

AMCHP Annual Conference, 2010

Moving Ahead Together:

Celebrating the Legacy, Shaping the Future of Maternal and Child Health

Plenary III:

Improving Birth Outcomes – What is next for MCH?

March 6-10, 2010

SPEAKER: Last year, those of you who were here may remember that for the first time I forgot to bring anything and so I was in a panic. This year, I compulsively reminded everyone over and over again that we have a fabulous basket that everyone would be delighted to win. So, here I go. Okay, I have Artis Olsen from Hanover, New Hampshire.

MODERATOR: We do have an overflow room next door. We have about 200 people having lunch in another room that will be watching the live video. So, she could be over there. So, you don't need to be present to get this. If you're eating lunch in the other room don't worry about it. We'll hang on to it. Now for Region 2, I would like to introduce Linda Jones-Hicks. Please come to the podium.

LINDA JONES-HICKS: Hi, everybody. I hope you're having a great time. I represent Region 2, which consists of New York, New Jersey, Puerto Rico and the Virgin Islands. If any of you are here, please I just want you to stand so the people here can know who we are. We're a mighty region that's right. What I'd like to do is go ahead now and choose our lucky winner for our regional basket. I don't have my glasses on.

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MODERATOR: Maggie Devo from Minnesota.

LINDA JONES-HICKS: Congratulations, Maggie.

MODERATOR: You can come get it at the end of the session. It'll be here. Now, I'd like to introduce our regional director for Region 3, Malita Jordan. You are actually in Region 3, which is a big region, Mid-Atlantic.

MALITA JORDAN: Good afternoon everyone. I'm like Linda. I don't have my glasses on either, Dawn Raderga from Rhode Island. I'm sorry if I mispronounced that.

MODERATOR: Dawn are you here? I know she's here somewhere. So, congratulations to all of you. We'll be doing our next regional drawing at the exhibit hall at 2:45. Please continue to enjoy lunch and our program will start in about five minutes.

RACHEL: This is Evan. He was born February 17, 2008. We found out soon after he was born that he has a metabolic condition. He of course had the regular infant screening test at Virginia Hospital where he was born. About a week after we came home from the hospital we received a letter from the Virginia Board of Health Title V Division telling us that he had an abnormal screening result for one of his metabolic tests and of course parents think my baby is fine. He looks great. I don't know what that

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test is talking about. We took him to the pediatrician and she performed a second test to rule out an abnormal test and about a week later we got the same results. His official diagnosis is dorate glautacemia (phonetic), which is the recessive, less serious form of the metabolic disorder and we didn't find this out until we had further tests done but that initial screening letter was what helped us educate ourselves on this condition. I guess I was first educated about the infant screening right after I had him, so yes I was a little out of it but the nurse at Alexandria Hospital informed me that he would have the infant screening test and then that letter from the Virginia Department of Health was our first contact from the Title V program that educated us and led us to understand more about his condition. What we were advised by a pediatric metabolic specialist was to go ahead and put him on soy formula instead of breast milk and cow's milk and he was on soy formula for about six months and they invited us to come back and they submitted him to a milk challenge. So for two weeks he had regular cow's milk formula and then his blood was tested again and they found that he was doing well because he was also eating table food and solid food at that point. So, his primary diet was no longer all milk. So, since he passed his milk challenge he was therefore permitted to have anything in his diet. He can have any kind of dairy now and he's fine. He's a healthy, happy toddler. Our families are very appreciative for the Virginia Department of Health Title V services program for educating us on Evan's condition otherwise we would have not known anything about metabolic disorders or glautacemia or his condition, dorate glautacemia. So, we're very thankful for that education.

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MILLE JONES: Good afternoon. Thank you for joining us for this important luncheon session on Improving Birth Outcomes. Rachel and Evan's story is a good news story. The kind of work that you do everyday in this state to help families stay healthy. Rachel and I know that she's around but she may not be in the room, thank you for sharing that story with us. It highlights one of the many ways that Title V touches the lives of all women and children. For those of you who have not met me, I'm Millie Jones. I'm Secretary and Clinical Consultant at the Wisconsin Department of Health. In my state and nationally the question of how to improve birth outcomes is a tough one. There is so much we know but so much we don't know about how to reduce disparities in infant mortality, help mothers have healthier pregnancies, reduce prematurity and how to improve women's health overall so that healthy women are prepared to have healthy babies if they choose but before we invite our delightful panel to the stage and get into our discussion of birth outcome, I'd like to ask you in joining me to welcome Assistant Secretary, Howard Cole, to MCHP. Dr. Cole is a former Massachusetts commissioner of health and knows well our experiences at the state level. In his new role as assistant secretary he supports Secretary Sibelius (phonetic), the president and the administration carrying out their health and human service agenda. Dr. Cole will you join us. (Applause)

COLE: Thank you very much, Secretary Jones for that very warm welcome and it's just so wonderful to be here and feel the energy and expertise of this tremendous group. So, thank you for inviting us today and for all the leadership you have shown in public health over so many years. I am really delighted to see so many old friends starting with Mike

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Frazier. I knew Mike from (inaudible), so it's great to see him in a happier environment here at MCHP. I can say. I know we have great leadership from President Slawyer and President-Elect Stephanie Birch. So, thank you to our leaders for hosting us today and we have a tremendous panel following in just a couple of minutes where we have experts like Dr. Gail Christopher from the Kellogg Foundation, Dr. Jennifer Howse from the March of Dimes and then of course I represent Health and Human Services today, so we have tremendous leaders from the CDC, colleagues like Dr. Ed Trevanthen and Dr. Charlan Kroelinger. You heard from Dr. Ursula Bauer last night. From HRSA, where we are going to hear from Dr. Peter Van Dyck and you heard from my wonderful colleague, Mary Wakefield last night. From my office of the Assistant Secretary we have Dr. Nadine Garcia who is our Chief Medical Officer and a pediatrician and a wonderful colleague. Nadine can you just stand up and get a little round of applause here? (Applause) I feel so at home here because in my previous tenure as a health commissioner of Massachusetts I worked very closely with two of your former presidents, Debbie Walker and Sally Fogerty and I want to thank Debbie and Sally for their leadership and everything they taught me about MCHP, so, a round of applause for them too.

I just want to express my appreciation to you because I have the honor of looking at public health and healthcare for many years as a physician, as a clinician, as a researcher, as a former commissioner of health in Massachusetts from 1997 to 2003, four governors by the way. Working closely at that time with Debbie and Sally and so many members of MCHP on issues of maternal and child health, of WIC, of children's

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health insurance, on newborn screening, all the issues that you are expert in and now I have the great honor of working with you as the Assistant Secretary for Health or what they call me in government, the ASH. (Laughter) As one who has worked for many years in tobacco control to be now called the ASH I find a bit ironic but as the Assistant Secretary for Health or the ASH I have the great pleasure of overseeing some 13 offices including women's health, minority health, the commission core, the surgeon general's office, ten regional health administrators and their staff, nine presidential and secretarial advisory committees and many, many colleagues who want to work closely with you and respect you for your leadership on maternal and child health issues.

The challenges for maternal and child health you know so well and for so many years people could look at these challenges of special healthcare needs of infant mortality of disparities and say that there was no hope but you have demonstrated for so many decades that instead of no hope that there is always new hope represented by MCHP and the fact that you are celebrating 75 years of Title V and have built this tremendous legacy for family, women, youth and children across this country is something that we all respect and admire very, very much and your legacy is one of increasing quality and access for all families for eliminating health disparities, an issue that I'm particularly concerned about as the ASH and also as Korean American and what I'm very, very grateful to all of you is that you understand public health from it's broadest perspective. You understand that public health is not simply addressing healthcare and treatment issues but also addressing the broader issues of prevention. You know that prevention delivered for pregnant moms through good pregnant care improves health. You know

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that getting health coverage for pregnant moms and substance abuse and tobacco counseling for pregnant moms is critical for launching a new child into a healthy future. I often reflect that prevention starts literally within the first minutes of life through newborn screening as we just saw from this marvelous video, an area that I had a lot of experience in as a former health commissioner. With hepatitis vaccination, which occurs in the first hours or days of a person's life and these are all very important issues for our kids across the country from literally the moment they are born. When you have the privilege of taking on a new post like this you often think about our goals in health and what we can do together and how we define health and I often think of the lines from the World Health Organization that our collective goal should be to help all people "reach their highest obtainable standard of health", reach their highest obtainable standard of health and you help with that legacy from literally the moment of birth through the commitment you have to public health and prevention.

In another wonderful definition of health from the World Health Organization is that health should be "a state of complete physical, mental and social wellbeing and not really the absence of disease or infirmity" and I love that definition too because you the leaders of MCHP have understood that for many, many decades. So, we're at a critical time now and I want to say to you that we have a department, a secretary, a president that wants to work closely with you to help all people reach their highest attainable standard of health. We are on the cusp of health reform and we need to pass health reform so we can have truly a system of coordinated care and prevention for people and

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not just a sick care system. So, thank you for your support of that. (Applause) Thank you.

As one who oversees the Office of Minority Health in the Office of the ASH, I am very pleased that MCHP is working so closely with us on the healthy baby initiative to reduce disparities in infant mortality. So, thank you for your collaboration on that issue. We know the administration is working closely with many of you on early learning challenges and also on quality improvement in Head Start, a critical issue for our kids. Some of you are working with SAMSA and ACF and CDC on so-called Project LAUNCH, Linking Action for Unmet Needs in Children's Health and we're very excited about that collaboration. We are thrilled to keep working closely with you on home visiting programs for new and expectant moms and their families. And then, as the ASH, I am very excited to say that we are very pleased to announce a new Office of Adolescent Health that just started a month ago in the Office of the Secretary, thank you. (Applause) And, you'll be hearing much more very soon about dedicated teen pregnancy prevention efforts coming out of the Office of Adolescent Health that shift from a focus of abstinence only to evidence based programs. (Loud Applause) Thank you, thank you.

I'm sure you were all thrilled when the First Lady unveiled her "Let's Move" Program several weeks ago. (Applause) And, we are all concerned about the rising rates of childhood obesity, which threatens to shorten life span for the next generation. So that is a broad partnership that's involving all of government in fact not just Health and

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Human Services but also many private partners and we want to work closely with you on promoting obesity prevention for the next generation.

Then, of course, we have Title V, which is celebrating 75 glorious years and you'll be very pleased to know that the administration is very supportive and proud of Title V and in the President's 2011 budget has put in an increase in Title V funding. So, we want that to continue in the future. Thank you. (Loud Applause) As I conclude here with my brief remarks, I want to say that the Secretary wanted to extend her thanks to all of you as well and one of my wonderful privileges as the ASH is to oversee a process called Healthy People and I'm sure everybody in this room is very familiar with this process. 2010 is a key year for Healthy People because we're concluding Healthy People 2010, launching Health People 2020 and we should work together to monitor our progress, see where we have come as a country in terms of maternal and child health outcomes but more importantly where we can work together to make sure that every child is reaching his or her highest attainable standard of health. There's a wonderful line in Health People that I absolutely love and it reads as follows. "The health of the individual is almost inseparable from the health of the larger community." That basically means that we're all interdependent. We are all interconnected. We are all working together and we all have promises to keep. That in essence is what public health is all about and MCHP has been at the forefront for 75 years and counting and it is your leadership and your legacy that has changed the paradigm from no hope to new hope. So, have a wonderful, wonderful conference and thank you again for having us today. Thank you. (Applause)

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MILLIE JONES: Dr. Cole, thank you so much. We know that you understand the issues we care so much about and we appreciate your leadership nationally to improve maternal and child health. Thank you for being with us today. (Applause)

Our session today is going to be a great one. I'm so excited about the all-star group we have with us today. If you were here last year some of you may remember I wore this kind of glittery jacket that when the light hit it, it really turned into quite the event. I don't do camera a lot but I'm happy to report your glitter and your pizzazz today is actually not coming from my clothing but it's going to be our speakers. Here's what we're going to do today. First we're going to hear from two public health leaders, Dr. Gail Christopher and Dr. Jennifer Howse about efforts of their two very different organizations to address improving birth outcomes. We will then be joined by a panel of federal representatives whose agencies are also working hard to improve birth outcomes nationwide. Dr. Christopher and Dr. Howse will give short overviews of their work and then we will have a broader conversation with them and our invited panel of federal agency representatives. Dr. Christopher if I could ask you to please join me on the stage. Dr. Christopher, as she's making her way up, our share with you that she is vice president for programs at the WK Kellogg Foundation where they are hard at work with their grantees to address a number of issues including disparities in birth outcomes. Dr. Christopher welcome to MCHP. We're so glad you can join us. (Applause)

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GAIL CHRISTOPHER: What an exciting day. It really is an honor to be here and to represent our foundation to share with you our commitment to continuing to move forward and to experiencing some success, additional, more success in this great challenge. The Kellogg Foundation has recently reaffirmed its mission. When our founder left his fortune to the Foundation he basically said, "Do what you will with the money so long as it helps children." So, our new sort of wording of that mission is to support children, families and communities as they strengthen and create conditions that propel," and those are two critical words, "conditions that propel vulnerable children to achieve success as individuals and as contributors to the larger community and society. We define vulnerable in many ways but the first has to do with poverty and income and we consider children vulnerable who live in families whose income is up to 200% of the poverty level. We look at other dynamics in our society that lead to vulnerability like in some cases being raised in a single-parent family. We look at the disparities that are so stark by race and ethnicity and so these combine to give us our focus on vulnerability. We look at children that are born with challenges in terms of ability or children with disabilities.

We have had a long history of investing in this work but we decided in preparation for this meeting that we would take a look at what's been going on for the last five years and the Kellogg Foundation has invested roughly \$64 million to improve birth outcomes in the last five years. Now taking that mission, "the creating the conditions", a lot of that

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work is around improving conditions within communities, addressing teenage pregnancy, strengthening families and some of that work was very specifically focused on improving birth outcomes. What you will find over the next decade is that those charts will change a little bit and we'll be trying to raise the bar for accountability, for results. We know that many efforts through Healthy Start, through community based programs have actually succeeded, the nurse family partnership is an illustration, home visiting programs, optimizing breastfeeding. Many of these efforts actually do bring about tangible results in improving birth outcomes. So, we're really going to be focused on trying to support work that is evidence based that will actually lead to measurable changes and improvement.

We think that the poverty disparities have to be considered and that the social determinants of health framework, we have to find a way to weave it into our collective and community based efforts. It is about care. It's also about caring and creating a climate and an environment in which caring and the demonstration of caring for the mother and for the expectant family becomes the norm and these types of disparities, if you look at this particular one, it reminds us of the infants and toddlers in our society who are in an impoverished situation by race and these disparities are simply unacceptable.

This one is even more stark and it's the one that gets me up in the middle of the night. When you look at the fact that the children of this nation are becoming increasingly children of color, we funded Delores Acavedo Garcia and her colleagues at Harvard,

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now at Northeastern University to do some assessing and reexamining of census data and she came up with a concept called Double Jeopardy and it refers to living not only in poverty but in impoverished communities, which is a reflection of our persistent legacy of racial segregation and if you look at the stark contrast in terms of the future, we have a crisis that has not really been verbalized and embraced and brought to the light that requires our collective efforts. This is not the America that we were promised. This is not the best of America and something has to be done to reverse these trends and we believe that this is intimately tied to improving birth outcomes.

Ultimately, we feel that we have to do two things simultaneously. Our foundation has made a commitment to be the most effective antiracist foundation that it can be to work deliberately to promote racial equity and the slides that I just showed you helped to drive that commitment. And so, while we're working on that through funding efforts like the partnership to end health disparities, a collaborative effort to find a way to promote racial healing in this country, I say often we have to put race in front of us so that we can put it behind us. (Applause) But, we have to find safe, healthy ways to do that. We have to heal this legacy and we recently and I'll draw to a close very quickly, we recently issued a call for proposals, a request for proposals to communities who wanted to work on racial healing, who wanted to bring diverse groups together to confront this dynamic. We thought we'd get a few hundred proposals. We actually received about a thousand and they represent every state in this country except Wyoming. (Laughter) Now, now. (Laughter) We are funding work in Wyoming too, I want you to know. What that revealed to us is that this is a felt need in our society. We are ready to grow up and

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to move passed this legacy that is so evident in the disparities that we see. So, we applaud your work, your leadership. We ask you to continue to evolve with us. We ask you to embrace this commitment that the foundation has and figure out how do we peel the onion and get back to the dynamics that perhaps increase vulnerability holistically speaking. How do we help build resilience in these mothers who face the conditions that challenge them physically, mentally, emotionally and spiritually? How do we help to make resilient families at the same time that we help to heal the dynamics that have persistently and consistently divided us? So, it's an honor to be here to share our perspective with you and thank you all very, very much.

MILLIE JONES: Thank you. You're doing important work at the Foundation and we appreciate your leadership so much. Wisconsin was one of the states that actually had the privilege to be part of the six-state partnership and we specifically looked at the impact of racism and it's impact on birth outcomes related to father involvement. So, thank you for that opportunity. I would now like to invite Dr. Howse to the stage. Dr. Howse is the president of the March of Dimes. So, many of us know her, which is we know to be the leading national organization and they're involved with the campaign to increase prematurity nationwide and to do so now internationally. Dr. Howse, you're a good friend of Maternal and Child Health and it is our pleasure to welcome you back to MCHP this year. I would also like to acknowledge the several March of Dimes staff that are here with you. So, if you would please stand. (Applause)

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JENNIFER HOWSE: It is wonderful to be here. I am honored to represent the March of Dimes and to just be part of the great energy of this conference. I want to join with Dr. Cole and Dr. Christianson in bringing forth the idea of new hope and bringing forth the idea of renewal and charging batteries in maternal and child health. I'm going to touch on three things. First of all, the present situation and the idea that the knot that we have in our stomachs sometimes when we wake up in the morning trying to figure out how to move our organizations forward that's real and I think it's very important to stay very grounded in that present reality. Secondly, just to touch on some of the remarkable assets that you all have as the leadership in maternal and child health. Things you've been doing for a long time or the things that are now really coming to the fore as the right tools and the right approaches to problem solving. Thirdly, just touch very quickly on the March of Dimes' national prematurity campaign and where we see it going from here. So, first title, Improving Birth Outcomes: Charting a Future Course of MCH.

Okay, I wanted to go back to that knot in your stomach like maybe the sun will go down and you'd be hiking in the woods when you were a kid and the sun would go down and you'd get this knot in your stomach because you kind of don't know where you are. So, what did we all learn to do? We learned how to find the Big Dipper. We all know how to do that. Then, we go right to the very edge of the Big Dipper and we follow it up to the North Star. We find that fixed point don't we? We find that fixed point in the dark woods and we can figure how to get out. So, what are your fixed points? These are the things that I think MCH has been doing for quite a number of years and doing extraordinarily well. I want to congratulate our colleague, Dr. Peter Van Dyck for being a real leader in

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developing state data sets and developing those in a way that they would be uniform across states, uniform in a national rollup and making us all understand the importance of data. So, lets thank our colleague. (Applause) You all have a phenomenal database. You already have some phenomenal demonstration programs that are scattered out in different locations including Wyoming, I might add. Scattered out in different locations but are demonstrating measurable results in improving birth outcomes and it's a strength that I think we need to build on. Thirdly, we're pretty good at dissemination but not as good as we need to be.

So, here we are. We're trailblazers for public health as a community. There we are in the woods but we're sort of figuring out where we're going to go. We're marking our trail. Title V, a critical program in blazing trails and developing new approaches and new programs, health reform, whatever that's going to look like in the future is going to make a big difference in the environment in which we are blazing our trails but the point here is that we know where we want to go. We want to improve birth outcomes. We want to improve maternal health and we know those fixed points.

Let me comment on our March of Dimes prematurity campaign. We launched in 2003. We launched because we've been looking at birth outcome data and we understood that preterm birth was getting worse and that as an organization devoted to improving infant health that this was an area that we wanted to focus on. We launched the campaign to do two things. First of all, to improve the rates of preterm birth, i.e., drop rates of preterm birth by 15%. We set a five-year target optimistically in the beginning

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and secondly to raise public awareness about the problem because the public just didn't get the fact that babies born too soon don't just graduate from NICU and everything is beautiful and perfect for the rest of their lives. So, we felt that we really needed to raise public awareness about the fact that the problem is common and you can see there that rates of premature birth have increased by about 30% over about the last 30 years. You can see with the orange bar that's healthy people 2010 that you heard Dr. Cole referring to and you know that we're going to have a new set of national outcomes with Healthy People 2020 but this is how the rate of premature birth in our country compares to the target that we set out for ourselves. This is not good. I said premature birth is common. It is one in eight births, 543,000 babies a year out of a birth cohort of 4 million babies. This is the leading cause of neonatal mortality, black infant mortality. The second leading cause of infant mortality after birth defects, major contributor to morbidity and what I mean by that is about 25% of babies born preterm have lasting, long-term health consequences like cerebral palsy, mental retardation, learning disabilities, neurological deficits, hearing issues and vision issues.

Very familiar to you all in the maternal and child health community, let's look at the risks. Let's divide them into two kinds of risks, those that are modifiable and those that are not modifiable. So, the non-modifiable risks basically are in the left-hand column there and that's where we focus and emphasize in our campaign in funding new research to really look at ideology and to look at some of these intractable risk factors but modifiable risks and they're in the right-hand column, these are programs that you all are already doing. So, improving maternal health status is going to make a difference in improving birth

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outcomes just looking at these different clusters of risk. Multiple gestation you say, well you know, we don't need more Octomom's delivering in this country. What we need is assisted reproductive technology for couples who want to have a baby but done in a sensible way according to professional guidelines. I can make similar comments all the way down the list but I think you know these programs very well for yourselves. There is one modifiable risk that stands out above all in our opinion at March of Dimes after running this campaign for over five years and that is the gestational divide in the problem of preterm birth. What do I mean by that? It's on the chart. 70% of preterm birth in the United States of America is in the category of late preterm birth and that means babies born between 34 and 36 weeks and if you take this chart and you overlay on top of it the rising rates of C-section in our country, you will find some remarkable alignment in these trends. Why is it modifiable? It's modifiable because of professional guidelines by ACOG were followed in all hospitals and birthing centers there would be no such thing as elective inductions, elective C-sections prior to 39 weeks. (Applause)

March of Dimes loves Healthy People 2010 because we like to take some of the key indicators out and convert them into something that is extraordinarily media friendly called a report card. I know you all don't love these report cards. I know you don't love them but think about what a lovely effect they have on the public that you have to educate and better that we seek to educate the public and then let you do your fantastic work. So, we've made now through the public awareness campaign preterm birth report cards. These deal with rates of preterm birth in the United States compared to Healthy People 2010 and you can see the geographic disparities. You can see a blue state

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that's Vermont at 9.4%. There are lots of reasons for this and you all are doing great work in Vermont. But, our job here was to really bring public attention to the seriousness of the problem.

This is the top half of the report card. We have one for every state. This happens to be the US report card receiving a D again compared on the far right, 7.6% Healthy People 2010 and what the rates look like in the US. The bottom half of the report card deals with three modifiable risks. They were rates of un-insurance amongst women of childbearing age, women smoking and rates of late preterm birth in states. We're choosing to track those three modifiable risk factors on an annual basis, state-by-state and then we have a star system whereby if your rate improves year-to-year, you get a star. It sounds very simple. It sounds like something that would be very attractive to the press and believe me it is. It's something very attractive to the media because it translates health into terms that are really quite accessible and allows us to talk about three modifiable risks we can really make a difference. Finally, I said the reduction of late preterm birth are very attractive and important, relevant target. I'm just going to give you two examples, number one, Utah, Inner Mountain Health. In 2002, they said no more elective inductions. No more elective C-sections before 39 weeks. They did education. They did consumer education. They did protocols. They did a whole bunch of stuff but what do you see? You see a reduction in 24 months from 30 plus percent rates of elective C-sections and today it's below 5%. So, it's a program that works. It can be done in other places. I really urge you to consider.

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Another program, Kentucky, Healthy Babies are Worth the Wait. A prematurity prevention partnership with the Department of Health, local health department, six hospitals, Johnson & Johnson Pediatric Institute and the March of Dimes, we funded for three years a study that again is aimed at reduction of late preterm birth, provider education, consumer education, hospital protocols, bundling successful clinical interventions during the time of prenatal care. We're just getting data on this project and I have something. The data is going to be shared formally with our board this week. It's preliminary data. It's not published yet. Do you want to know something? Rates of prematurity in Kentucky have gone down as a result of this program. So, there is much to be proud of. (Applause) You can check it out yourself at prematurityprevention.org. You can get some early information and some ideas about how these projects work.

There we are back to the beginning. We have our North Star networks of best MCH practice. You have data sets. You have demonstration programs. You have the capability to do phenomenal demonstrations and dissemination but you know I don't think we've done enough yet to create a national exchange of best practice between MCH programs. I think it needs to be powered up. I think it needs to be thought through, lightly resourced but nevertheless steadily and sustainably resourced thereby any MCH program leader, private sector leader, public sector leader but you all as the key leaders could come to this national exchange of best practice from MCH programs and, of course, I hope prematurity prevention is maybe the prototype by which we develop this idea of a national exchange can come to the exchange and get these program ideas and find the person in the state that initiated the program to talk with. Find somebody to

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talk with. We don't have to be face-to-face anymore to exchange information in a way that is vital. So, I hope we can create a network of best practice and by applying the tools that you know so well and by understanding what works we can together create that new hope but even do better than that. We can create lasting and permanent results that will improve the health of babies for generations to come. Thank you very much. (Applause)

MILLIE JONES: Thank you, Dr. Howse. Your work in prematurity is so important. Thank you for partnering with state in moving our shared goals forward and we look forward to hearing more about our mini-march for babies after this session. So, I hope you all brought your walking shoes. Now, I'd like to invite our federal panel to the stage and we'll move into our conversation about federal initiatives and connections between the work that Dr. Christopher and Dr. Howse discussed and work at HRSA, CDC and the National Institute of Child Health and Development. Joining us are Dr. Charlan Kroelinger and Dr. Ed Trevanthen from the Center of Disease Control, Dr. Peter Van Dyck from Maternal and Child Health and Dr. Trisca Fowler-Lee from the National Institute of Child Health and Development. In your chair you should all have a mic. So, I'm going to ask each of you to just provide a brief overview of your programs and initiatives and then we can lead into a discussion.

PEETER VAN DYCK: Good afternoon. It's fun to be part of a distinguished panel. Just very briefly, clearly one of our priorities is improving low birth weight and improving health outcomes and wellbeing for mothers, infants and children and we have a national

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Healthy Start program, which you heard about and you've heard people mention. Just to give you a couple of numbers, Healthy Start supports 102 communities in 38 states, the District of Columbia and Puerto Rico and it is in high areas of vulnerable families. In 2006, when the national infant mortality rate was 6.7 or so per 1,000 live births, the infant mortality rate among notably these high risk participants on the Healthy Start side was 5.6 and in 2007 that further had decreased to 5.1. So, just to continue for a minute, 22 of those Healthy Start of the 102 Healthy Start communities had no infant death at all in 2007 and in 2007, I'll talk about the low birth weight related to the prematurity rate. The nation was at it's highest with 8.2 and going up as Jennifer has said for years. In Healthy Start in 2006 the low birth weight percent had been reduced to 10.3, higher than the national average but reduced and maintained this rate over the next couple of years. So, we found a way at least in the Healthy Start side to stop the increase in low birth weight percent. We have two other or three other brief programs. We have first time motherhood programs, which is \$5 million to 13 states to improve services for first time mothers. Thirteen of you are recipients of that and they'll be a new competition this next year. We have a \$1.5 million to do a program to improve community health work outreach to help new mothers. We've been working with CEC and City Match and the March of Dimes and I don't want to forget this in improving preconception, women's health and for those of you involved with Healthy Start we have just begun a 27-month inter-conception care learning community collaborative where all 102 Healthy Start sites are involved. Breastfeeding is very important to us and we think it contributes to improved birth outcomes and we have a business case for breastfeeding program, which has been very, very popular and to let you know that the federal office of

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personnel management, which manages all of the federal personnel issues across all federal agencies, 40 of the operating divisions had a business case for breastfeeding learning collaborative in November and we think this is going to lead to federal agencies becoming more friendly in the worksite for breastfeeding. (Applause) I'll stop there although there are many other programs but I want to give my colleagues a chance to highlight their activities.

ED TREVANTHAN: It's a pleasure to be here and it's always a pleasure to listen to Jennifer speak and others that are very inspiring and we do have a large number of programs that we work together with HRSA and our friends at NIH on and I don't think that time allows us to discuss all of them but let me just mention a few things briefly. First, our new director Tom Frieden (phonetic) has been most interested in targeted interventions that can be shown to make a difference especially areas in which policy can be used to improve health and there are a number of opportunities in areas that we're focusing on. I'll mention just three very briefly. One is folic acid, which is well known I think to everyone here. One of the areas that we feel very good about is the progress that's been made in reducing the instance of neuro tube defects through folic acid fortification of wheat flour. I think it's been a major public health success not only here but internationally. However, we know that we have really not yet achieved all that we can with folic acid fortification and there is a real push now for us to do more globally where we think as many as 300,000 births with spinal bifida and hydrocephalus every year can be prevented and those children can be born healthy. So, there is a major global opportunity and I think really a moral imperative there that we're working on. Here

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domestically the Hispanic community has not benefited as has the rest of our population primarily because most of their bread products they consume come from corn masa (phonetic) flour and there may be some genetic issues that need to be investigated that are part of our ongoing research but we are working very closely now with FDA and the March of Dimes has been a very important partner as have other organizations but we're really hoping that over the next many months to a year or so we can really accomplish corn flour fortification with folic acid with partners and this is not something the CDC does but actually requires public/private partnerships and is really a community effort. So, those of you that will be involved with that thank you in advance and there's a charge for us to move forward there. I think another area that is really a statistic that we need to do something about is teen pregnancy, which does impact maternal outcomes. It impacts prematurity rates, impacts infant mortality and we have very high teen pregnancy rates in this country, approximately twice those found in Europe even though we have some data to suggest that the sexual activity rates in US teenagers is about the same that it is in Europe. So, we should be able to reduce our teen pregnancy rates with proper interventions and that's a major focus of interest. Breastfeeding has been mentioned and breastfeeding along with folic acid is one of the key areas of intervention. As an agency part it's been addressed by Dr. Frieden (phonetic).

We have a large number of individual programs at CDC that many of which we partner with our colleagues at HRSA that are really interventions to help women prepare for healthy motherhood and actually prepare to have healthy lives and improve birth

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outcomes and these include attaining an ideal body weight, early identification of pre-diabetes and diabetes again preventing teenage pregnancy as I mentioned, reducing smoking, preventing alcohol exposed pregnancies, folic acid fortification supplementation, other micronutrient programs and I can go on and on. I think that one thing that we are working on now is to try to take these programs that scientifically really do need to be isolated and we need to drill down to the individual programmatic level to do the right science. We need to merge these programs together to be more effective on the ground and that's an area that's a challenge for us and I think that's an area where many of you can be helpful and not only do we need to merge all of our different programs together in a way that's more effective and something we're working on with partners across our center and our agency, there really is an opportunity I think going forward especially in this administration where the agencies are working well together and we're coordinating across agencies for us to really have a more targeted approach across agencies to reduce infant mortality. I think we really can no longer accept the rates of infant mortality that we have in this country and we all need to join together to address that and also to reduce maternal mortality rates that are especially unacceptable in African American women who still suffer four times the maternal mortality of Caucasians in this country. So, we need to do a lot of work there.

Let's mention one other area that I think touches both on infant mortality and maternal mortality. As an example, we very often don't enough reach out to fields outside of the traditional maternal/child health family. I think we need to, to improve some of these health outcomes and there's a real opportunity now to start doing that. One example will

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be in the area of blood disorders. So, if you look at maternal mortality, the number one cause of maternal mortality we believe in the US today is pulmonary embolism associated with deep vein thrombosis and there may be some reasons why African American women suffer disproportionately from these outcomes because they may be prone to certain clotting disorders that tend to predispose them to having deep vein thrombosis and pulmonary embolism. We don't usually think of that as a part of maternal and child health but we're pushing a new initiative really in deep vein thrombosis and pulmonary embolism prevention that I think should connect nicely with reducing maternal mortality. Another area is sickle cell, which is a major cause of early childhood death due to preventable sepsis in children with sickle cell. There are problems with disproportionate numbers of children who are African American having strokes that often are just recognized as sudden declines in cognitive ability and learning impairment but these strokes can be prevented. So, we think our new programs in sickle cell can do quite a bit to improve outcomes. (Applause)

KROELINGER: Thank you colleagues for including me on this panel. It's an honor to be here and Dr. Trevanthen has done a wonderful job of talking about the overarching goals and mission of CDC and the direction it's going. So, I'd like to focus a little bit on what the Division of Reproductive Health is doing at CDC specifically in applied sciences and I'd be remiss if I didn't mention some of the programs in applied sciences like PRAMS, the Pregnancy Risk Assessment Monitoring System, adolescent reproductive health and research and evaluation in examining chronic disease and its impact on the life force of women. But, I'd specifically like to focus on the maternal and

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child health epidemiology program. It's a program that places senior level MCH epidemiologists in states that provide and have a need for MCH epidemiology. The goal of this program is to promote the health and wellbeing of women, children and families by building capacity at the state, local and tribal levels through the use of applied epidemiologic research and findings and MCH programs and policy development. Now, you may ask me, Charlan, what does capacity building mean exactly in states and I would say to you that capacity building includes things like enhancing MCH leadership within the states. Facilitating training in MCH not only epidemiology but the translation of epidemiology and research findings to program and policy. I'd also say that it includes peer exchange not only in science but in program work and helping to build infrastructure in state health departments and local department. Now, our program works in partnership with HRSA and MCHP and our epidemiologists are partially funded through Title V funds. So, there's a marriage there between what Title V does and what our epidemiologists do in the state. Currently, we have ten assignees in states, regions and with national partners that are helping to translate these data findings to action at all of these levels. We also partner with the Council for State and Territorial Epidemiologists to house newer and young and burgeoning MCH epidemiologists in the field and states and currently we have eleven CSTE fellows in different states and localities that are either mentored or supported by our program. I think that's just about all I'd like to say. I'd like to give my esteem colleague some time to speak about her program as well. (Applause)

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FOWLER-LEE: Good afternoon. I'd like to extend greetings from our acting director, Dr. Ellen Goodmarker and our deputy director, Dr. Evon Mattocks from the Eunice Kennedy Shriver National Institute of Child Health and Human Development. Our mission at NICHD definitely speaks to the heart of the health of all women and children and their infants and we have a breadth of research that covers almost all the areas that have been discussed here. We work in partnership with many of the organizations represented at the panel. There are three specific programs that I'd like to highlight in the interest of time. One is going on right as we speak is our Feedback Consensus Conference that is going on. We are very interested in hearing the outcomes of because it will definitely speak to one of the issues that Dr. Howse mentioned, which is the elective C-section. So, we're all very excited to hear what comes out at the end of that conference. Also, we are one of the lead organizations in the National Children's Study that I know you all are aware of and we are extremely excited to be moving into a lot of the recruitment phases and the feasibility phase of this study and this wealth of information and this breadth of data that we're going to be gathering over the 21 years of the study we're very excited to use in a number of areas particularly in the areas of infant outcomes. One of the last programs I would like to mention is a fairly new one that was launched just June of last year is our national child and maternal health education program. This program is lead by a coordinating committee of 32 professional medical organizations and some of our sister agencies represented here on the panel. The coalition uses evidence based information to address some of the key challenges of maternal and child health. The first issue that we decided to address or challenge ourselves with is the issue of late preterm birth, which again is very timely to what's

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been spoken about on the panel today. Specifically, late preterm birth, the rising rates as well as the elective term decision making. Our first audience to address in that effort would be the provider audiences and this is covering all providers, nurse practitioners, midwives, nurses, etcetera. We feel that in educating them appropriately about the ACOG guidelines that were spoken about as well as making them aware of the rising percentages of this late preterm birth and elective term deliveries or inductions that have been occurring we can somehow inform their practice and bring the rate down ultimately. So, we just convened our second coordinating committee meeting last week. We had a wonderful turnout and we are extremely excited to have the outcome of that in this education initiative. One particular project that we are working with in conjunction with MCHP, which is the education program, is a survey of the Title V states. We are very interested to hear what you are doing now in the field of late preterm birth so that we can learn from your experiences, grow in new experiences and expand them to have a wider audience. So, we're also excited to work with you and thank you again for inviting me. (Applause)

MILLIE JONES: Each of you have given us a really good starting place for this conversation and we knew that this would be challenging that this would just be the beginning point for a conversation but I'm intrigued as each of you talked and some of you have actually shared your ask for today. We have over 700 people at our conference and so it's a wonderful opportunity not to mention this illustrious panel. So, I'm curious and would like to know what ask do each of you have for us as we help one

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another move forward in this daunting challenge but one that we will meet? So, I'd like to start with any of you.

JENNIFER HOWSE: I'll just recap what I ask at the end of my remarks, which is that we together collectively create a means to have a best practice exchange that's very functional and practical and usable so that we can benefit from each other's results and we can both improve programs on the ground and also help to launch programs that are going to improve birth outcomes in the most efficient way possible.

ED TREVANTHAN: I know that many of you since we met together last year have spent a lot of time working on maternal/child health related issues with H1N1 influenza and certainly we all learned this year that a large percentage of the community that all of you serve are among the highest risk for both hospitalization and deaths, specifically pregnant women and children and especially children with special healthcare needs, those with chronic lung disease and neuro-developmental disorders. At the very highest rates of death from H1N1 were among children with neurological and developmental disorders of a certain type such as cerebral palsy. My ask is this. It's that our after action evaluation of the H1N1 outbreak and response to that outbreak begins next month and one of the things that we've learned so far is that although this year there was a lot of attention brought to the needs of pregnant women and children with special healthcare needs as a vulnerable group this is not the only season in which that's happened. In fact, it happens every single season. It's just that the numbers may not totally be as great but relatively speaking pregnant women and children with special

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healthcare needs in those special neurological disorders are among the highest risk groups. So, we need to take this opportunity to learn what we did right, to learn what we can do better and then do even better this next flu season with preventing illness and death in these vulnerable populations. It's a real opportunity now for us to make a move on this and have the field of MCH take a real lead in prevention of flu related death beginning this year. Thanks.

PEETER VAN DYCK: I'd like to ask for your working with us as we move forward this next year on rewriting our strategic plan along the life course multiple determinants of health, social determinants of health. It's time for us to rethink our approach I think to low birth weight, prematurity, infant mortality, among other of our problems and as we know now interventions that have been classically and traditionally tried over the last 20 or 30 years do not seem to be successful at this point. We need to rethink and creating a life course multiple determinants approach I think gives us an opportunity to rethink and recast and create a new foundation and perhaps increase our energy in re-attacking the problem and the issue and you've heard some of that from both Jennifer and Gail at the podium earlier. We hope to have a plan conceptualized by our celebration for the 75th anniversary on October 20th. So, we have much work to do and I ask you to please review, give us ideas as we send things out and send pieces out please help us review. Give us your best ideas as we move forward. That's my, ask for you, your participation and partnership. Thank you. (Applause)

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KROELINGER: I think in terms of our program what we would ask from you all is that you help us to determine the tools that you need in order to translate research and data findings to program and policy use. We host a conference in December, the MCH Epidemiology Conference in partnership with MCHP and with City Match and we provide trainings to your staff and your epidemiologist on these types of topics. I think we'd like to know from you what your needs are. For instance, I've heard a lot of talk the past couple of days about the social determinants of health and really understanding how to measure them and directly apply those measures to what you do in your programmatic work. Things like that would be helpful for us to know in order to bring together better trainings to help you and your staff in the future.

FOWLER-LEE: I guess my ask is a little bit more definitive because we do have a survey that's currently being distributed. Thanks to Dr. Frazier's help and the participation in our program is that you definitely share with us your expertise, your experiences for the late preterm birth and your programs and your best practices. So, we can find out what is working so we can let others know and we can build upon that. So that's what I would ask.

GAIL CHRISTOPHER: In the spirit of all that has been shared our ask is for greater levels of collaboration and community based participatory engagement in shaping this conversation. There's a book out by Dr. Farley that speaks to a better health for America and it's really about improving the everyday lives of people and I think that's the key in terms of improving birth outcomes. Yes, there's this critical component of

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clinical intervention but there's also the 90%, which is the everyday life of the mother, the everyday life of the family and the baby and so to the degree that we can accelerate, moving the needle in indicators of quality everyday life and then translating that into policy recommendations, whether it has to do with housing or education or transportation or the big elephant in the room, which is exposure to environmental toxins that are affecting. All of these things combine to make everyday life a challenge long before conception ever occurs. And so, we have to figure out what's our role in that and my ask would be for partnership and more collaboration as we move this conversation forward. (Applause)

MILLIE JONES: Well, they say you should be careful what you ask for because you just may get it. So, I hope that we will all be in a position to meet the requests of one another and more importantly I would ask that we look at every opportunity to keep these conversations going and open and flowing because that's what's going to get us to a good end result. So, thank you so much. Thanks to this wonderful panel. (Applause) You've done so much but there's so much more to do. Right now though, I'm going to turn this over to Mike Frazier who is going to lead us into our afternoon exercise literally and figuratively along with Michael, Ashley and Caitlin.

MIKE FRAZIER: Thank you again for a great panel. We're going to have a transition now. So, I'll ask Dr. Howse to remain on the stage and ask our other guests to come off the stage and then I'll invite our local ambassador family, Michael, Ashley and Caitlin Hall to join us on the stage. Thank you all again for a great panel. (Applause)

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MIKE FRAZIER: Well, the next portion of our program involves a wonderful chance to enjoy what I've heard is 60-degree weather outside. I haven't been outside since Friday afternoon to be honest with you but it's supposed to be the best day we've had so far this year and I want to remind all of you that the march is a fundraising march. Our goal is to generate \$5,000 for the March of Dimes Prematurity Campaign. (Applause) If everybody gives \$10, we will exceed our goal this afternoon and there are envelopes and ways to donate online if you just can't get to the ATM before the end of our walk. So, we look forward to reaching that goal together and sharing that great news with you. Dr. Howse is going to introduce our local ambassador family from the March of Dimes to share with you why this march is so important and why this march is part of a much bigger set of activities that the March of Dimes has planned for this year. Dr. Howse.

JENNIFER HOWSE: Thank you very much. We're very much looking forward to the annual March for Babies event, which as you know is the largest fundraiser for the March of Dimes. We are aiming to raise over \$100 million this year and as you heard earlier it is really aimed and focused at that preterm prevention campaign. So, we need your help. You are not alone. You are joining one million other Americans. You are joining 20,000 business teams and this location is the first location in the country of what will be 900 different locations around America for fundraising for March for Babies. (Applause) At each of the 900 events we have a local ambassador family, a family who has experienced firsthand usually the birth of a preterm baby. You all are very privileged today to be hearing in just a few seconds from our 2009 national ambassador family,

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the Halls. Caitlin who was born at 25 weeks who underwent a great number of medical challenges and her wonderful mom, Ashley and her wonderful dad, Michael. So, it's my privilege to introduce you to our national ambassadors, the Halls. (Applause)

CAITLIN: Hi, everyone.

MR. HALL: First, I'd like to say, thanks for having us here and letting us tell our story. Our story started November 16, 2003 and thanks to organizations like the March of Dimes and groups like you all our story is now six years old. So, Caitlin was born at 25 weeks weighing less than a pound. The first time we saw her we were able to see right through her. She was the size of a ballpoint pen. Within the first week she had open heart surgery and numerous surgeries throughout our five and a half month stay at the Georgetown NICU. It was a very traumatic experience for us. Her hospital bills were over a million dollars. So, our goal has been to give back a million dollars to the March of Dimes to assure that every baby has a healthy start and today we've raised just over \$200,000 in events we've put on in Lowden County where we're from. (Applause)

MS. HALL: As Michael said Caitlin was one of the over 500,000 babies that is born prematurely every year. She was chosen as the 2009 national ambassador because she exemplifies some of the preterm or some of the long-term affects that often go with children that are born so early. She suffers from very slight cerebral palsy on the left side of her body and has some learning difficulties and developmental delays and she sees physical, occupational and speech therapists on a regular basis to address these

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issues but despite these things she's doing beautiful. (Skip in the recording) ever going to walk or talk. She's doing those things. She's made up for lost time. She didn't start walking until she was three or talking until she was four but she has since made up for the gaps there. She keeps us on our toes. So, we're very thankful for you having us here today. Thank you to MCHP for being a partner with the March of Dimes and helping out with the prematurity campaign because without your support she wouldn't be here and many other babies like Caitlin wouldn't be here. So, we really help that we will be able to one day every baby born healthy that's our goal. Thank you. (Applause)

MIKE FRAZIER: Thank you so much. The reality of your story is an inspiration to all of us and it makes real the work that you all do. Thank you again. So, now I'm going to invite you to literally change your shoes, get your sunglasses, take a stretch and we will be kicking off, sun block, yes, hydrate. What else? Hats. We will be meeting in the foyer area here in about five minutes to cut the ribbon and have a wonderful, leisurely or aerobic depending on your skills and abilities about a mile, which sounds a lot but it's a beautiful day through this wonderful part of National Harbor together to really put our talk and walk together. We've been doing a lot of talk, now it's time to walk the walk and let's get that goal of \$5,000 to give back to the March of Dimes using the Hall Family as our inspiration. We'll meet you in five minutes out front. We have a ribbon cutting and we're going to take a great walk and then there's dessert in the exhibit hall and another raffle at 2:45. (Applause)