

- The Women's Services Practice Improvement Collaborative (WSPIC) - WSPIC is co-sponsored by the Department of Mental Health and Addiction Services (DMHAS) and the CT Women’s Consortium. Collaborative members are the Department’s treatment programs for women. WSPIC is a conduit for a rapid response by EWCT to needs identified WSPIC members.
- The Women and Opioid Workgroup - This is another DMHAS-sponsored group designed to communicate and coordinate services for women dealing with opioid use.
- The Medicaid Strategy Group (MSG) - MSG is a coalition of health advocates working together to improve and protect the quality and reach of HUSKY/Medicaid programs in Connecticut through administrative and legislative advocacy.
- Health Equity Solutions, COVID-19 Outreach - This ongoing outreach effort is collecting information about the impact on COVID-19 on underserved communities to help center health equity in Connecticut’s response and recovery efforts.
• The ACES Task Force - This Task Force was convened by the Women’s Consortium to support efforts to address racism in trauma. Participation in these groups expands partnership potential as it increases EWCT’s platform for addressing pre/interconception healthcare, health equity and racism from a comprehensive and holistic perspective.

Participation in WSPIC and the Women and Opioids Workgroup supports and strengthens EWCT relationship with DMHAS, which includes the Department offering, for the past two years, EWCT-sponsored workshops on OKQ/human sexuality/reproductive health and on implicit bias as well as creating an on-line OKQ training module.

CT Coalition Against Domestic Violence’s (CCADV) representative on the EWCT Advisory Committee will help to facilitate opportunities to present OKQ to CCADV member agencies.

EWCT will continue to support the use of the Xedos system developed by Stellar RX, a pharmacy distribution services company based in Pennsylvania. The XpeDose system is a unit that can be placed at a clinical site, for the stocking and distribution of a comprehensive array of contraceptive methods, at no cost to the site, essentially erasing the barrier of upfront provider cost for stocking. This also ensures same-day availability of the patient’s chosen form of birth control. Stellar RX has encountered a number of unexpected challenges to obtaining Medicaid approval to offer the XpeDose in Connecticut. Once a Medicaid approval is obtained, EWCT will work with Stellar RX in introducing the system to community health centers.

EWCT will use the EWCT Learning Collaborative (EWCTLC) as the major vehicle to increase provider expertise and self-efficacy in implementing: routine pregnancy intention screening and appropriate care, education, and services. The aim is to ultimately improve birth spacing, increase pregnancy intentionality, as well as increase the proportion of Connecticut women who deliver a live birth and report discussing pre-/interconception health with a healthcare worker. The Collaborative will also support implementers of OKQ.

Currently there are over 350 EWCTLC members consisting of OKQ implementers and/or those who have attended an EWCT sponsored training. EWCTLC members will receive at least quarterly Notes of Interest through Constant Contact supported emails and at least two trainings on topics identified by EWCTLC members or through the groups identified above (WSPIC, the Women and Opioid Workgroup, Health Equity Solutions’ COVID-19 Outreach, and the ACES Task Force). Opportunities for local networking and one on one meetings will also be offered virtually until it is safe to resume in person meetings.

Planned Parenthood will continue to assure that all clients who receive a reproductive health exam participate in the development of a Reproductive Life Plan. The discussions are conducted by a licensed healthcare provider and the client.

COVID RELATED WORK

Every Women Connecticut (EWCT) and Every Woman Connecticut Learning Collaborative (EWCTLC) will be addressing and responding to the impact of COVID-19 and the increased awareness around health equity, social justice, and social determinants of health. With guidance from EWCT Advisory Committee members and implementers of OKQ, lessons learned from providing clinical and non-clinical services during the perinatal period in a pandemic will be shared with EWCTLC, the MCH Coalition and the SHIP Advisory Council.
SUMMARY STATEMENT

For the past decade the State of Delaware’s Department of Health and Social Services (DHSS), the Division of Public Health (DPH), has focused on providing the medical care necessary for high-risk pregnant women. This effort has been spearheaded by the current Governor appointed, Delaware Healthy Mother and Infant Consortium (DHMIC), which has helped decrease the infant mortality rate from 9.3 deaths per 1,000 live births to 7.5. This is still, however, higher than the national average of 5.9 deaths per 1,000 (2011-2015). Although both Black and White infant mortality rates have fallen, the racial disparity persists at 12.3, in 2014-2018 the Black infant mortality rate is still 2.7 times higher than the White infant mortality rate. Going forward, interventions need to do a better job at addressing disparities and addressing social context issues. Factors such as obesity, diabetes, hypertension, chronic disease, smoking, stress, race and racism, maternal age, all contribute to preterm birth along with multiple social determinants. The available research is clear that the path to more significant and sustained improvement in the statewide rate and eliminating the persistent racial disparity lies in addressing social determinants of health, the social context factors that compromise the health of women and families, which then makes them susceptible to poor health outcomes. An emerging effort to address social determinants of health needs to be expanded to help decrease the percentage of women in the state who have a preconception health issues. Resolving these issues before pregnancy will help enable women to carry a healthy pregnancy. Two of the biggest factors driving the infant mortality rate in Delaware are preterm births and low birthweight births. With the collaboration of Delaware's many MCH stakeholders through the Delaware Healthy Mother and Infant Consortium (DHMIC), the Healthy Women Healthy Baby (HWHB) Program 2.0, medical intervention and the HWHB Zones mini grants, there have been local and statewide interventions throughout Delaware to provide the necessary care and support for women and babies who are considered high risk for poor birth outcomes.

ACTIVITIES AND RESULTS

Since 2019, six HWHB Zones (zones are based upon zip codes and census tracts), local place-based strategies, were formed in an effort to bring more awareness to programs, better educate and serve women of reproductive age (15-44 years old) and give a clarion voice to Black maternal health grassroots organizations statewide. HWHB Zones are a part of the Infant Mortality reduction work in Delaware, in which the mission is to spread evidence-based and place-based strategies to improve social determinants of health and equity in birth outcomes, which compliments the medical intervention, HWHBs 2.0.

The HWHBs 2.0 program implements an outcomes-oriented and learning collaborative approach where continuous quality improvement (CQI) is marked essential when collecting data and during the resulting analysis to ensure continuous improvement throughout the contracting process. Being entirely outcome focused ensures that the program takes an equity-driven approach that fosters mutual accountability between the funder, provider and participant in developing and carrying out services focused on reaching at least six benchmark indicators (i.e., screening for pregnancy intention. The indicators are as follows: increase the percentage of women who receive a well woman visit; screen for substance misuse; increase the proportion of HWHB participants that abstain from tobacco use; social determinants of health screening, depression screening and referral, etc.).

DPH worked with Health Management Associates (HMA) to serve as a backbone agency to develop a mini-grant process to award funding for local communities/organizations to implement local interventions that address social determinants of health in priority communities throughout Delaware in 2019. These first-ever mini-grants support the ongoing effort to lessen the unfortunate disparities in birth outcomes between Black and White women by using small-scale innovative strategies on both a state and local level. The grantees were provided with coaching and technical assistance (TA) that included collaborative meetings and individual coaching for the life of the funding. Beginning on January 1, 2021, the second cycle of funding will be available to two or three new mini grantees (who must be classified as new non-traditional partners, broad-based group of nonprofit organizations and/or new grass roots community-based organizations) to address social determinants of health with the aim of improving health outcomes for women and babies. Existing mini grantees will have money to support and continue their HWHB zone programs through June 2022. All the capital afforded to these organizations through these grants will help better serve women of reproductive age in each HWHB zone and find interventions to address the root causes of infant mortality across Delaware that contribute towards the disparity. For more information, visit www.DEThrives.com/minigrants.
SUMMARY STATEMENT

Through collaboration and partnerships, the Indiana Department of Health, Maternal and Child Health Division has been working to reduce the overall infant mortality rate. One way that Indiana is working to support pregnant women and their family is the development and implementation of an obstetrician (OB) Navigation program. In partnership with Indiana’s Family and Social Services Administration (FSSA) and the Department of Child Services (DCS), the Health Department is working to proactively connect women to local support services in her community.

ACTIVITIES AND RESULTS

In 2019, the Indiana Department of Health partnered with the Department of Child Services and the Family and Social Services Administration (FSSA) to launch an initiative that connects expectant mothers to health, social and other services they need via a navigator who provides personalized support, resources and referrals through the first year of their babies’ lives. Indiana’s Governor Holcomb signed House Enrolled Act 1007 into law in 2019 to create this project, and the state legislature committed $6.6 million toward the program over two years.

The program, which is transitioning to be known as My Healthy Baby, officially launched in January of 2020 with a goal of serving 20 counties by the end of 2020. At this point, the initiative is focusing on women enrolled in Indiana’s Medicaid program. The partnership hopes to expand services to all 92 counties over the next three years.

Indiana Medicaid at FSSA provides the contact information for women who are recently identified as pregnant to the Maternal and Child Health (MCH) Division at the Department of Health. Call Specialists in the MOMS Helpline, a longstanding, phone-based section within MCH, call the women and offer to connect them to home-visiting services in their communities. If the woman agrees, the Call Specialist then sends the referral directly to the appropriate local support service. The home-visiting provider will then contact the women directly to complete the referral and begin home-visiting services.

Crucial to the success of My Healthy Baby is the partnership the Health Department has with local home-visiting providers. MCH has a long-standing relationship with Indiana Healthy Families, (administered by the Department of Child Services), Nurse Family Partnership, and many other evidence-based or informed services provided by organizations across Indiana. MCH staff meet with local support providers and home-visiting services in each of the My Healthy Baby counties to determine each services’ unique eligibility requirements. Together, My Healthy Baby and the local programs develop a referral plan that makes sense for each county.

The launch of My Healthy Baby is part of a continued investment in projects to reduce Indiana’s infant mortality rate. In addition to the federally funded Maternal, Infant, and Early Childhood Home Visiting (MIECHV) and Health Resources & Services Administration (HRSA) Title V Block Grant programs, the state of Indiana has also provided state funding for community grants, administered by MCH, that support a variety of established and innovative ways to improve the health and well-being of mothers and their families.

In the last few years, MCH has fostered a partnership with Indiana 211 in order to expand the number of resources Call Specialists in MOMS Helpline can share when helping families. Around this same time, MCH embedded Help Me Grow into MOMS Helpline services. Help Me Grow creates ability to connect families to appropriate developmental screening. In 2018, Help Me Grow Indiana was established to help the network of community resources work like a power grid. When the grid functions well, families can plug in to an organized flow of resources and easily access the ones they need. Help Me Grow Indiana is available to all children, including those whose families may have concerns or simply want to learn more about their child’s development.
Indiana has seen a three-year reduction in its infant mortality rate from 7.3 deaths per 1,000 live births in 2017 to 6.5 in 2019. A critical part of this reduction is the continued decline in infant deaths due to perinatal risks. MCH and the Health Department recognize the importance of providing wraparound services to women before, during, and after pregnancy, and believe that home visiting and building community systems is a key strategy to help do this.

As of September 2020, the My Healthy Baby project had attempted to reach 3,440 women, using phone calls and letters. MCH had successfully made contact with 1,220 (35.5%) women and 649 women (over half, or 53.2%, of women with whom we made contact) have agreed to be referred to a home visiting program in their community. The project is working to obtain data on what percentage of referred women go on to enroll in local programs.

**COVID RELATED WORK**

Indiana quickly published a number of guidance documents during the beginning stages of the pandemic in order to inform the public and clinicians on topics related to pregnancy and parenting. Throughout the response, the Department participated in clinically focused webinars hosted by the Indiana Hospital Association. In addition, Maternal and Child Health funded projects were encouraged and allowed (as appropriate) to redirect activities to become telehealth-based.
**SUMMARY STATEMENT**

The Kansas Title V Maternal and Child Health (MCH) program continues to support development and sustainability of Kansas Perinatal Community Collaboratives (KPCCs), aimed at reducing infant mortality and improving birth outcomes through group prenatal education and integration efforts (tobacco cessation, mental health, breastfeeding, safe sleep, oral health, physical activity, and more). Data indicates communities with successful collaboratives have better outcomes related to infant mortality, preterm birth, and breastfeeding. The primary goal has been to build capacity for existing collaborations and expand the model to include both rural and urban communities experiencing disparities in birth outcomes. This model provides the backbone for dissemination of targeted public health programming and positions communities for success and sustainable community collaboration.

**ACTIVITIES AND RESULTS**

The Kansas Community Collaborative Model utilizes a Collective Impact framework and emphasizes community needs to ensure local relevance. Currently there are 16 KPCC sites with more than 30 locations pending implementation. View a map of existing sites and implementation progress on the KPCC website. Since inception in 2010, KPCCs have been a driving force behind improved birth outcomes in Kansas. Overall, KPCCs have a lower preterm birth rate than the state (6.7% compared to 9.4%). Attention should also be directed to the reduced infant mortality rate (IMR) per 1,000 live births (5-year average) from pre-implementation to post-implementation in two of the longest running sites. The Geary County IMR decreased significantly from 11.9 in 2005-2009 to 5.7 in 2014-2018. The Saline County IMR decreased from 9.0 in 2005-2009 to 5.5 in 2014-2018.

The KPCC model is changing the perinatal care delivery paradigm statewide by creating updated, more effective systems of care. Program capacity building is dependent on shared resources (e.g., patients, staff, facilities, educational materials, toolkits) and services (e.g., clinical, public health) across the patient care continuum. Standardization of screening, referral, education and shared data collection/measurement processes (DAISEY) have been pivotal to Kansas expansion efforts. Integration toolkits, such as the Mental Health Toolkit, as well as toolkits on tobacco cessation, breastfeeding, safe sleep, and oral health have been produced, piloted, and implemented to facilitate integration into this infrastructure.

The prenatal education component of the collaborative model, featuring the March of Dimes (MOD) Becoming a Mom/Comenzando bien® (BaM/Cb) curriculum, has been standardized to ensure program fidelity across communities. An agreement is now required for all sites to gain access to training and program resources. In partnership with the University of Kansas (KU) Center for Public Partnerships & Research, MCH developed referral and evaluation systems. Resources identified as needed for statewide expansion and protection of program fidelity and MOD trademark agreement have been developed and include: 1) guidance documents and training videos; 2) standardized resources such as session slides, lesson plans, activity plans, and supplemental handouts; 3) promotional material templates and 4) a private website portal for direct access to resources. All supplements to the MOD curriculum have been translated to Spanish (partnership with the KU School of Medicine-Wichita, Department of Pediatrics and a workgroup with representation from five Spanish dialects). The extensive tools and resources have provided the mechanism for statewide expansion and support both growth and future sustainability.

The first regional perinatal community collaborative (launched in SWK) is now operational with four lead sites serving a total of 16 counties. The SWK collaborative has come to be the greatest cross-sector collaborative formed to date, with the region’s four leading (and competing) birthing facilities, public health departments, FQHCs, large employers, and other community partners working collaboratively with each other. Partners within this collaborative have worked to develop regional marketing tools, press releases, shared class schedules, and numerous other resources, all to engage pregnant women across the region while offering multiple class locations and schedules to choose from.

For a brief overview of the KPCC program and its impact, see the Fact Sheet. For an illustrated view of the KPCC approach and its impact, see the Infographic. Read more about the program, impact, and evaluation findings in the most recent State Aggregate Report.

It’s important to note that many other MCH investments related to women’s health, Long Acting Reversible Contraceptives (LARC), pregnancy intention screening, and stillbirth prevention are aligned with and/or integrated into the KPCC model.
Additionally, the KPCC model addresses Kansas Maternal Mortality Review Committee recommendations driven by findings from cases.

**Women's Health:** It has been a priority for KPCCs utilizing the MOD BaM/Cb® curriculum to focus on women's health in the interconception period, including but not limited to the importance of annual well visits. Activities include the integration of personal health plans and the development of a reproductive life plan for each woman completing the program. The handout “Keeping Healthy After Pregnancy” and resource “Show Your LOVE – Steps to a Healthier me!” by the CDC have been incorporated into the lesson and activity plans. Participants set goals for their health plan, such as: scheduling their postpartum appointment and annual well-woman exam with their provider; planning for the prevention of an unplanned pregnancy; healthy diet and exercise plan; planning for daily consumption of at least 400 mcg of folic acid; updating and maintaining vaccinations; practicing stress management techniques; and managing chronic health conditions. Program evaluation data shows improvements in knowledge and planned behavior related to education received. A Well-Woman Toolkit and Reproductive Life Plan resource will be released in 2020. An integrated prescreening tool is launching July 2021 with training and assistance.

**LARC:** A LARC Learning Collaborative launched last year will continue with a Lunch and Learn series. An integration toolkit was released online in 2019.

**Pregnancy Intention Screening (One Key Question® Trainings):** The One Key Question® (OKQ) evidence-based initiative implementation continues, focused on asking women and men about their reproductive goals (Would you like to become Pregnant in the Next Year?). A formal partnership with Power to Decide was established to offer free trainings in 2019, greater than 100 participants attended and are now certified to integrate the model into practice and ongoing technical assistance is provided. Coming in 2020, Kansas will be the first state in the nation to offer OKQ, reproductive well-being, and unconscious bias training virtually (piloting with a group of 8-15 providers).

**Stillbirth Prevention:** A formal partnership with Healthy Birth Day will continue to support the Count the Kicks (CTK) campaign to prevent stillbirth. Since August 2018, approximately 90,000 pieces of material have been sent statewide, 1,500 app downloads have completed and full-access to videos and educational materials is available (posters, brochures, appointment cards—English and Spanish). Read the KS success story: Deanna Cummings. In 2020 we will also be adding social media and sharing data and information with the MCH network, having CTKs webinar done for midwives and doulas, and CTKs magnet will be added to educational materials providers can order for free.

**COVID RELATED WORK**

**COVID + Pregnant Support Services:** The Kansas MCH Woman/Maternal Health Consultant and Perinatal/Infant Clinical Consultant have been working with the Bureau of Family Health/Title V MCH Director and Epidemiology Team to identify COVID-19 positive pregnant women. The staff follow up by telephone and provide support and contact is made at least once a week via telephone for those who accept the support. The consultant inquires about how they are feeling physically, emotionally, and determines if they are in need of any services or support. They are followed until after delivery and through the early postpartum period when possible. Information about local resources and referral information is provided as needed, and connections are made with providers as needed for peer-to-peer learning and support.

**COVID-19 Resources:** The Kansas MCH team has continuously provided resources and information for the Kansas/KDHE COVID-19 Resource Microsite targeting pregnant and postpartum women and providers/partners who care for them at the community level. Resources include, but are not limited to, the following: Guidance and FAQs for the pregnant and perinatal population (monitoring with leading organizations such as CDC, ACOG, AAP, etc.); guidance for home visitors; telehealth toolkit; best practices in telehealth for preventive services; overview related to food insecurity and emergency food providers; domestic violence and sexual assault/intimate partner violence resources (with the Kansas Coalition Against Sexual and Domestic Violence) (for providers and victims/survivors).

All resources have been made available online, disseminated to local providers/through statewide networks, and are continuously updated.

The Spotlight documents were prepared by state health departments to highlight state progress toward improving health outcomes for moms and babies. ©2020 March of Dimes
SUMMARY STATEMENT

In Kentucky, the preterm birth rate had its peak in 2007 at 15.2 percent. This has slowly decreased to 11.3 percent in 2018, but still higher than national average of 10.0 percent. A related measure is a slow decline is Kentucky’s infant mortality rate, 6.7 per 1,000 live births in 2017, but nearing the U.S. rate of 5.8 per 1,000 live births in 2018. Complications of preterm birth comprise the number one cause of infant deaths in Kentucky, with sudden unexpected infant deaths (SUID) a close second. Of the SUID cases, in one of four cases, preterm birth was an associated risk factor. Because of disparities in preterm birth rates and infant mortality by race and geographic area in Kentucky, the Department for Public Health Maternal and Child Health Division (DPH-MCH) has focused on the Social Determinants of Health (SDoH) as a major driver for Kentucky’s birth outcomes.

ACTIVITIES AND RESULTS

The programs of Kentucky DPH-MCH are carried out in partnership with other Departments and Offices within the Cabinet for Health and Families Services (Medicaid Services, Community-Based Services, Behavioral Health, Office of Health Equity, Office of Children with Special Health Care Needs), as well as organizations (March of Dimes, Kentucky Perinatal Association, Kentucky Hospital Association, Birthing hospitals, Universities) and other partners and stakeholders. The DPH-MCH programs use community based and multidisciplinary approach and strongly consider the SDoH such as poverty, nutrition, safe housing, access to care, in addressing health and the preventable and modifiable risk factors. The Kentucky DPH-MCH guides the Local Health Departments (LDHs) with evidence-informed strategies for providers in reaching out to their communities. Statewide programs such as Health Access Nurturing Development Services (HANDS) and the Special Supplemental Nutrition Program for Women, Infants and Children (WIC) are accessed through the LDHs. The MCH Division also participated in the Association of Maternal and Child Health Programs (AMCHP) Collaborative Improvement and Innovation Network (CoIIN) to reduce infant mortality by addressing SDoH. The Kentucky DPH-MCH together with the Office of Health Equity, the Louisville Metro Healthy Start Program, and the March of Dimes represented the state’s effort in the CoIIN. Major efforts were directed to effect systems change through regulations and by increasing awareness of providers of the importance of addressing SDoH in improving maternal and child health outcomes. As a result, a statement was added to the clinical service guidelines and administrative references used by all LDHs about health equity. Additionally, LDHs in receipt of MCH Title V Grant funds for targeted public health initiatives, were required to complete the MCH-sponsored web-based implicit bias course. The number reached over two years in four statewide and eight regional MCH conferences totaled 1,552 participants. These conferences would not have been successful without the partnerships with March of Dimes and the Kentucky Perinatal Association. Topics included at these meetings were preterm birth, infant mortality, neonatal abstinence syndrome, sudden unexpected infant death, plan of safe care, and discharge planning and follow-up of preterm and high-risk infants. Other topics and data presented were related to equity, racial and geographic disparities and bias.

Because of the association of preterm birth with infant mortality and the high rate of SUID, Kentucky embarked on a media campaign to reach urban and rural areas through TV, radio, Facebook, and print (posters, brochures, booklets, and etc.). During the conferences, providers were apprised of the safe sleep campaign and encouraged to promote the ABCD of safe sleep (A - Alone, B - Placed to sleep on infant’s back, C- Crib, D - Danger of Distraction or when the caregiver is impaired). The number of SUID cases in Kentucky was 71 in 2012 with a steady rise to 103 in 2016. On the following year, the statewide Safe Sleep Campaign was heavily promoted with engagement at all levels of providers and since then, the rate has decreased to 62 in 2018. Please see [CDC website link](https://www.cdc.gov) and [Kentucky Safe Sleep](https://kentuckysafesleep.com).

COVID RELATED WORK

DPH-MCH continued its surveillance and statewide service delivery programs during the COVID-19 pandemic. Activities have shifted to telehealth and teleintervention, especially with the clinics for children with special health care needs, the early intervention services and home visiting program. Since USDA provided a waiver on the requirement of in-person enrollment for WIC benefits, the number of mothers and infants receiving benefits increased. In person conferences and meetings are held virtually.
SUMMARY STATEMENT

Louisiana has worked tirelessly to reduce preterm births and infant mortality through: focused interventions with health systems and families, Medicaid reforms, increased access to quality reproductive health services, sexually transmitted infection (STI) prevention, testing, and treatment and smoking cessation for Louisiana residents of childbearing age. Louisiana has taken concrete steps to address racial disparities in birth outcomes like those seen in our premature birth report card. These actions are being taken across the spectrum, including with members of the Louisiana Perinatal Quality Collaborative. They require a long-term commitment with multiple partners to implement effective changes. We still have a long way to go, but we are confident that by continuing to work together with health care providers and health systems, community leaders and individual Louisiana residents, we can change the future of our children’s health.

ACTIVITIES AND RESULTS

In 2020, the Louisiana Department of Health, Office of Public Health, Bureau of Family Health used the Perinatal Periods of Risk (PPOR) approach to identify potential strategies that would have the greatest impact reducing on fetal, neonatal, and post-neonatal mortality, of which prematurity is a key factor. Through PPOR, suggested actions for the prevention of fetal and infant deaths, including those associated with prematurity, include: focusing efforts on preconception health, reducing unintended pregnancies, addressing maternal risk factors such as high blood pressure and other chronic diseases, and easy access to family planning.

With continuity of Louisiana’s Medicaid Expansion, people in Louisiana have had greater access to family planning and STI services. More consistent health coverage for women across the life span (preconception, post-partum, and interconception periods) improves maternal health. Reducing the number of Louisiana babies born to mothers with STIs helps reduce premature births, and reducing preterm births reduces the number of days that babies spend in neonatal intensive care units, which improves infant health trajectories.

In addition, Medicaid covers all FDA-approved contraceptive methods, including long-acting, reversible contraceptives (LARCs), which is critical to improving birth spacing and reducing the 60% of unintended pregnancies in Louisiana, both of which contribute to poor birth outcomes. For decades Office of Public Health Parish Health Units (OPH-PHU), funded by Title X and the state, have been a critical safety net for these services. Medicaid expansion has increased access to these services for all, both in and outside of the PHUs.

The Louisiana Department of Health (LDH) has partnered on several additional activities to improve birth outcomes for both mothers and infants, because healthy mothers lead to healthy babies. Since 2014, LDH, Medicaid, and all Louisiana hospitals have committed to curb the practice of early inductions and cesarean sections, implement extensive birth outcomes quality metrics for Medicaid managed care organizations, and introduce payment reform. The Bureau of Family Health leads the Louisiana Perinatal Quality Collaborative (PQC). The PQC is a network of perinatal care providers, public health professionals, and patient and community advocates who work to advance equity and improve outcomes for women, families, and newborns in Louisiana. This team of people works together to better understand and respond to the complex challenges women face during the perinatal period in order to catalyze transformational change to improve population health and achieve equity.

Furthermore, LDH has worked with the March of Dimes (MOD) to identify actions to reduce severe maternal morbidity and mortality as well as infant mortality. This work has a special focus on racial disparities in mortality, specifically through membership on the Healthy Moms, Healthy Babies workgroup and by co-hosting a summit on addressing infant mortality disparities.
COVID RELATED WORK

The Louisiana Department of Health has implemented strategies to protect the lives of pregnant and postpartum women and promote healthy birth outcomes during the pandemic in several ways. First, LDH greatly expanded access to telehealth services and quickly implemented telehealth options both via Medicaid coverage and through programs serving families. Notably, the Maternal, Infant, Early Childhood Home Visiting (MIECHV) programs shifted to a telehealth model to minimize disruption in family coaching and support provided to enrolled families. In addition, the Reproductive Health Program implemented telehealth and introduced additional options for people using injectable LARCs so they would not have a lapse in contraception and also minimize the need for an office visit during clinic closures.
SUMMARY STATEMENT

Over the past year we have made progress in the number of sleep related deaths. We created a new website and campaign to help educate families about safe sleeping environments for babies, www.safesleepforme.org. Through a survey, we learned that some of the families we aimed to help, did change the way they were putting their baby down to sleep. More importantly, they were talking to others about it.

ACTIVITIES AND RESULTS

Safe sleep materials were created and sent to MaineCare families who were pregnant or had a baby in the past year. A crib distribution program was also set up to ensure that hospitals who were safe sleep certified had access to cribs to distribute. This was a cross-department project. TV and radio advertisements, along with purchased media presence were also created and distributed.

COVID RELATED WORK

Public Health Nursing continued to provide visits for pregnant and postpartum women. In addition, Maine Families Home Visiting provided virtual visits with families. Additionally, work was done with the immunization program to increase the number of children who received their immunizations on time or were provided the opportunity to get caught up. This was done through clinics with Public Health Nursing and promotional messaging.
SUMMARY STATEMENT

Since 2000, the infant mortality rate in Maryland has decreased by 20% from 7.4 infant births per 1,000 live births to 6.1 in 2018. Through collaborations and partnerships, the Maryland Department of Health has been working to improve birth outcomes in the state.

ACTIVITIES AND RESULTS

BABIES BORN HEALTHY

The Babies Born Healthy (BBH) program is a care coordination program that reduces stressors that can lead to infant mortality. BBH addresses prenatal mothers’ immediate needs, including social needs, health education, and access to healthcare including behavioral health. BBH administers programming to seven of Maryland’s 24 jurisdictions with the highest numbers and highest rates of infant deaths. These seven jurisdictions accounted for 78% of all infant deaths in Maryland from 2012 through 2016. The Maryland Department of Health dedicates a total of $2.1 million dollars to these efforts. In the State Fiscal Year 2020, 483 participants were enrolled. BBH programs also provided 1,734 intimate-partner violence, 1,710 smoking cessation, and 1,825 depression assessments.

PILOTING A SEVERE MATERNAL MORBIDITY REVIEW PROCESS

In July 2020, the Maryland Maternal Health Innovation (MHIP) Program launched a pilot program in six birthing hospitals to begin a severe maternal morbidity (SMM) review process. This pilot is the first phase of a larger initiative to establish a statewide SMM review program in Maryland. MHIP is a collaboration between the Maryland Department of Health, Johns Hopkins University, Maryland Patient Safety Center, and the University of Maryland, Baltimore County. Currently, there are six birthing hospitals who are piloting the SMM review process.

PERINATAL STANDARDS OF CARE TO IMPROVE VLBW AND LBWS

In April 2019, Maryland Department of Health and the Maryland Institute for Emergency Medical Services Systems (MIEMSS) updated the Maryland Perinatal Standards to reflect the latest standards of perinatal and neonatal care by the American Academy of Pediatrics and the American College of Obstetrics and Gynecology. Standards of care are maintained through a review process with MIEMSS and MDH for Level III and Level IV perinatal centers. MDH and the Maryland Morbidity Mortality and Quality Review Committee follow the very low birth weight (VLBW) who are born at the Level I and Level II hospitals. The Level I and Level II hospitals are also asked to complete a self-assessment form to review their compliance with the Perinatal Standards, and site visits to those hospitals are completed. The percentage of low birth weights (< 2,500 grams) has remained stable at 8.9% in 2017 and 2018. The percentage of very low birth weights has slightly decreased from 1.8% in 2017 to 1.7% in 2018.

MARYLAND FAMILY PLANNING

The Maryland Family Planning Program (MFPP) provides high-quality, culturally-sensitive family planning, preconception health, and teen pregnancy prevention services. Typically the program serves approximately 64,000 women and men each year in over 62 sites statewide. MFPP provides awards to local health departments, federally-qualified health centers, and private non-profit providers such as Planned Parenthood for clinical and other preventive healthcare services for low-income, under-insured and uninsured individuals.

Women who practice family planning can avoid high-risk births and reduce their chances of having a baby who will die in infancy. There is a strong negative correlation between levels of contraceptive use and levels of infant mortality. Family planning firstly, allows very young women, whose infants are prone to higher mortality, to delay childbearing until a later age; secondly, allows older and higher parity women, whose infants are at a higher risk of dying, to stop having babies; thirdly contributes to longer intervals between births and fourth, reduces maternal mortality.

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BREASTFEEDING IN MARYLAND
The Supplemental Nutrition Program for Women, Infants and Children (WIC) provides nutrition education, breastfeeding promotion and support, selected supplemental foods and health referrals for over 120,000 Maryland women, infants, and children a year. The State WIC Office works together with 86 local clinics across the state. The Maryland Hospital Breastfeeding Policy Committee works with birthing hospitals in the state to either become Baby Friendly™ or to commit to the Maryland Hospital Breastfeeding Policy Guidelines. There are currently 11 hospitals designated as Baby-Friendly™, which means the hospitals support breastfeeding through standards implemented by United Nations Children's Fund (UNICEF) and World Health Organization (WHO). In 2017, 89% of mothers in Maryland initiated breastfeeding, an increase of 10% since 2010.

IMPROVING SURVEILLANCE AND QUALITY INITIATIVES TO IMPROVE INFANT HEALTH
In an effort to reduce infant and child mortality, the Maryland Department of Health provides $1.3 million dollars in funding to local health departments to address drivers of maternal and infant deaths in Maryland. In 2018, the leading causes of infant death included prematurity, low birth weight, congenital abnormalities, Sudden Unexpected Infant Death (SUID), maternal complications of pregnancy, and cardiovascular disorders. Local jurisdictions develop, implement and align local recommendations and implement activities aimed at improving rates of infant and child fatalities. Several jurisdictions are developing programs aimed at increasing social support for women during the perinatal and postpartum periods. To guide implementation of these support groups, select health departments have selected the March of Dimes Becoming A Mom curriculum to provide prenatal education to women and families in their jurisdictions.

HIGHLIGHTING COLLECTIVE IMPACT IN BALTIMORE CITY WITH B'MORE FOR HEALTHY BABIES
In 2009, B'more for Healthy Babies (BHB) was launched to address the high infant mortality rates in the city. Using the social-ecological framework, BHB works to strengthen policy, systems, healthcare services, and community support for women and families throughout the life course and address the social, economic, and racial inequities that affect health.

By 2018, BHB had made significant progress on other key indicators: 1) decrease in infant mortality by 35%, 2) decrease in infant mortality Black-White disparity by 64%, 3) decrease teen births by 49%, 4) decrease in teen birth black-white disparity by 75%, and 5) decrease in sleep-related infant deaths.

HIGHLIGHTING COLLECTIVE IMPACT IN FREDERICK, MARYLAND
The Frederick County Maternal Child Health Collaborative led by the Frederick County Health Department, is conducting a community engaged needs assessment to identify the factors contributing to health disparities in maternal and infant health outcomes. This project, aimed at Black women in two neighborhoods in Frederick, will identify possible community-based solutions and determine how best to implement with community input and support from the Maternal Child Health (MCH) Collaborative. This project hopes to promote best practices for the delivery of essential health services for women and their infants.
COVID RELATED WORK

COVID-19 SURVEILLANCE AND PREGNANCY
In August, Maryland began participating in the Surveillance for Emerging Threats to Mothers and Babies Network (SET-NET) program in collaboration with the Centers for Disease Control (CDC). MDH is expanding current activities to conduct surveillance of COVID-19 in pregnancy and monitor pregnancy and infant outcomes. This project aims to 1) Support surveillance systems developed to address emerging threats for COVID-19 to mothers and babies, to identify and monitor adverse outcomes of infections on pregnant women and their infants, 2) Work collaboratively with state, local, and territorial health departments to implement longitudinal follow up of pregnant women with evidence of infections to detect adverse pregnancy and fetal/infant outcomes; 3) Work with clinical experts and clinical professional organizations to develop recommendations for enhanced follow up and targeted screening and evaluation of infants; and 4) Develop and disseminate clinical guidance and health communications materials and tools for mothers and babies and their providers when new evidence emerges.

WIC WAIVERS
The Supplemental Nutrition Program for Women, Infants and Children (WIC) received waiver approval from the United States Department of Agriculture Food and Nutrition Service (USDA-FNS) to waive certain program requirements defined in federal regulations. These waivers allowed approximately 60,000 moms and babies to receive services from the program safely and obtain some supplemental foods not routinely authorized by the program. Waivers received related to providing direct services included:

Physical Presence: waived the requirement that all individuals seeking to enroll or re-enroll in WIC do so in person (i.e., physical presence).

Remote Benefit Issuance: removed the barrier for remote issuance of WIC benefits, such that participants do not have to come into the clinic to pick up WIC EBT cards.

Food Package Substitution: permitted appropriate substitutions for types and amounts of certain WIC-prescribed foods if their availability was limited.

Food Package Medical Documentation: allowed for the extension of existing prescriptions, for up to two months, for participants that were unable to contact their health care provider.

Separation of Duties: allowed single employees to determine eligibility for all certification criteria and issue food instruments and supplemental foods for the same participant to promote social distancing at time of certification.

HOME VISITING
The Maternal, Infant and Early Childhood Home Visiting (MIECHV) program funds 14 sites in 10 jurisdictions with families most at-risk for poor outcomes. To support Maryland home visitors doing front line work, MDH began a COVID-19 Resource List that can be found here. This list includes resources and virtual supports for the home visiting workforce.

The MDH home visiting training center asked the home visiting workforce what they could do to best support home visitors and supervisors — and received a resoundingly strong response to a topic on caring for themselves during these stressful times. A Self Care and Stress Management webinar was conducted in August 2020. The webinar recording is available here.

The Spotlight documents were prepared by state health departments to highlight state progress toward improving health outcomes for moms and babies.
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SUMMARY STATEMENT

In Massachusetts (MA), opioid-related deaths have increased 450% since 2000, with all communities in the state affected. In 2015 Governor Baker signed into law Chapter 55 of the Acts of 2015 to permit linkage and analysis of state data to guide decision making. Analysis of linked data underscored high rates of opioid use disorder (OUD) in pregnant and postpartum women, with the greatest risk of fatal overdose occurring 7–12 months after delivery. The incidence of Neonatal Abstinence Syndrome (NAS) has also been increasing, five times higher than the national average in 2015. Using the Pregnancy to Early Life Longitudinal Data System (PELL), MA has created a statewide NAS dashboard which includes data that address a variety of different measures across three key time periods: pregnancy (prenatal), birth (neonatal), and infancy (post-discharge). This fosters a unique collaboration that combines clinical care, quality improvement, public health, and community support. Examples of key initiatives to address perinatal opioid use are described below.

ACTIVITIES AND RESULTS

MA implemented the Pregnancy Risk Assessment Monitoring System (PRAMS) opioid call-back survey (OCBS) from October 2019 to April 2020 to evaluate women several months after they completed the initial PRAMS survey, and at a time when women with substance use disorders are at greatest risk of having an opioid overdose. The addition of a targeted set of questions to the PRAMS survey will allow Massachusetts Department of Public Health (MDPH) to assess maternal behaviors and experiences related to the use of prescription pain relievers and other opioids, and to help understand the effects of opioid use and misuse on the health of mothers and infants in MA. OCBS data will support and enhance state surveillance systems to better identify community needs and policy gaps.

The MA Perinatal Neonatal Quality Improvement Network (PNQIN) is an umbrella collaborative that unites the efforts of the MDPH, the Neonatal Quality Improvement Collaborative (NeoQIC), the MA Perinatal Quality Collaborative (MPQC) and the MA chapter of March of Dimes. PNQIN has been working for the past four years on addressing perinatal opioid use by targeting outcomes during pregnancy, at delivery, and during the first year of life. Examples of PNQIN’s current goals include increasing provider training in stigma, bias, and trauma-informed care; increasing the number of birth hospitals with referral plans to improve the follow-up of infants with NAS after discharge; and increasing the percent of infants at risk for NAS who are referred to Early Intervention (EI) and Early Head Start by hospital discharge (leading to an increase in the percent of infants with NAS receiving EI services from 36.7% in 2015 to 70.3% in 2017).

MDPH and MassHealth (the state Medicaid program) participated in technical assistance supported by the Centers for Medicare and Medicaid Services as part of the Medicaid Innovation Accelerator Program (IAP) to improve severe maternal morbidity (SMM). The goal of the IAP was to strengthen partnerships while developing data analytic capacity to support reduction of maternal mortality and SMM in the Medicaid population, and support implementation of the Alliance for Innovation on Maternal Health patient safety bundle focused on obstetric care of women with OUD. MDPH and MassHealth had three objectives: 1) perform data linkage between claims data and vital statistics, 2) build capacity for data analysis that can contribute to eventual elimination of inequities in health outcomes, and 3) identify risk factors among Medicaid enrollees (including gaps in accessing care).

In 2019, with funding from the Substance Abuse and Mental Health Services Administration, MA began implementing a new home visiting initiative called FIRST (Families in Recovery Support) Steps Together for opioid affected families. This program aims to provide parenting and recovery support by peer family recovery support specialists. Services are provided by peers who are themselves in recovery from addiction and who often also had experience with the child welfare and criminal justice systems. Program services include: integrated home-based peer recovery support, individual and group parenting interventions, care coordination, Plans of Safe Care, mental health services, dyadic therapy and systems advocacy. An implementation study and implementation toolkit will be completed in FY21.

With supplemental funding from the CDC to develop strategies to reduce child abuse and neglect for families affected by OUD, the Essentials for Childhood initiative is coordinating with communities implementing FIRST Steps Together.
to develop a community perinatal opioid action plan for families with OUD. This includes engaging with families with OUD and in recovery in a Network Mapping exercise to examine the community continuum of care from the family perspective; engaging with community leaders and providers to define the community response to opioid and substance use; and convening a community Perinatal Opioid Coalition to develop an action plan that includes multiple perspectives and could serve as a community Plan of Safe Care. In the coming year, this work will be completed and documented as a model for other communities.

COVID RELATED WORK

Massachusetts is responding to the impact of COVID-19 on pregnant women and infants in a variety of ways, such as: supporting data collection and surveillance activities (e.g. establishing a surveillance system to monitor outcomes for pregnant women with lab-confirmed COVID-19 and their neonates and adding COVID-19-related questions to the PRAMS survey); facilitating access to concrete supports (e.g. unemployment benefits, diapers); allowing flexibility in use of state and federal funding to respond to the pandemic, when possible; and ensuring policy and decision making consider MCH needs and interests.
SUMMARY STATEMENT

All Michigan mothers, infants and families have the right to optimal health. Disparities that show up in every facet of maternal and infant health are rooted in long standing systemic inequities, often based on race. In 2018, there was a threefold difference in infant mortality rates by maternal race/ethnicity, 14.5 Black non-Hispanic babies died for every 1,000 live births, whereas 4.6 White non-Hispanic babies died for every 1,000 live births. That same year, there were 6.6 infant deaths for every 1,000 live births, well above the national rate of 5.7. Institutions, policymakers, government, communities, as well as extended families and friends, play an integral role in improving these health outcomes and eliminating disparities. In September 2019, Michigan released the *Mother Infant Health & Equity Improvement Plan (MIHEIP)* with the vision of zero preventable deaths and zero health disparities. Priority areas of the MIHEIP are health equity, healthy girls, women and mothers, optimal birth spacing, full term and healthy weight babies; safe sleep for infants and mental, emotional and behavioral well-being.

ACTIVITIES AND RESULTS

During the last year, many successes have improved the lives of mothers, infants, and families in Michigan. At the 2020 State of the State address, Michigan renewed its commitment to maternal and infant health, and recommended expanding access to comprehensive health care and social support for women and infants.

Stakeholders in Michigan, along with the Michigan Department of Health and Human Services (MDHHS) have worked to align programs and strengthen partnerships statewide; the Statewide Perinatal Quality Collaborative comprised of nine Regional Perinatal Quality Collaboratives (RPQCs) is an integral part of this work. The RPQCs conducted quality improvement projects and implemented data-driven strategies to address their regions most pressing maternal infant health challenges. The multisector stakeholders addressed social determinants of health and equity while elevating the voices of Michigan’s families.

Several RPQCs have prioritized the implementation and expansion of universal screening for Substance Use Disorder (SUD), utilizing telehealth and electronic screening. RPQCs worked with hospitals to implement rooming-in models of care, and several of Michigan’s birthing hospitals have joined initiatives to safely decrease pharmacological treatment of newborns, support maternal-infant dyad and prevent and/or decrease Neonatal Intensive Care Unit (NICU) length of stays. To decrease stigma and focus on prevention, RPQCs and birthing hospitals have provided clinical and community education and created educational materials for families affected by SUD. Additionally, RPQCs have leveraged innovative partnerships to co-locate services and coordinate care with Medication Assisted Treatment (MAT) providers and perinatal care providers.

The Regional Perinatal Quality Collaboratives (RPQCs) aligned with the Michigan Alliance for Innovation in Maternal Health (MI AIM) to decrease maternal mortality and morbidity. MI AIM has been working on the implementation of the Obstetric Hemorrhage and Severe Hypertension Patient Safety Bundles in Michigan’s birth hospitals. The partnership is driving forward maternal health initiatives in southeast Michigan, specifically the metro-Detroit area. MI AIM is addressing health disparities by supporting implementation of additional patient safety bundles focusing on racial and ethnic disparities and postpartum care and safety.

To provide actionable and locally relevant joint recommendations Michigan’s Fetal Infant Mortality Review (FIMR) and Michigan Maternal Mortality Surveillance (MMMS) underwent quality improvement and alignment. Both programs worked to adopt a health equity framework to address and incorporate equity into case reviews and recommendations. The FIMR Network developed a Health Equity Toolkit and MMMS released the Maternal Deaths in Michigan Data Update, emphasizing racial disparities.
MDHHS has partnered with maternal infant health stakeholders to work towards zero health disparities. RPQCs have worked to increase access to implicit bias trainings statewide and assist in the creation of internal health equity policies in hospitals and other organizations serving moms and babies. MDHHS created the Maternal Infant Health, Health Equity website to provide trainings, and resources to partners in Michigan. Governor Gretchen Whitmer prioritized health equity across Michigan by: requiring all healthcare professionals to receive training to recognize and mitigate implicit bias and recognizing and addressing racism as a public health crisis, making health equity a major goal for MDHHS, and requiring implicit bias training for all State of Michigan employees.

In alignment with Michigan’s work to ensure emotional and behavioral wellbeing and eliminate disparities, Child & Adolescent Health Centers and Title V have worked to ensure comprehensive screening, assessment, and treatment for children and focus on implementing bullying prevention initiatives in schools.

In an effort to capture the voices of families and strengthen partnerships, Michigan’s Safe Sleep program aligned with breastfeeding initiatives to increase knowledge of best practices in monthly webinars, create and disseminate safe sleep messaging made by families, and train professionals in safe sleep, motivational interviewing and risk reduction. MDHHS is slated to release the second edition of the Michigan Breastfeeding Plan in partnership with stakeholders in early 2021.

The third annual Mother Infant Health Summit was held in September 2020. Over 650 people took part in the virtual event which focused on the root causes of systemic racism, health equity and implicit bias. The Michigan Alliance for Innovation on Maternal Health (MI AIM) hosted a national update during the Summit, discussed the continued work in Michigan to eliminate preventable maternal mortality and conducted a strategic planning session. The Mother Infant Health & Equity Improvement Plan (MIHEIP) - Year One Highlights document was released at the Summit, giving a brief overview of the successes in maternal infant health statewide, and acknowledging the invaluable commitment of stakeholders.

**COVID RELATED WORK**

Michigan’s maternal infant health stakeholders worked throughout the pandemic to protect and promote the health and wellbeing of moms, babies, and families. MDHHS provided up-to-date information to stakeholders by aligning programs and ensuring Maternal Infant Health communications were distributed widely.

RPQCs worked to ensure access to care and support by adapting care models to virtual platforms (ex. Centering, Baby Café’s, prenatal care, prenatal education, and other support groups). RPQCs have championed the expansion of virtual services by adding resources on maternal infant health, smoking cessation, and SUD into existing initiatives, such as MyStrength and MiRecovery. Michigan also worked to increase access to behavioral healthcare through the release of Stay Well, a statewide telehealth resource for self-care and wellness.

The RPQCs partnered with Birthing Hospitals, Health Plans, and the Preeclampsia Foundation to provide patient education materials and blood pressure cuffs to high-risk women to improve the safety of telehealth prenatal care. While many hospitals struggled with the pandemic and quickly changing policies, Michigan’s Hospital Association partnered to host weekly calls with labor and delivery units statewide to ensure quality, data-driven care was afforded to families. In addition, to decrease the impact of the pandemic on maternal health outcomes, MI AIM modified the Hemorrhage & Hypertension recommendations to address the impact on Patient Safety Bundle implementation.

Michigan’s Home Visiting programs rapidly responded to policy changes in response to COVID-19. Their programs switched to virtual visits, incorporated telehealth and filled social service gaps caused by the pandemic. Along with home visiting and many other local services, Women, Infant and Children (WIC) program quickly adapted and maintained services statewide due to waivers by the USDA for remote certifications, remote service delivery and expansion of authorized foods to increase access to fruits and vegetables. WIC also implemented automated certifications and benefit extension processes during the pandemic.
SUMMARY STATEMENT

The Mississippi (MS) State Department of Health houses MCH programs that seek to help improve the health outcomes of women and infants residing in the state of Mississippi. Through collaboration and partnerships, the Mississippi State Department of Health initiatives address the disparities and inequities of the health outcomes.

ACTIVITIES AND RESULTS

FETAL AND INFANT MORTALITY REVIEW

Infant mortality is defined as the death of a baby before his or her first birthday and is considered an important indicator of the overall quality of health and health care of a population. Infant mortality is closely related to the social determinants of health (e.g. race, education, poverty). As a result of Mississippi’s infant mortality rate, the Fetal Infant Mortality Review (FIMR) Program was implemented by the Mississippi State Department of Health in the Southern Region - Gulf Coast lower six counties (Harrison, Hancock, Jackson, George, Stone and Pearl River) in 2012. FIMR is a national program that is active in 28 states in the U.S.

The most recent United States Infant Mortality rate is 5.79 deaths per 1,000 live births. According to the 2019 MS Infant Mortality Report, the MS Infant Mortality rate decreased from 8.72 deaths per 1,000 live births in 2017 to 8.43 deaths per 1,000 live births in 2018; however, last year the Mississippi Infant Mortality report (2013 - 2017) for four of the most populated counties in the gulf coast section of the southern region (Jackson, Harrison, Hancock & Pearl River) lists 6.68 deaths per 1,000 live births. Due to the continued decrease over the past eight years in infant mortality in these most populated four lower counties, we have expanded FIMR into the Hattiesburg area and are hoping for further expansion across the state through local partnerships with Healthy Start Programs.

THE INSTITUTE FOR THE ADVANCEMENT OF MINORITY HEALTH

In partnership with the Mississippi State Department of Health, the Institute for the Advancement of Minority Health implemented the Healthy Families Maternal and Child Health Program. The program utilizes community health workers to reduce maternal and child health disparities in Copiah, Hinds, Madison Rankin, Simpson counties in Mississippi. Community advocates work directly within the community to promote knowledge and awareness about maternal and child health, promote healthy behaviors and to identify barriers to accessing services.

The program has created a maternal and child health coalition to obtain feedback from the community. This coalition is composed of healthcare providers, social support service providers, educators, community advocates and other stakeholders dedicated to working together to improve the lives of children and women in the area. Over the last year, the Institute has developed a coalition of 13 organizations that have worked together to provide community education, link patients to healthcare services, provide peer support and resources to the community. The program provided community education to 1,155 individuals through a series of educational workshops. These training opportunities addressed postpartum depression, maternal mortality, child lead poisoning, and the impact of COVID-19 on the family.

Community outreach is another important aspect of the program. The program conducted four community baby showers to provide items, such as car seats, play pens, bottles, pacifiers, diapers, wipes, baby lotion, and health education to mothers and children. The events reached 1,030 individuals in the community. Initially, community outreach and education were conducted using traditional face-to-face methods. However, the program has adapted, considering the COVID-19 pandemic, and virtual technology is currently being used to maintain our connection to the community. Community events have been transformed into “drive-thru” no-contact events to ensure that mothers and children can still receive needed supplies and health education.

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COVID RELATED WORK

The Institute for the Advancement of Minority Health also works with community stakeholders to develop community-based solutions that are responsive to the community’s emerging needs. In March 2020, the country experienced a nationwide shutdown because of the COVID-19 pandemic. To respond to this urgent public health need, the program began to provide education to families in the area about COVID-19, risk factors, signs, and symptoms and how to prevent transmission. Leveraging existing community partnerships, the program began a campaign to provide personal protective equipment (PPE) to families in the area. Since its inception, the program has provided 3,378 reusable masks; 500 disposable masks; 300 children’s disposable masks; 240 rolls of paper towels; 74 rolls of toilet tissue; 17 packets of Kleenex; 15 goggles; 1,421 sanitizers. The PPE was provided to daycare centers, adult care centers, churches, schools, community health centers and barbershops.
SUMMARY STATEMENT

Nebraska utilizes the Title V Maternal Child Health (MCH) Block Grant to leverage a variety of efforts to improve MCH issues across the state, particularly those that help improve birth outcomes. These efforts include improving access to prenatal care, encouraging women to become healthy before becoming pregnant, and including MCH training for Community Health Workers (CHWs) in Nebraska, among other strategies. In addition, Title V leverages other programs including the Nebraska Maternal, Infant, Early Childhood Home Visiting (MIECHV), Women, Infants and Children (WIC), Pregnancy Risk Assessment Monitoring System (PRAMS), newborn screening, and immunizations to broaden the reach of efforts and better support pregnant and parenting women.

ACTIVITIES AND RESULTS

The MIECHV program regularly works with pregnant women to ensure that they have access to prenatal care and promote healthy lifestyles to ensure good birth outcomes. MIECHV proactively reaches out to pregnant women, who are primarily low-income, and upon enrollment into the program works on benchmarks such as tobacco usage, intimate partner violence, and continuity of insurance coverage – all metrics which point to good birth incomes if improved. Additional benchmarks which point to improved maternal and child health include safe sleep, breastfeeding, depression screening, early language and development, and developmental screenings. The model utilized by MIECHV is an evidence-based model that has a foundation consisting of randomized control trials resulting in 12 publications, an impressive and significant base which justifies continuing support of the program overall.

Additionally, by including MCH topics in Community Health Worker training, Nebraska has extended the capacity of the workforce working with pregnant and parenting women. CHWs have been shown to be effective members of healthcare teams, and when fully integrated in health systems, can ensure that care is delivered in a culturally competent way and that a personal connection is made with the client. These measures can help to ensure positive health outcomes in a variety of ways.

COVID RELATED WORK

One example of how service delivery for pregnant and postpartum has been changed due to the COVID-19 pandemic lies within the WIC program. WIC quickly altered policies and guidance so that local agencies could shift to a virtual format. They also allowed for funds to be used to purchase supplies needed to be successful (i.e., hotspots and laptops). Typically, most WIC services are handled in-person at a WIC clinic, and participants are required to make those visits every couple of months. To ensure the safety of the pregnant and parenting women served by the program, Nebraska WIC staff worked with federal and state partners to ease the program requirements to allow services to be provided remotely.

The Spotlight documents were prepared by state health departments to highlight state progress toward improving health outcomes for moms and babies.

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SUMMARY STATEMENT

Nevada’s progress in Maternal and Child Health (MCH) includes the establishment of a Maternal Mortality Review Committee (MMRC), both in statute and in convening the MMRC. Nevada also became an Alliance for Maternal Innovation (AIM) state with plans to launch the hypertension patient safety bundle in late fall of 2020. The purpose of the safety bundle is to reduce preventable maternal mortality and severe maternal morbidity statewide, as well as address associated racial and ethnic disparities. Statewide efforts to promote early prenatal care and decrease preterm birth and teen birth align with positive perinatal birth outcomes trends reflected in National Vital Statistics System (NVSS) data. The percent of women who receive prenatal care beginning in the first trimester increased by 13.2% (from 65.9% in 2010 to 74.6% in 2018), percent of preterm births less than 37 weeks gestation decreased by 6.5% (from 10.8% in 2009 to 10.1% in 2018), and teen birth rate, ages 15-19, per 1,000 females decreased by 53.4% (from 44% in 2009 to 20.5% in 2018). Appropriation of six million dollars in state general funds to support reproductive health, access to contraception, and immunizations is another statewide initiative benefiting MCH in Nevada.

ACTIVITIES AND RESULTS

Nevada’s efforts to improve birth outcomes and associated evaluation efforts include: robust prevention of substance use in pregnancy efforts through internal and external stakeholder engagement, Nevada Home Visiting (NHV) efforts to improve dyad outcomes and reproductive health, strong relationships with local health authorities, MMRC and AIM development, and establishment of the Account for Family Planning to improve access to reproductive health statewide.

Association of State and Territorial Health Officials (ASTHO) Opioid Use Disorder, Maternal Outcomes, and Neonatal Abstinence Syndrome Initiative (OMNI) efforts and quality improvement of Comprehensive Addiction and Recovery Act (CARA) Plan of Care processes support positive birth outcomes, as do efforts to create robust wrap around care and referrals for women who are pregnant and use substances.

Nevada is an Alliance for Maternal Innovation (AIM) state and the Nevada MMRC was established to reduce preventable maternal mortality and severe maternal morbidity. Exploration of perinatal quality improvement efforts more broadly continue as a possible space to leverage efforts of substance use, reproductive health, and perinatal mortality review committees. Continuing to seek opportunities to expand NHV capacity to serve more families through additional funding streams is a priority in supporting healthy birth outcomes.

Bilingual substance use and safe sleep Public Service Announcements (PSAs), websites, social media, and print campaigns are ongoing. The SoberMomsHealthyBabies.org website provides information to women of childbearing age, providers, and concerned family and friends. The website provides the substance use help line number, plan of care, and other resources, as well as education on the treatment priority status for pregnant women at Substance Abuse Prevention and Treatment Agency (SAPTA)-funded organizations.

The Nevada Department of Health and Human Services (DHHS) Community Reproductive Engagement Committee also dovetailed with substance use prevention efforts, as did Nevada Division of Child and Family Services Families First efforts. Marijuana-specific perinatal resource development was also completed and shared in all dispensaries and to statewide partners and providers.

The Nevada Women, Infants, and Children (WIC) Breastfeeding Program in collaboration with the Title V MCH Program continued statewide campaigns to improve infant feeding practices in maternity hospitals and increase community and business support for breastfeeding mothers. Nevada WIC supported participants by providing free professional lactation services, breast pumps and an enhanced food package to breastfeeding mothers. Nevada WIC continued to promote and support breastfeeding using an existing campaign to model Baby Steps to Breastfeeding Success (BS to BS). Two breastfeeding campaigns in Nevada increase awareness, promote WIC breastfeeding services, and normalize breastfeeding in public locations. For the Breastfeeding Welcomed Here (BFWH) campaign, Nevada businesses
pledge their commitment to provide welcoming environments to breastfeeding mothers. Nevada WIC and Title V MCH participate in the Association of State Public Health Nutritionists’ (ASPHN) Children’s Healthy Weight Collaborative Improvement and Innovation Networks’ (CHW CoIIN) Breastfeeding Stream at the Intensive Learning Level focusing on promoting breastfeeding support to partners of WIC mothers to increase breastfeeding rates.

The Nevada Pregnancy Risk Assessment Monitoring System (PRAMS) is part of a national effort to reduce infant mortality and adverse birth outcomes. It consists of a survey administered to randomly selected women 2-3 months after they give birth, and the questions cover the period before, during, and shortly after pregnancy. These data help refine Nevada programmatic efforts.

Fetal Infant Mortality Review (FIMR) activities at the Washoe County Health District (WCHD) are fully funded by the Title V MCH Block Grant and recommendations have led to the launch of the Go Before You Show campaign statewide. Staff participated in the Nevada State Congenital Syphilis Workgroup of DHHS and Nevada Division of Public and Behavioral Health (DPBH). Numerous DHHS agencies are currently drafting a congenital syphilis action plan to build on prior work.

Title V MCH programs support Cribs for Kids (C4K) efforts providing educational resources and surveys to parents and caregivers on the importance of practicing safe sleep behaviors with infants to prevent mortality. Partner agencies participate in train-the-trainer sessions, which include evidence-based, best practice safe sleep education endorsed by the American Academy of Pediatrics (AAP). Safe Sleep Survival Kits for infants are provided to families who cannot afford to purchase a crib for their infant and surveys measure retention of educational components.

MCH staff participated in a technical assistance opportunity, Maternal Infant Health Initiative (MIHI), in partnership with Nevada Medicaid, national consultants, local Primary Care Association staff, and DPBH leadership. Efforts focused on rural access to prenatal and obstetric care and generated rich perinatal data for both Fee-for-Service and Managed Care Organizations related to trimester of care initiation, adequacy of care, disparity in outcomes, neonatal intensive care unit (NICU) stays, and policy related to neonatal levels of care. Rural birth outcome improvement and roles of federally qualified health centers (FQHCs) in increasing access to care in one rural area were foci, along with logic model development and analysis of policy and perinatal data.

To address issues relating to birth outcomes and Social Determinants of Health, Nevada Title V MCH is involved in several statewide initiatives as part of the Infant Mortality Collaborative Improvement and Innovation Network (IM CoIIN) 2.0 in partnership with the Association of Maternal and Child Health Programs (AMCHP). Nevada CoIIN partners included Title V MCH, NHV, Nevada Healthy Start Program, Southern Nevada Health District (SNHD), WCHD, Nevada Medicaid, and March of Dimes (Nevada Chapter). The aim of the IM CoIIN 2.0 is to build state and local capacity and test innovative strategies to shift the impact of social determinants of health and increase equity in birth outcomes by developing evidence-based policies, programs, and place-based strategies. Education on 17-alpha-hydroxyprogesterone caproate (17P) and long-acting reversible contraception (LARCs) are embedded in Nevada IM CoIIN efforts. The Nevada IM CoIIN efforts have led to further distribution of Go Before You Show campaign materials, preterm birth continuing medical education (CME), and March of Dimes preterm birth resources and information distribution.

COVID RELATED WORK

Nevada Maternal, Child and Adolescent Health (MCAH) COVID-19 efforts to promote positive birth outcomes and postpartum health include posting MCH-specific resources on their website, engaging in pregnancy surveillance monitoring with Centers for Disease Control and Prevention (CDC) as part of an Office of Public Health Informatics and Epidemiology (OPHIE)-led team, sharing resources and technical bulletins to partners, reaching out to stakeholders and sub-awardees on how COVID-19 is affecting their efforts and assisting in any technical assistance and adaptations needed. Title V MCH staff facilitated a COVID-19 and MCH data presentation by the Office of Analytics at an 8/7/20 Nevada Maternal and Child Health Advisory Board (MCHAB) meeting which will be updated at the November meeting.

WIC efforts included launch of innovative means to deliver benefits to clients during the pandemic and working in partnership with local WIC agencies to ensure continuation of essential services. Immunization Section efforts included
statewide release of data on COVID-19 impacts on immunization rates and heightened flu season vaccine promotion, including for pregnant women. COVID-19 vaccine planning will benefit post-partum women.

Nevada Early Hearing Detection and Intervention (EHDI) Program COVID-19 supplemental funds were awarded to enhance capacity; Nevada Rape Prevention and Education (RPE) Program was also awarded additional funds to help support heightened demand for crisis line support due to COVID-19 effects. MCAH staff participate in bimonthly state sharing meetings specific to COVID-19 and MCH. Title V MCH launched a social media campaign on the importance of keeping all prenatal visits spurred by feedback and concerns voiced by FIMR providers and national trends. Messaging on the importance of keeping well visits also launched. The entire NHV program transitioned to virtual visits, along with Nevada’s Teen Pregnancy Prevention Programs, Personal Responsibility Education Program (PREP) and Sexual Risk Avoidance Education (SRAE). MCAH partners reporting COVID-19 impacts were provided grant adaptations where allowable and redirection of funds to support their needs and barriers.

MCAH staff have contacted the Statewide MCH Coalition and partner networks to broadly disseminate numerous resources related to MCH populations and COVID-19, as well as for the Medical Home Portal and the Mountain States Regional Genetics Network (MSRGN) where staff helped translate COVID-19 information into Spanish. COVID-19 and Critical Congenital Heart Disease (CCHD) information is also being monitored, along with COVID-19 impacts to EHDI screenings and hospital and Nevada Early Intervention Services (NEIS) flows throughout.

**COVID-19 SURVEILLANCE**

OPHIE-led efforts include MCAH staff working with CDC on COVID-19 pregnancy surveillance in Nevada. CDC received approval to use COVID-19 supplemental funds to support this work through the existing Epidemiology Laboratory Capacity for the Prevention and Control of Infectious Diseases (ELC, CK19-1904) cooperative agreement. This funding supports surveillance of pregnant women with laboratory evidence of SARS-CoV-2 infection at the time of reporting and up to the day of delivery to monitor pregnancy, fetal, birth, and infant outcomes. MCAH staff also participate in MIS-C surveillance led by OPHIE. In addition, MCAH implemented the PRAMS COVID-19 questions in October 2020.
SUMMARY STATEMENT

Under the leadership of First Lady Tammy Murphy and Nurture New Jersey, our state is determined to eliminate disparities in maternal and infant health and become the safest place in the United States to give birth. Initiatives launched and continued in 2020 are explained below.

ACTIVITIES AND RESULTS

The New Jersey Maternal Mortality Review Committee has been re-launched with new, more interdisciplinary membership, statutory authority and funding to achieve more timely data, broader contributing factors to maternal mortality and stronger recommendations. In 2020, The Colette Lamothe-Galette Community Health Worker Institute (CLG-CHI), in collaboration with the Department of Labor, was also established. The CLG-CHI is developing a standardized statewide curriculum for community health workers, including trauma-informed care and other core competencies.

Another initiative, Healthy Women Healthy Families, works toward improving maternal and infant health outcomes while reducing racial, ethnic and economic disparities through a collaborative, community-driven approach with Community Health Workers and Central Intake Hubs. Overall, 43,955 clients have participated in Healthy Women, Healthy Families, 80 doulas have been trained, who assisted 390 women, which resulted in 315 births, the establishment of 6 group prenatal care sites, the participation of 521 fathers in fatherhood sessions, and the development of a statewide breastfeeding strategic plan that includes breastfeeding during a pandemic and telehealth.

Collaboration with the Department of Human Services includes doula certification to support Medicaid reimbursement, efforts to address substance use and Neonatal Abstinence Syndrome, implementation and interoperability of Perinatal Risk Assessment and the pursuit of better inter-agency data-sharing and data integration. The State is pursuing Doula Certification to ensure that reimbursement is sustainable and supportive of doulas. Doula care provides a powerful and personalized strategy for improving birth outcomes for mothers and babies. From prenatal planning to postpartum visits, doula care can impact more than a patient’s experience. Evidence demonstrates that doula care can play an important role in improving health outcomes by acting as a mitigating factor for maternal mortality, particularly in low-income communities and communities of color.

NJDOH published the second Maternity Care Report Card using 2018 data to provide insight into the disparities that characterize severe maternal morbidity and indicate pathways toward quality improvement. NJDOH continues to implement activities to decrease maternal mortality and morbidity through the CDC ERASE Maternal Mortality cooperative agreement and the federal Health Resources Services Administration (HRSA) Maternal Health Innovation Program, with a focus on addressing implicit bias, increasing shared decision-making, designating maternal levels of care, increasing use and interoperability of the Perinatal Risk Assessment and supporting access to Long-Acting Reversible Contraception (LARCs). The Maternal Care Quality Collaborative (MCQC), to be launched in the first quarter of 2021, is a cross-sector entity to connect data with action in coordination with the Governor’s office. NJDOH is in the process of finalizing the 34 critical state and non-governmental health stakeholder representatives. The MCQC will convene for the first time during the first quarter of 2021. One of the primary goals of the MCQC will be to review the Nurture NJ Strategic Plan and devise an implementation plan.

The New Jersey Department of Health (NJDOH) also continues to work with the Departments of Children and Families, Human Services, Education and Labor and Workforce Development to stand up Central Intake, address Adverse Childhood Experiences (ACES) and provide MIECHV (home visiting) services. A few more activities that have taken place in the past year are listed below:

Establishment of a standardized community health worker curriculum, registration/certification to ensure CHW work is sustainable and eligible for potential Medicaid funding.
Meaningful contraception choice and access through a fully funded state family planning program and partnership with the New Jersey Family Planning League, Planned Parenthood, and other advocates. NJDOH’s efforts are reinforced through collaboration with fellow agencies, and Medicaid’s Plan First benefit and OAG’s special litigation to defend and expand reproductive freedoms.

NJDOH supports the pursuit of non-punitive, universal guidelines for screening and referral for Neonatal Abstinence Syndrome (NAS).

COVID RELATED WORK

On June 29, 2020, NJDOH issued an Executive Directive stating that a doula, who is part of the patient’s care team, is essential to patient care throughout labor, delivery, and the entire postpartum hospital stay and shall not count as a support person. This executive Directive replaced the previous March 29th, 2020 directive allowing for one support person in labor and delivery which could be a doula, partner, husband, or other chosen person per the laboring woman. To ensure doulas’ safety, online training about safety, and the proper use of personal protective equipment, occurred on July 13, 2020.

Additionally, comprehensive recommendations for perinatal care during the pandemic were published on May 7th by a workgroup convened by the New Jersey Healthcare Quality Institute and included state agencies, providers and support services. The recommendations of the New Jersey Perinatal Care During COVID-19 workgroup are updated weekly.

The NJDOH Division of Family Health Services shared information documents electronically with grantees, partners, and families concerning pregnancy, labor and delivery support, doulas, home visiting, Women, Infants and Children (WIC), Supplemental Nutrition Assistance Program (SNAP), and Early Intervention and other resources, in addition to holding virtual “town halls” offering general information and resources for pregnant women, new mothers, and families.

In efforts to understand effects of COVID-19 on pregnancy and birth outcomes, the New Jersey Department of Health (DOH), in collaboration with CDC together will be monitoring pregnant women who test positive for SARS-CoV-2 through the end of their pregnancy, including birth outcomes of their infant(s). By collecting existing laboratory and clinical information on these mothers and infants, we will be able to characterize the spectrum of health effects associated with SARS-CoV-2 infection during pregnancy to inform clinical guidance, programs, and services. DOH staff have already begun to work with hospital Health Information Management Departments and are currently abstracting data from medical records for cases where delivery has already occurred.

Finally, state agencies, providers and Rutgers University implemented multiple Project ECHO (Extension for Community Healthcare Outcomes) sessions to educate and support New Jersey’s perinatal providers as they faced the challenges related to safe and pregnancy, childbirth and new parenthood amidst COVID-19.
SUMMARY STATEMENT

With considerable support from Executive and Legislative leadership, the New York State Department of Health (Department) is dedicated to improving perinatal health outcomes across the state. Of particular focus are initiatives designed to address and improve racial and ethnic disparities in outcomes, especially in maternal mortality and morbidity. Black women in New York State (NYS) are between two and three times more likely to experience a maternal mortality than their white counterparts. This disparity among Black women persists across socio-economic, educational, and income groups and is a call to action for the perinatal continuum of care. By understanding the root cause of this disparity lay not in individual variations among people, but historical and systemic inequities rooted in racism, NYS is committed to centering its perinatal health work on anti-racist goals and activities.

ACTIVITIES AND RESULTS

Guided by a series of recommendations from the NYS Task Force on Maternal Mortality & Disparate Racial Outcomes the Department leads efforts to improve birth and maternal health outcomes which include:

The NYS Maternal Mortality Review Board (MMRB) is charged with reviewing all maternal deaths in NYS to determine cause and preventability. The MMRB is comprised of over 30 perinatal experts including physicians, midwives, and community-based providers.

The NYS Maternal Mortality & Morbidity Advisory Council is designed to work in collaboration with the MMRB to identify social determinant factors that impact maternal health outcomes and design recommendations to improve outcomes.

A comprehensive learning collaborative project designed to address the impact of racism on birth outcomes within birthing hospitals across NYS. This project will help birthing hospitals better understand the impact of racism on birth outcomes at their respective facilities, assess current policies and procedures and make changes to integrate an anti-racist framework when necessary, and take steps to integrate patient experience and feedback in hospital policy and assessment.

Develop a perinatal data module which can support access to timely perinatal data and quality improvement initiatives.

Increase access community health workers (CHWs) to provide education and support to pregnant and postpartum people and their families.

Establish a postpartum workgroup to offer recommendations to improve care and outcomes in NYS.

The Department is updating regulations that support the statewide system of perinatal regionalization for birthing hospitals. Focused on improving the quality of care for all pregnant and postpartum individuals and newborns in New York State, this process included an expert panel of perinatal health experts which provided recommendations to strengthen the system of perinatal care, addressing both obstetrical and neonatal services. These new regulations are intended to expand the regionalized system of birthing hospitals in NYS to incorporate birthing centers, including midwifery birthing centers as the first level of care; formalize the relationship between the Regional Perinatal Center (RPC) for training, consultation and quality improvement through an affiliation agreement; strengthen the requirement for transfer agreements with higher level perinatal hospitals as well as the requirements for all levels (including birthing centers) to improve obstetrical and neonatal outcomes.

In addition, the NYS Department of Health has continued its highly successful work through its NYS Perinatal Quality Collaborative (NYSPQC). Currently the NYSPQC is engaged with over 80 birthing hospitals in two active learning collaborative projects designed to improve care for obstetric hemorrhage and to address opioid use disorder in pregnancy and neonatal abstinence syndrome. Previous NYSPQC projects have included reduction of scheduled obstetric procedures and sedation during labor for women in their first stage of labor who do not require pain management.

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deliveries <39 weeks gestation without a medical indication, hypertensive disorders of pregnancy, infant safe sleep and improving growth for neonates born <31 weeks gestational age.

While much of the work focused on improving outcomes with the Department of Health is overseen by the Division of Family Health, the NYS Medicaid program, operated by the Office of Health Insurance Programs is also engaged in several initiatives to improve perinatal and birth outcomes. This includes activities as part of the “First 1,000 Days Initiative” to improve birth outcomes for Medicaid recipients in the first thousand days of life. Through that initiative the Department is supporting several projects including a pilot for enhanced reimbursement to implement Centering Pregnancy, a home visiting pilot service, and a pilot study on Medicaid reimbursement for doula services. Ontario Health Insurance Plan (OHIP) is also prioritizing perinatal health improvements in ongoing activities to redesign the Medicaid system. As part of the Medicaid Redesign Team (MRT) II project, the Department is working on several perinatal improvement projects including a review of prenatal care standards, ongoing support of the NYSPQC work, our role in telehealth services, as well as improving care coordination and/or home visiting.

COVID RELATED WORK

As part of NYS COVID-19 response efforts, there has been a commitment to ensuring that pregnant and birthing individuals have access to care and support to deliver a baby during the pandemic. To that end, Governor Cuomo directed the NYS Council on Women & Girls to work in collaboration with the Department to convene a COVID-19 & Maternity Task Force. Chaired by Secretary to the Governor Melissa DeRosa, this Task Force was comprised of 15 members with expertise in perinatal health who met three times in April 2020 to assess the status of maternity care during the COVID-19 pandemic and recommend steps to improve care.

After three successful meetings the Task Force shared six different recommendations with Governor Cuomo in April 2020. Recommendations included: support for increasing the diversity of birthing site options (including access for midwifely led birthing centers), clarification of executive orders mandating that all birthing persons be allowed to have a support person accompany them, steps to ensure universal testing for all pregnant individuals, continued prioritization of racial justice and equity in all aspects of Department of Health work, creation of a messaging and education campaign on COVID-19 and pregnancy, and a literature review on the impact of COVID-19 and pregnancy with plans to share information with NYS Regional Perinatal Center staff. These recommendations were submitted to Governor Cuomo and the Department is working to implement them.
SUMMARY STATEMENT

Implicit bias refers to the attitudes or stereotypes that affect our understanding, actions, and decisions in an unconscious manner. They are activated involuntarily and without an individual’s awareness or intentional control. Biases reside deep in the subconscious and cause us to have feelings and attitudes about other people based on characteristics such as race, ethnicity, age, and appearance. They are associative in nature and can be formed through repeated exposure or experiences. It’s important to explore types of implicit biases, understand them, what effects they can cause, and how to address them.

Implicit bias impacts all aspects of our decision-making and thus is a contributing factor to health disparities. Health disparities are the differences in the incidence and prevalence of health conditions and health status between groups. Educating staff at the state and local level about implicit bias supports maternal, child, and family health practitioners in taking action to ensure equitable development and implementation of policies and programs that impact the women, children, and families served.

Ensuring programs are equitably designed and delivered by agency staff and subrecipients is paramount to ensuring equity in maternal and child health outcomes.

ACTIVITIES AND RESULTS

The first round of implicit bias trainings began with Ohio Department of Health, Bureau of Maternal, Child and Family Health (BMCFH) program and policy staff on September 2019, and was followed by five subsequent trainings that were hosted in the five Ohio regions for BMCFH grantees. The trainings ended in January 2020 and served a total of 193 participants.

The second round of implicit bias trainings was hosted by the Ohio Department of Health Pregnancy-Associated Mortality Review (PAMR) program. One training was held for Ohio Department of Health staff on May 12-13, 2020, followed by five virtual trainings for maternal healthcare providers on July 15, Aug. 5, Aug. 12, Sept. 1-2, and Sept. 15-16, 2020. These trainings served 208 participants total.

Among the 208 participants in the second round of trainings, 37% were registered nurses, 10% were social workers, and 5% were community health workers. The remaining participants ranged from lactation consultants, OB/GYN or family medicine providers, dieticians, certified midwives, and other public health employees (i.e., WIC, home visiting, OEI, etc.). The ODH PAMR program will continue to hold fifteen additional trainings between Oct. 1, 2020, and June 30, 2022. The next five trainings have been scheduled for Oct. 20, 2020, Dec. 2, 2020, Dec. 8, 2020, Jan. 12-13, 2021, and Feb. 9, 2021.
SUMMARY STATEMENT

The mission of the Pennsylvania Department of Health (Department) is to promote healthy behaviors, prevent injury and disease, and to assure the safe delivery of quality healthcare for all people in Pennsylvania. Throughout 2020, the Department has prioritized collaboration with agency and community partners to identify opportunities for improvement in policies, healthcare, and social services to build capacity for improving maternal and infant outcomes. The Department also recognizes the importance of addressing the root causes of racial disparities in maternal and infant mortality and is committed to changing the systems that perpetuate disparities to achieve health equity in the commonwealth.

ACTIVITIES AND RESULTS

The Department continues to take action to improve maternal and infant outcomes in the commonwealth. In partnership with state and community stakeholders throughout the commonwealth, the Department completed the Title V Maternal and Child Health Services Block Grant (MCHSBG) Needs and Capacity Assessment in 2020. As a result of the Needs and Capacity Assessment, the Department identified maternal and child population priorities, including reducing maternal mortality and morbidity and reducing infant mortality, especially where there are inequities. These priorities lay the foundation for strategies and initiatives to be funded by the MCHSBG and implemented during at least the next five years. Strategies that are currently underway include support for building capacity to implement the Centering Pregnancy model of group prenatal care, and home visiting services for people who are pregnant or parenting.

In 2020, Pennsylvania’s Department of Human Services expanded home visiting services for infants who are insured by Medicaid. Parents or caregivers of Medical Assistance-enrolled infants are eligible for at least two home visits to be provided during pregnancy or postpartum. The home visits are individualized to the needs of the family. The first two visits focus on ensuring the parent or caregiver and infant receive recommended health care, completing assessments to identify any risks or needs and making referrals to appropriate services to address those risks or needs.

In recent years, Pennsylvania has started building capacity to address maternal morbidity and mortality through the work of several collaborative initiatives focused on quality improvement. The Pennsylvania Maternal Mortality Review Committee (MMRC), established in 2018, is working to systematically review all maternal deaths, identify root causes of the deaths and develop strategies to reduce preventable morbidity, mortality and racial disparities related to pregnancy in Pennsylvania. The Pennsylvania Perinatal Quality Collaborative (PA PQC), launched in 2019, has recruited 65 birth hospitals and neonatal intensive care units (NICUs), representing 87% of live births, and 14 health plans across the commonwealth to join the effort to reduce maternal mortality and improve care for pregnant and postpartum women and newborns affected by opioids. As of October 1, 2020, Pennsylvania became the 38th state to join the Alliance for Innovation in Maternal Health (AIM). The Pennsylvania AIM Task Force is working to implement the AIM Severe Hypertension patient safety bundle, with a focus on racial disparities. Pennsylvania has also received the Pritzker Children’s Initiative Implementation grant, to support a public-private partnership for advocacy and policy work to improve access to high quality services, including evidence-based home visiting and services to address maternal depression and anxiety.

COVID RELATED WORK

The Department has taken extraordinary measures to mitigate the spread of COVID-19 and save lives. As part of the response measures, the Department has taken action to ensure that pregnant and nursing people receive supportive care in safe and respectful environments.

Throughout the pandemic, Department has worked with hospitals and birthing facilities to balance the implementation of infectious control measures with providing dignified and respectful care for patients in labor and delivery. On April 2 and August 20, 2020, the Department sent letters to maternal health providers, including obstetricians and gynecologists,
administrators of birthing hospitals, and midwives, encouraging alignment with recommendations from the CDC, World Health Organization (WHO), and the American College of Obstetricians and Gynecologists (ACOG) on caring for pregnant patients during the pandemic. Additionally, the Department advocated for the inclusion of support person(s) in labor and delivery through updates to the Guidance on Hospitals’ Responses to COVID-19. Through the hospital guidance, the Department recommends that facilities, through their visitor policies, allow for the presence of a support person for patients in labor and delivery, and the presence of a doula, in addition to a patient’s support person, in labor and delivery.

The Department has continued to provide services and education to pregnant people during the pandemic. Pennsylvania home visiting programs, funded by MCHSBG and the Maternal, Infant, and Early Childhood Home Visiting (MIECHV) have adapted services to a virtual model in order to continue to provide support during pregnancy or early childhood while maintaining safety precautions for staff and families alike. Additionally, the Department developed guidance for pregnant and nursing people during COVID-19. The guidance documents include information about the risks associated with COVID-19 for pregnant people and infants, as well as recommendations for how to prevent spreading the virus and protect pregnant people and their families.
SUMMARY STATEMENT

South Carolina Department of Health and Environmental (DHEC) continues to work with its partners to improve the health outcomes for women, children, and their families. In 2018, the prematurity rate was 11.3 and the infant mortality rate was 7.0 infants per 1000 live births. Health disparities continue to be an issue across both infant mortality and preterm birth and is closely tied to maternal risk factors. Multiple initiatives have been launched across the state to address maternal and child health outcomes and the inequities that exist among them.

ACTIVITIES AND RESULTS

DHEC partners with several organization and agencies across the state to improve outcomes in perinatal and infant health. One of these partnerships is the South Carolina Birth Outcome Initiatives (BOI). South Carolina BOI brings together community partners to discuss issues that impact moms and babies across the state. Workgroups are multidisciplinary and include: Access to Care Coordination; Baby-Friendly/Safe Sleep; Behavioral Health; Data; Health Disparities; and Quality and Patient Safety.

South Carolina also continues to maintain a successful and robust perinatal regionalization system that ensures infants are born and cared for at the appropriate designated hospitals. As part of this effort, and our BOI partnership, DHEC has been involved with a vaginal birth simulation project, SIMCoach. This project helps women avoid C-sections that are not medically necessary and helps providers get the practice they need to help women during high-risk deliveries. Similarly, South Carolina launched its Alliance for Innovation on Maternal Health (AIM) program, increasing the adoption of safety bundles in birth facilities.

Other efforts to address infant birth outcomes includes expansion of Baby and Me tobacco free to address smoking cessation during pregnancy; expansion of the Perinatal/Infant Quality Improvement Expansion Grant to support oral health in pregnant women and infants; expansion of the Managing Abstinence in Newborns (MAIN) project to prevent the symptoms and complications of neonatal abstinence syndrome in otherwise healthy infants at birth; and nurse home visiting to women and infant before and after pregnancy. Through unified messaging, education and awareness, safe sleep continues to be a priority of DHEC.

COVID RELATED WORK

To ensure the safety of all South Carolinians, especially those who are considered high risk, services for pregnant and postpartum women were transitioned to telehealth services. Efforts are ongoing to strengthen infrastructure and capacity in this area, including providing comprehensive data and programs.
SUMMARY STATEMENT

The South Dakota Department of Health has provided nurse home visiting services to young families since 2000 using the Nurse Family Partnership (NFP) model. Trained nurses support pregnant women and families with children until age two or three. This agile and dedicated team has responded to two emerging issues in the last year to ensure that young families thrive: maternal mental health and the COVID-19 global pandemic.

ACTIVITIES AND RESULTS

In the last few years, the Bright Start Home Visiting team has noticed an increase in the number and complexity of mental health crises among the pregnant women and mothers of young children that they serve. According to the 2018 South Dakota Pregnancy Risk Assessment Monitoring System (PRAMS) report, 16% of women reported depression three months before pregnancy, and 17% reported it during pregnancy. Of those that attended postpartum visits, 13% reported symptoms indicative of postpartum depression. Additionally, women who were enrolled in the South Dakota Women, Infants and Children (WIC) program were more likely than those not enrolled in WIC to have depression during pregnancy (26% vs. 13%). These same women were also more likely to score high on indicators of postpartum depression (21% vs. 10%).

To address this need, the Bright Start team chose to participate in an NFP pilot project, which provided specialized monthly NFP mental health consultation. Over six-monthly video calls with a consultant and a home visiting team from another state, there was the opportunity for peer-to-peer learning and mentorship. The Bright Start team experienced success in monitoring and assessing their comfort level in intervening with families through regular surveys completed by nurses. The team developed a “Crisis Intervention Decision Aid” with a pathway for nurses to help them decide on the course of action in working with families in the moment. Nurses carry the Aid during visits to use in the event of a mental health crisis. The team also developed relationships with local mental health agencies and law enforcement crisis units to enhance referral resources. Nurses felt more confident making a referral based on a high screening result for maternal depression screening.

This project resulted in 87% of Bright Start clients screened for maternal depression using the Patient Health Questionnaire (PHQ) 9 screening tool; the home visitors referred 100% of those clients that screened positive to a behavioral health provider, and 28% of those completed their referral by making an appointment.

COVID RELATED WORK

The Bright Start Home Visitors are committed to supporting families through the COVID-19 global pandemic using almost exclusive telehealth visits. Since the early days of the pandemic, the nurse home visitors have been pleasantly surprised by the very high acceptance rate of telehealth visits, increased number of completed visits in March and April, and continued enrollment of new families.

This transition was improved by Nurse Family Partnership’s prior integration of telehealth as a standard component of services, allowing for greater flexibility to stay in contact with families. Before the pandemic, very few families requested telehealth visits, preferring to meet in person with their assigned nurses. However, the initial introduction of phone or video visits as an option eased the transition in March. It is common for clients to request more frequent “check-in” visits rather than more extended visits every 2-3 weeks.

The Nurse Family Partnership program provided a unique opportunity locally to offer cell phones with a data plan to clients who needed a way to stay in touch with the nurse home visitors to complete telehealth visits. Verizon partnered with NFP to provide the phones and data, and local agencies could request the number of phones they would need. South Dakota nurses requested 14 phones for clients and reported that these have turned out to be a lifeline for families.
SUMMARY STATEMENT

The Tennessee Department of Health (TDH) is working to improve birth outcomes for both moms and babies. Various programs and initiatives within the department aim to improve the medical, behavioral and social factors that impact birth outcomes. In Tennessee, women experience disparities in birth outcomes based on race. Black women are more likely than White women to experience preterm birth, low birth weight, and both infant and pregnancy-related mortality. Overall infant mortality rate has improved 7.4 deaths per 1,000 live births (2016) to 7.0 (2019), however racial disparities persist. The department is working to decrease adverse birth outcomes overall as well as disparities between groups through awareness, understanding, partnership, and action.

ACTIVITIES AND OUTCOMES

The department’s activities to reduce adverse birth outcomes mostly focus around five areas: decreasing unintended pregnancy, increasing early and continued prenatal care, decreasing pregnancy smoking, providing social support to reduce stress, and ensuring delivery at the appropriate level of care facility. To decrease unintended pregnancy, providers who see women of reproductive age are trained to utilize reproductive life plan assessments, visits are available via telehealth and include discussions on birth spacing, family planning clinics work to be male and teen friendly, and the Sexual Risk Avoidance Education Program is provided throughout the state. TDH works to increase early and continued prenatal care by temporarily enrolling pregnant women in Medicaid through presumptive eligibility and training the workforce, including clinical providers and home visitors, on trauma-informed care to ensure patients and participants feel comfortable receiving services. To lower smoking during pregnancy, women of reproductive age are offered nicotine replacement therapy to help them quit smoking. For women who are already pregnant, they can enroll in Baby and Me Tobacco Free (BMTF), which is a program that offers diapers as an incentive for smoking cessation. In some areas of the state this program is also offered to other members of the household to create a smoke free environment for the pregnancy woman and infant. In 2018 participants in this program had an 12.05% prematurity rate, compared to 13.42% among the reference group. Social support is provided through referrals to health insurance, employment and housing resources through the Community Health Access and Navigation in Tennessee (CHANT) program. Evidence-based home visiting programs also provide social support to families as well as health education on birth spacing, screening and referral for depression, substance abuse, and domestic violence services. To ensure babies are delivered at the appropriate level of care facility the state utilizes a regionalization system. This system provides a mechanism statewide to healthcare providers for consultation and referral of high-risk patients, which leads to diagnosis and treatment of life-threatening conditions in pregnant women and newborns. By identifying high risk cases early, patients can plan to deliver at a place with the appropriate level of care. For example, in 2019, 86% of low birth weight babies were delivered at level III and IV hospitals.

The March of Dimes recommends three key policy actions to reduce premature births. Tennessee has implemented activities around two of the recommendations. First, the state funds the March of Dimes to provide technical assistance to providers implementing group prenatal care. Second, the state established a Maternal Mortality Review Committee (MMRC) in 2017 to review all deaths occurring during or within a year of pregnancy to understand the causes and contributing factors of the death. Prevention recommendations are identified based on what is learned through the reviews. This information is shared in infographics and an annual report, as well as timelier, quarterly notifications sent to providers. Funding has been provided to the Tennessee Hospital Association and Tennessee Initiative for Perinatal Quality Care to provide training to hospitals and healthcare providers around the top causes of death identified by the MMRC. To further implement the recommendations, a maternal health task force was formed in 2019. The task force consists of approximately 75 members from a wide variety of organizations interested in improving women’s health. Through the taskforce, community grants have been provided to address the recommendations, including the implementation of implicit bias training.
COVID RELATED WORK

The department has been tracking the impact of SARS-CoV-2 (the virus that causes COVID-19 disease) among pregnant women in Tennessee. Through data analysis, stark ethnic disparities were identified among pregnant women. Typically, 11% of births in Tennessee are to Hispanic/Latina women. However, when reviewing SARS-CoV-2 confirmed cases in pregnant women, almost half were among Hispanic/Latina women. This is a difference in magnitude of 4.2, showing that these women were being infected at a much higher rate than expected.

The findings were communicated to TDH’s Division of Health Disparities, as well as the emergency response leadership. Staff reached out to multiple stakeholder groups, including the Health Disparities Task Force and Statewide Regional Call for Health Officers, both of whom confirmed these findings were consistent with what was happening on the ground. Staff then worked with the Office of Communications to produce a COVID-19 and pregnancy public service announcement (PSA) specifically featuring a Hispanic/Latina pregnant woman and included messaging around the importance of receiving prenatal care. This PSA was distributed to partner organizations around the state and is featured on the Spanish website for COVID-19.
SUMMARY STATEMENT

The Vermont Department of Health Division of Maternal and Child Health works collaboratively with hospitals, health care providers, home health agencies, social service organizations, and other community partners across the state to support Vermonters throughout pregnancy and postpartum. A few examples are shown below.

ACTIVITIES AND RESULTS

STRONG FAMILIES VERMONT

The Vermont Department of Health partners with the Department for Children and Families Child Development Division to deliver a comprehensive system of voluntary home visiting in Vermont. While there can be some variation regarding eligibility or length of service, all home visiting includes trained professionals — nurses, social workers, child development specialists and more — who meet regularly with expectant parents or caregivers with young children in their homes. Home visitors partner with parents and caregivers to tailor services and resources to best meet the unique needs of each family. We work with families and caregivers to:

• Recognize and build on the strengths of the family, parents and children in the home.
• Teach parenting skills and model effective techniques.
• Promote early learning in the home with an emphasis on positive interactions between parents, caregivers and children.
• Provide information and guidance on a wide range of topics including breastfeeding, safe sleep position, injury prevention and nutrition.
• Conduct screenings and provide referrals and connections to resources if necessary.
• Connect families to other services and resources as appropriate.

OBSTETRIC OUTREACH

The Vermont Department of Health partners with the Vermont Child Health Improvement Program to improve the health of pregnant women and neonates across Vermont. Our objectives are to focus on quality improvement, to strengthen our network of Maternal Health and Family Medicine providers, and to provide a home base for up-to-date obstetrical information, guidelines, and hot topics. This partnership has resulted in a number of significant improvements in the health of pregnant women and neonates by assessing timely state perinatal outcomes and understanding how perinatal care is delivered and incorporates social determinants of health.

Objectives

• To improve access, coordination, and quality of care, including prenatal, perinatal, and preconception care, provided to Medicaid-eligible women and infants
• To establish prenatal care standards and recommendations by standardizing quality assessment, benchmarking, and reporting.
• To identify potential recommendations for changes in the State Medicaid policy for obstetrical care of women

Offerings

• 24-hour telephonic consultative services for referring Medicaid participating providers
• Patient Status for Transferring OB Providers
• Educational webinars for providers
Educational Webinars:
The Vermont Child Health Improvement Program (VCHIP) OB/GYN Webinar Series is designed in collaboration with the Vermont Department of Health (VDH) and the University of Vermont Medical Center’s Obstetrics, Gynecology, and Reproductive Sciences team to educate Vermont obstetrical providers with up-to-date information on obstetrical standards of care, public health, and healthcare reform to ensure best care practices for our community.

Quality Improvement:
A collaboration with University of Vermont OB/GYN, Vermont Regional Perinatal Health Project (VRPHP), Improving Care for Opioid-Exposed Newborns (ICON), and the Vermont Department of Health (VDH) allows for improvements in the collection and provision of timely feedback to all hospitals regarding important aspects of perinatal care and to provide recommendations for improvement.

Vermont Family Based Approach (VFBA) HIP Moms Study:
A program that focuses on the entire family, recognizes emotional and behavioral health as the key aspect of health, and emphasizes health promotion along with evidence-based intervention. The VFBA teams comprise of the child and family, Family Wellness Coaches, Focused Family Coaches, Family-Based Psychiatrists, primary care providers, and community partners. The goal of our research is to take a preventive approach to children's mental health by offering evidence-based wellness interventions in the perinatal period. Our program uses “wellness coaching” to bring health promotion (mindfulness, yoga, nutrition), illness prevention, and family-based intervention for pregnant women. Women are paired with a Family Wellness Coach (FWC) who provides education regarding how wellness activities can support mental health, collaborates with women to set goals, and coordinates resources to meet their goals.

VERMONT REGIONAL PERINATAL HEALTH PROJECT (VRPHP)
VRPHP is a collaboration of Vermont Child Health Improvement Program, Vermont Department of Health, and the University of Vermont College of Medicine Departments of Pediatrics, and Obstetrics, Gynecology and Reproductive Sciences.

Objective
The mission of VRPHP is to be a high-quality academic health care resource for education, skills, competencies and quality improvement in perinatal health care. We partner with the VDH, community hospitals and multi-disciplinary teams of health care professionals to facilitate timely, effective and patient-centered perinatal health care in a rural setting.

Accomplishments
- Annual Statewide Statistics conference to review perinatal outcomes data in the context of key maternal and newborn quality indicators.
- Maternal/Newborn Transport Conferences to provide a format for maternal and neonatal case review for those VT and upstate NY patients who were referred to The University of Vermont Medical Center.
- Nurse Manager’s from the Birth Centers at Vermont Community Hospitals meet quarterly to review policy and discuss efforts for best practice.

IMPROVING CARE FOR OPIOID-EXPOSED NEWBORNS (ICON)
The ICON project partners with the Vermont Department of Health and The University of Vermont Children’s Hospital to improve health outcomes for opioid-exposed newborns. Improved health outcomes are achieved by provision of educational sessions on up-to-date recommendations and guidelines to health care professionals who provide care for opioid-dependent pregnant women and their infants.

The project also maintains a maternal and newborn population-focused database for tracking process and outcome measures. This data is used to identify gaps in care and systems related resources; the project addresses these gaps through quality improvement initiatives, focused on enhanced care processes and systems’ changes.
Objectives
• Improved availability of, and access to prenatal and postnatal care for opioid-dependent, pregnant women and opioid-exposed infants
• Coordination of services for women to connect them with substance abuse treatment providers, housing, newborn care, and resources to support and achieve a healthy family
• Promotion of evidence-based guidelines for use by health care practitioners who provide management of the newborn infant

Accomplishments
• Development of The Care Notebook, a resource guide for opioid-dependent mothers
• Creation of resource booklets for providers working with pregnant women in treatment for opioid-dependence
• Provision of ongoing educational training sessions throughout Vermont
• Collaboration with Alcohol and Drug Abuse Prevention (ADAP) on providing tools and resources for substance abuse screening

COVID RELATED WORK
Vermont Maternal Child Health has worked closely throughout the COVID-19 pandemic to support lives of pregnant and postpartum women and promote healthy birth outcomes. We have done this through a number of ways including: coordination with UVM Maternal/Fetal Medicine and community-based OBs regarding messaging around COVID-19 and pregnancy; coordination with Vermont’s home visiting programs to provide ongoing services and supports to families through remote service delivery; development of materials to support families around safety, resiliency, and prevention during these complex times; and development of guidance and technical assistance and supports for child care providers providing essential and ongoing care during the pandemic.
SUMMARY STATEMENT

Following the aims outlines in Virginia’s Plan for Well Being, the state well-being plan, and in direct response to Governor Ralph Northam’s 2019 mandate to eliminate the Commonwealth’s racial disparities in maternal mortality rates by 2025, state agencies have worked to break down silos and act in tandem to achieve these goals. Interagency and cross-sector collaborative work has started in several statewide initiatives addressing upstream factors and social determinants of health, utilizing a racial equity lens, to have long lasting impacts on maternal and child health outcomes. These relationships have proven paramount and ones which we would like to highlight.

ACTIVITIES AND RESULTS

TITLE V MATERNAL & CHILD HEALTH SERVICES BLOCK GRANT PROGRAM

The Virginia Department of Health (VDH) administers the Title V Maternal & Child Health Services Block Grant Program, a critical resource for improving the health of women and infants across Virginia. Title V serves as a convener and catalyst for policy and systems change and as a foundational funding stream for public health infrastructure at the state, regional, and local levels. Title V funds are allocated to 35 local health districts and a broad network of regional health systems and community-based organizations. The scope of the program includes but is not limited to: newborn screening, including early hearing detection/intervention; early child development support, including developmental screening and home visiting; services for children with special health needs, including care coordination and insurance case management programs; parent-to-parent support; maternal mortality and child fatality review; and various investments in workforce development, provider engagement, and data capacity.

The 2021-2025 Title V Needs Assessment noted continued racial disparities in infant and maternal health outcomes. Efforts to address these disparities include assuring equitable access to: (1) perinatal care and supports, e.g., home visiting and doula services; (2) family planning services, e.g., sexual education, reproductive life plans, grief and fertility supports; (3) maternal/caregiver support, e.g., injury prevention, breastfeeding, and mental health; and (4) cross-sector strategic planning to address upstream factors, e.g., financial stability, housing, and transportation.

In addition, the Title V program is working to align the goals and objectives of various state and federal funding streams into an equity-centered Shared MCH Agenda by 2025, in partnership with the state’s Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Program, Healthy Start Program, Resource Mothers Program, Title X Family Planning Program, and numerous partners including health systems, universities, and nonprofit organizations.

HOME VISITING PROGRAMS

VDH administers three home visiting programs: MIECHV, Healthy Start, and Resource Mothers.

MIECHV supports pregnant women, families, and at-risk parents of children (birth to age 5) to access resources and develop the skills needed to raise children who are physically, socially and emotionally healthy and ready to learn. The MIECHV program implements voluntary evidence-based home visiting programs using proven, cost-effective models. MIECHV currently funds 18 Local Implementing Agencies that provide direct home visiting services, and two centralized intake sites that coordinate referrals. In addition, MIECHV supports two core state infrastructure investments for home visiting: (1) the Institute for the Advancement of Family Support Professionals, a portal of online training modules for home visitors, and (2) Early Impact Virginia, a nonprofit coordinating body that convenes Virginia’s Alliance for Early Childhood Home Visiting and supports professional development, continuous quality improvement, and statewide data reporting.

Healthy Start focuses on communities with infant mortality rates that are at least one and a half times the U.S. national average and aims to address both disparate birth outcomes and poverty, education, access to care, and other socioeconomic factors. The program centers Black and Hispanic families at highest risk of experiencing poor birth outcomes.

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The Resource Mothers program is an adolescent health program that provides support services specifically for pregnant and parenting teens and their families.

Each program has worked to sustain delivery of services during COVID-19 via telehealth services.

**INTERAGENCY COLLABORATION**

Notably, in 2019, Governor Ralph Northam and his administration committed to eliminating racial disparities in maternal mortality by 2025 and mandated all state agencies to work in tandem to achieve this goal. VDH worked with the Office of the Secretary of Health and Human Resources (SHHR) to conduct community listening sessions on maternal mortality across the state to inform this work.

VDH actively collaborates with its sister agencies to meet shared maternal and infant health goals. For example, VDH actively partners with the Virginia Department of Medical Assistance Services (DMAS) on a variety of projects supporting pregnant and parenting people, many of which center the Governor’s directive to eliminate racial disparities. Current collaborations are detailed below.

In 2020, VDH has collaborated closely with the DMAS maternity program, Baby Steps Virginia, on topics such as Medicaid member outreach including a social media campaign, newborn screening education, Women, Infants and Children (WIC) enrollment and services, maternity care coordination by managed care organizations, breastfeeding awareness, flu vaccine access, and efforts to promote health equity in maternal health outcomes across Virginia. VDH has also collaborated with DMAS throughout the year to support pregnant and postpartum people during the COVID-19 pandemic, and DMAS has been represented on the VDH Health Equity Work Group.

VDH and DMAS are working closely with SHHR and state stakeholders to study requirements to operationalize a doula Medicaid benefit (led by DMAS) and execute a streamlined statewide doula certification process (led by VDH). Stakeholders engaged include doula groups, DMAS managed care organizations, the Virginia Hospital and Healthcare Association (VHHA), the Virginia Neonatal Perinatal Collaborative (VNPC), and other key statewide advocacy groups supporting families. The final report is scheduled to be released in December 2020.

VDH and DMAS have also collaborated on services to support pregnant and parenting people experiencing substance use. The DMAS Addiction and Recovery Treatment Services team partnered with VDH to facilitate a training needed to obtain a waiver to prescribe buprenorphine. Forty-three providers utilized this training across the state, including obstetric and gynecologic providers (OB/GYNs), a target group for the series. In 2019, Virginia was one of eight states selected to participate in the National Academy of State Health Policy Maternal and Child Health Policy Innovations Program Policy Academy. Through this project, DMAS and VDH are partnering with the Virginia Department of Social Services (DSS) and the Virginia Department of Behavioral Health and Developmental Services (DBHDS) on a statewide, collaborative effort to improve Screening, Brief Intervention, and Referral to Treatment (SBIRT) services for pregnant and parenting people via two health system pilot sites.

Both agencies attend monthly Maternal and Infant Health State Partner meetings, with representation from VDH, DMAS, other state human services agencies (including DSS and DBHDS), VHHA, and VNPC.

**COVID RELATED WORK**

The following are efforts that have taken place in response to the COVID-19 pandemic:

Title V funds have been allocated to gap-filling investments in telehealth equipment/infrastructure for home visiting programs and for subrecipient health systems conducting developmental/behavioral assessments.
An internal dashboard has been created to track COVID-19 cases among pregnant women. Information available includes total number of cases, hospitalizations, outbreak associated cases, healthcare workers, number of cases by illness onset or specimen collection date, age distribution of cases, and race/ethnicity of cases. Case and hospitalization counts are available by locality.

Emerging needs for COVID-19 response/messaging for pregnant women and infants are discussed monthly at Maternal and Infant Health State Partner meetings.

A state Title V partner was recently awarded a CDC grant to assess COVID-19 barriers/opportunities related to parent-engaged developmental monitoring, screening, referral, and receipt of services for children (birth to age 5) across early childhood systems. A state team has been formed. This work will continue through August 2021.
SUMMARY STATEMENT

Addressing birth outcome disparities is a priority for the governor, state government, and Washingtonians, and is tracked as part of the state’s Results Washington performance management system. Washington has met the Healthy People 2020 objective to reduce total preterm birth to no more than 11.4 per 100 singleton births, however, significant disparities remain in preterm deliveries for racial/ethnic and low-income groups.

Our state can successfully reduce population-based disparities through culturally appropriate efforts that address social determinants. Through the Birth Equity Project, the Washington State Department of Health (DOH) provided funding to three local organizations to implement evidence-based/evidence-informed programs or community-informed practices that are culturally appropriate and focus on the root causes of inequities. In addition to supporting the launch of community programs that reduce health disparities, Washington is also seeking to provide learning opportunities for state and local leaders on health equity. The Maternal Mortality Review Panel is expanding their work with the American Indian Health Commission and has partnered with the Washington State Hospital Association to offer implicit bias training for perinatal service providers.

ACTIVITIES AND RESULTS

Cross-agency collaboration and engagement with partners across the health system is how we are working toward a state where healthy moms, dads, and babies can thrive. Among the activities:

The Birth Equity Project supports rural hospitals and tribal clinics to enhance prenatal resources and linkages through such approaches as the Family Spirit home visiting model, a Centering Pregnancy program, and prenatal yoga classes with an emphasis on expanding access in rural and tribal communities. In urban areas, partner organizations launched the Culturally Responsive Integrated and Strength-based Parenthood (CRISP) support group, with emphasis on reaching pregnant people and families from American Indian/Alaska Native, African American/Black, and Pacific Islander communities. In 2021 partner organizations plan to expand their services to offer drug and addiction recovery support groups to pregnant and parenting families as well as Tribal community doula services.

Washington state continues to address the impact of the opioid epidemic on premature births through health policy and substance use treatment innovation. This includes expanding access to medication-assisted treatment, group prenatal care that integrates substance use treatment into care, working with birthing hospitals to support non-pharmacologic interventions for withdrawal symptoms in newborns, working with child welfare to create policy regarding the notification of infants affected by substances, working with the Health Care Authority to explore bundled payment options to fund healthcare services, and expanding residential treatment to allow more women to bring their newborn with them into treatment.

The 2014-2016 Maternal Mortality Report for Washington State found that American Indian/Alaska Native people have higher maternal mortality rates than other racial or ethnic groups in the state. In response to those findings, the Department of Health (DOH) is partnering with the American Indian Health Commission to coordinate one or more listening sessions to discuss the issues contributing to maternal mortality in Tribal and Urban Indian Communities. To continue work towards improving health equity in perinatal care, the DOH has partnered with the Washington State Hospital Association (WSHA) and the Institute for Perinatal Quality Improvement to offer two implicit and explicit bias training for health care and service providers.

COVID RELATED WORK

In the spring of 2020 when COVID-19 cases were first documented in Washington, the DOH partnered with the Washington State Hospital Association (WSHA) to convene a workgroup to address the needs of people giving birth during the pandemic. This workgroup created guidance documents and a website for clinicians and pregnant people, prioritized pregnant people for testing, and advocated for doulas to be allowed in birthing hospitals for birthing women. The DOH is currently connecting with perinatal partners to get feedback on vaccination for COVID-19 during pregnancy.
SUMMARY STATEMENT

The Wisconsin Title V Maternal Child Health (MCH) Program in the Division of Public Health, Department of Health Services is striving to improve birth outcomes and reduce disparities. Based on the 2020 MCH Needs Assessment, the MCH Program identified new state performance measures related to African American Infant Mortality and High-Quality Perinatal Care. Through collaboration and partnerships, multiple strategies are being implemented.

ACTIVITIES AND RESULTS

The Wisconsin Division of Public Health recently established a new unit focusing on maternal and infant mortality prevention. A goal of the unit is to identify and expand promising practices in community-based health promotion. To support this work, two new Community Partnership Specialists positions were created. The Community Partnership Specialists serve in a role similar to organization navigators between the state and community-based organizations and support prevention work. They are recruited from, and based in, communities of highest need.

A new project is being implemented to identify strategies to integrate the Medicaid Prenatal Care Coordination benefit and doula services for women at high risk of an adverse pregnancy outcome. This effort will be implemented in Madison/Dane County and the City of Milwaukee. With this model, doulas will provide Prenatal Care Coordination services, adding a cultural perspective, community connectedness, and maternal advocacy, as well as support during labor and delivery.

Local and tribal health agencies in Wisconsin receive MCH funding to make improvements to advance health equity as they support mothers, children and families in their communities. Agencies assess organizational capacity by completing the Foundational Practices for Health Equity Checklist and Wisconsin’s Community Engagement Assessment Tool. Based on those assessments, agencies select areas for improvement, develop action plans, and implement practice changes to enhance community engagement and advance health equity for the MCH population.

Members of Wisconsin’s Perinatal Quality Collaborative recognize the importance of working together to improve the quality of perinatal care in Wisconsin. In the spring of 2020, the Alliance for Innovation on Maternal Health (AIM) accepted the Wisconsin Association for Perinatal Care’s application for Wisconsin to become an AIM state. The first quality improvement bundle to be implemented will focus on severe maternal hypertension.

COVID RELATED WORK

The Wisconsin Pregnancy Risk Assessment Monitoring System (PRAMS) collects population-based data on maternal attitudes and experiences before, during and shortly after birth. A grant was awarded from the University of Wisconsin-Madison, Contemporary Social Problems Initiative to support the addition of questions to the PRAMS survey focused on social determinants of health. All PRAMS respondents will be asked about housing stability and adequacy, respectful maternity care, and economic impacts of COVID-19 during 2020 data collection. The grant funding will also support an oversample of women who self-identify as American Indian or Alaska Native on the birth record. As additional PRAMS data becomes available, it will be disseminated to key partners, and data-to-action activities will be identified to promote healthy birth outcomes.
SUMMARY STATEMENT

The Title V Block Grant program responsibilities are assigned to the Maternal, Child and Adolescent Health Division (MCAHD) (Component A & B) and to the Children with Special Medical Needs Division (Component C) according to the operational structure of the Health Department. The MCAHD use the life course model as the framework for the approach of all strategies and activities. The Division works in collaboration with partners and stakeholders as allies, to reach goals and objectives. The better the health condition of woman of reproductive age (WRA), the healthier the baby will be and with the adequate care of the baby will result in a healthier adult.

Several core Title V programs facilitate and complement the health services in Puerto Rico at the health care system primary level:

**The Title Home Visiting Program (HVP)**, staffed by Home Visiting Nurses (HVNs), serves pregnant women and their children up to 24 months after delivery in 71 municipalities. The HVNs do screenings for maternal depression, intimate partner violence, substance use, child development and oral health.

**The Community Outreach Program (COP)** is staffed by Community Health Workers (CHWs) that provide community health education. Health Promotion is overseen by the Health Educators (HEs), responsible for offering community education, parenting courses, and technical assistance to the COP. A key component are media/internet campaigns, dissemination of educational materials and tools, and training and information to health professionals.

**The Perinatal Services** are provided by the Perinatal Nurses (PNs) that visit birthing hospitals to offer pregnancy and breastfeeding support and post-partum and infant health education. They also promote the Title V HVP and the Prenatal Courses among women.

ACTIVITIES AND RESULTS

Prematurity and low birth weight (LBW) infants are two leading causes of infant mortality (IM) in Puerto Rico. Puerto Rico Title V efforts include multiple strategies to decrease preterm births, decrease very low birth weight and prevent high-risk behaviors during pregnancy.

One key strategy of the Puerto Rico Title V Program to address poor birth outcomes is the four-session prenatal course, “A Baby on its Way” which promotes healthy pregnancy to prevent risk factors. The purpose of the course is for pregnant women and their partner to gain knowledge, which is measured in pre- and post-tests for each session. In fiscal year (FY) 2018-19, the average post-test score of pregnant women participants was 95% compared to 70% in the pre-test. The average post-test score of companions was 94% compared to 70% in the pre-test. Furthermore, we have been successful as 92% of 1,342 participants completed all four sessions.

Another strategy to address poor birth outcomes is the multimedia campaign, “The Encounter of My Life” that promotes healthy pregnancy and 40 weeks gestation. Videos appeared in movie theaters, TV, and the website: www.encuentrodemivida.com. Additionally, another activity includes the distribution of a magnetic pad featuring the warning signs and symptoms of preterm labor and the steps women should take if they suspect they are experiencing preterm labor.

In the past year, the Maternal Mortality Review Law was an achievement of our team. The regulation that is required by law for the implementation of the Maternal Mortality Review Law was drafted and will provide the tools to help identify preventable causes of death that will serve to prioritize the strategies chosen toward promoting healthier WRA. In addition, the WRA health services guidelines that have been implemented as public policy by the Department of Health (DOH), will help foster the improved quality of care based on evidence and changes in the delivery care system.
The Puerto Rico Fetal Infant Mortality Review (FIMR) identifies system-related risk factors for fetal and infant mortality and generates recommendations to address them. Puerto Rico FIMR has identified critical community strengths and weaknesses as well as unique health and social issues associated with poor outcomes.

At the individual level, the HVP offers case management, care coordination, support and educational services to pregnant and parenting women, their children up to age two and their families. A series of screening tools are used to identify participant’s needs and strengths and services are tailored accordingly. To enhance services, the HVP protocol underwent a complete revision to perform the interventions and documentation more efficiently. During 2018-19, the HVP provided services to 5,643 participants (pregnant women, interconceptional women, infants, and children). The HVNs also offer education, support and care coordination to pregnant and parenting women who do not qualify for the HVP. Partners, relatives, and friends of HVP participants also receive education that enables them to support their loved ones.

COVID RELATED WORK

Since March 2020, the COVID-19 emergency has made it impossible to continue offering educational activities in the community. In response to the current prohibition regarding group activities, one of the steps taken has been to adapt the prenatal course, “A Baby on the Way”, to an on-demand video presentation. It covers all the topics in an abbreviated fashion and refers viewers to the “Encounter of my Life” website where they can access more complete information. The video adaptation of the course will continue to provide participants with information leading to a healthier pregnancy and delivery, prevent risk behaviors, provide appropriate care for the baby, recognize the laws and regulations that promote quality birthing services and support for breastfeeding initiation in the hospital.

The “Encounter of my life” prenatal education campaign that started in 2018 acquired even more pertinence in the face of the pandemic, as it allows pregnant and parenting women to obtain information in a safe manner. The HVNs refer women to the website for information that complements their verbal communication. The campaign emphasizes the importance of completing 40 weeks of pregnancy, attending prenatal care regularly, adopting healthy behaviors and avoiding risks during pregnancy. It covers also the postpartum period and the importance of breastfeeding and having the father and other relatives support mom and baby.