

Alabama Perinatal Health Act
Annual Progress Report for FY 2011
Plan for FY 2012

*State and Regional Perinatal Advisory Councils and the
Bureau of Family Health Services, Alabama Department of Public Health*



STATE OF ALABAMA DEPARTMENT OF
PUBLIC HEALTH

Donald E. Williamson, MD
State Health Officer

February 2, 2012

Dear Senators and Representatives:

It is my pleasure to provide you the opportunity to read the current Alabama Perinatal Progress Report available at www.adph.org/perinatal. The report describes the activities of the State Perinatal Program during fiscal year 2011.

Alabama's infant mortality rate increased from 8.2 to 8.7 deaths per 1,000 live births in 2010. This rate is tied for the second-lowest rate ever recorded in Alabama's history. The increase is evidence that continued support for the State Perinatal Program is needed. Most importantly, we must address the increasing number of low birth weight births in Alabama and subsequent infant deaths and morbidities that have long-term consequences for families and society. To this end, the State Perinatal Program developed strategies to address these adverse outcomes of pregnancy. These strategies and the problems they address are described in detail in this report.

The leading perinatal providers in our state met throughout 2011 to guide the State Perinatal Program. I am pleased with the initiatives under development which will yield long-term benefits as more infants grow up to become healthy children and contributing adults.

I want to thank you for your continued support of the State Perinatal Program. Because of this support, Alabama's families can look toward the future with enthusiasm.

Sincerely,

A handwritten signature in blue ink, appearing to read "D. Williamson", with a long horizontal flourish extending to the right.

Donald E. Williamson, M.D.
State Health Officer

DEW/JMS/MCW

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2011-2012**

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INTRODUCTION

Infant mortality is an indicator used to characterize the health status of communities and states. In 2010 a total of 522 infants died in Alabama before their first birthday. The 2010 infant mortality rate (IMR) increased from 8.2 in 2009 to 8.7 infant deaths per 1,000 live births. The percent of births with adequate prenatal care increased to 73.0 percent, from 72.8 percent in 2009. At the same time, the number of births with no prenatal care decreased to 1,162 in 2010, from 1,242 in 2009. Consequently, Alabama's IMR continues to remain among the highest in the nation. The national 2009 provisional IMR rate was 6.3 infant deaths per 1,000 live births.

Factors contributing to infant mortality included maternal chronic health conditions existing prior to pregnancy, short pregnancy intervals, teen pregnancies, previous preterm births and unhealthy lifestyles and behaviors. Low birthweight (LBW) infants accounted for 68.7 percent of the 2010 infant deaths; however, survivability of these small infants has greatly improved in the past decade. In 2010, 16.0 percent of the births in Alabama were premature. A comparison to the national percentage of 12.3 in 2008 provides a picture of the severity of the problem. These small infants are at high risk for developing major long-term physical and cognitive problems with consequences that impact families and state resources. An additional concern is the significant racial disparity in premature and LBW births, a major contributor to infant mortality among the black population. Black mothers are 46.4 percent more likely to have a premature birth than white mothers. The 2010 rate of prematurity for black infants was 20.5 compared to 14.0 for whites.

An important indicator of infant morbidity is the number of newborns being admitted to neonatal intensive care units (NICU). Alabama has seen more than a ten-year trend of increased NICU admissions. In 2010, NICU admissions decreased, the third time since 2001, to 4,878 compared to 5,237 in 2009.

Long-term consequences of adverse outcomes of pregnancy include emotional and financial stress to families as well as the costs of special education and ongoing healthcare needs of children and adults with disabilities. The purpose of the Alabama Perinatal Program is to identify and recommend strategies that will effectively decrease infant morbidity and mortality.

The system of regionalized perinatal care needs strengthening in Alabama. Additionally, services must be available to address the entire perinatal continuum that includes the periods of preconception, antepartum, intrapartum, neonatal, postpartum, infancy and interconception. Promotion of healthy lifestyles and behaviors, along with disease prevention, are essential components of a plan that will improve the outcomes of pregnancy.

HISTORY OF ALABAMA'S PERINATAL SYSTEM

Neonatal intensive care and regionalization of perinatal care was developed in the late 1970s. In an effort to confront the state's high infant mortality rate, a group of physicians, other health providers and interested citizens came together and became the impetus behind the passage of the Alabama Perinatal Health Act in 1980 (Appendix A). This statute established the State Perinatal Program and the mechanism for its operation under the direction of the State Board of Health.

The program's functioning body is the State Perinatal Advisory Council (SPAC), which

represents Regional Perinatal Advisory Councils (RPACs). The RPACs make recommendations to the SPAC regarding perinatal concerns and strategies to improve the health of mothers and infants.

The State Perinatal Program is based on a concept of regionalization of care, a systems approach in which program components in a geographic area are defined and coordinated to ensure that pregnant women and their infants have access to appropriate care. Availability of neonatal intensive care directed the organization of the regionalized care.

Initially, Alabama had neonatal intensive care capacity in Birmingham and Mobile. Additional capacity developed in Huntsville, Tuscaloosa and Montgomery. The state adopted a perinatal plan based on six regions, which corresponded to the Health System Agency designations at the time of passage of the Alabama Perinatal Health Act. These regions were also the basis for the Public Health Areas. In 1988, Public Health changed to eight areas and the Perinatal Program followed. In 1995, Public Health reorganized to 11 areas and continues with this structure today; however, the perinatal system continued with the same eight regions that were designated in the 1988 reorganization.

In 1996 the perinatal program reorganized into the current five regions (Appendix B). The reorganization was based on each region's designated NICU. The five designated NICUs are: (1) Region I - Huntsville Hospital in Madison County; (2) Region II - DCH Regional Medical Center in Tuscaloosa County; (3) Region III - University of Alabama at Birmingham (UAB) in Jefferson County; (4) Region IV - University of South Alabama (USA) in Mobile County; and, (5) Region V - Baptist Medical Center South in Montgomery County.

The 2002 SPAC designed a plan to enhance perinatal leadership within each of the five regions. The plan redirected outreach education funds for creation of an Alabama Department of Public Health (ADPH) nurse position in each perinatal region. The purpose of these positions is management of the RPACs and coordination of all regional perinatal activities, including outreach education. The SPAC voted to approve the plan and the regional perinatal nurse positions were filled by August 2002. In FY 2011, these regional perinatal nurses collaborated with perinatal providers and advocates across the state to strengthen each region's system of care for mothers and infants.

CURRENT STATUS OF ALABAMA'S BIRTHS

Birth Rate

The birth rate for 2010 was 12.5 per 1,000 total population, a total of 59,979 births; the 2009 rate was 13.3 (62,476 births); the 2008 rate was 13.8 (64,345 births); the 2007 rate was 13.9 (64,180 births); and the 2006 rate was 13.7 (62,915 births) per 1,000 total population. The 2010 birth rate for white infants was 12.3 (40,193) per 1,000 white population, while the birth rate for the black population was 13.2 (19,786) per 1,000.

Infant Mortality Rate¹

Alabama's 2010 IMR of 8.7 (522) infant deaths per 1,000 live births is an increase from

¹Alabama statistics referred to in this report were obtained from the ADPH Center for Health Statistics.

the 2009 rate of 8.2 (513). It is tied for the second lowest IMR in the history of the state. The highest rate in 2010 was found in Bullock County with a rate of 34.7 deaths per 1,000 live births.

The difference between Alabama's IMR for black infants and white infants continues to be significant. This disparity is evidence that concerted efforts are needed to address the factors that contribute to poor outcomes of pregnancy for many black mothers. At 13.7, the IMR for blacks increased from the 13.3 rate of 2009; however, this is 101.5 percent higher than the rate for white infants. The IMR for white infants, 6.6, increased from the 2009 rate of 6.2.

Infant deaths are sentinel events that indicate overall social, economic and health problems for families and communities. Continued efforts to aggressively identify, plan and target contributing factors are essential if the health of Alabama's mothers and babies is to be improved.

ISSUES THAT NEED CONTINUED EFFORT

Several factors contributing to Alabama's high rate of infant morbidity and death require continued attention from healthcare leaders and policymakers including: (1) low birthweight infants; (2) unintended pregnancies; (3) teen pregnancies; (4) preconception status of mothers; (5) smoking status of mothers; and (6) availability of health insurance coverage for the mothers at the time of pregnancy. These factors also have a direct impact on each other.

Low Birthweight

Birthweight is a significant factor directly related to infant morbidity and the infant mortality rate. Babies born too soon or too small involve significant risks of serious morbidity. Very low birthweight (under 3 lbs. 5 oz.) infants accounted for 355 of the 522 infant deaths in 2010. These very small babies are medically fragile at birth and many become critically ill. Those who survive usually require weeks of medical treatment for life-threatening conditions and/or infections. Medical care provided in the NICUs has had a positive impact on neonatal mortality (the first 28 days after birth); however, the very low and extremely low birthweight survivors are vulnerable to critical illness during the post-neonatal period and many require hospital readmission. Over one-third of the total infant deaths occur in the post-neonatal period (after 28 days).

The definitive cause(s) of prematurity remains unknown; however, the increasing magnitude of the problem has gained attention of medical researchers and scientists. Currently, the one measure that can reduce prematurity is prevention of unintended pregnancies in women who have experienced a previous preterm birth. The probability of preterm birth is 30 percent greater for a woman who has had one previous premature infant and the risk increases to 70 percent for two or more previous preterm births.

Unintended Pregnancy

The latest data on unintendedness (2009 data) showed that 53.5 percent of births in Alabama occurred to women who wanted a later pregnancy or to women who did not want to ever become pregnant. Unplanned pregnancies have serious consequences. Women who experienced an unwanted pregnancy were less likely to have adequate prenatal care and were more likely to have unhealthy lifestyles. Smoking and substance abuse were more likely in

women who had an unplanned pregnancy. Additionally, unintendedness leads to inadequate spacing between pregnancies. Women who have birth intervals of less than two years are more likely to have negative outcomes than mothers who space their pregnancies at longer intervals.

Teenage Pregnancy

The 12.4 percent of births to teens in 2010 is the lowest in Alabama's history, less than the 13.4 percent in 2009. Live births to teens in Alabama were 13.3 percent in 2008, 13.7 percent in 2007, 13.8 percent in 2006, and 13.1 percent in 2005. Focus on efforts to reduce teen childbearing will only serve to positively impact Alabama's IMR. Of the adolescent births, 43.6 percent (3,250) were to black and other teen mothers, and 82.4 percent (6,135) were to unmarried mothers.

Adolescent births produce multifaceted consequences that impact families and society. Teens are more likely to have very low or extremely low birthweight infants and birthweight is the factor most clearly related to infant death. Additionally, the low breastfeeding rate among adolescent mothers increases the morbidity risk for these infants.

Preconceptional and Interconceptional Health Status

Poor maternal health prior to pregnancy is a factor that must be taken into account. Pre-pregnancy weight affects the weight of the infant. Women who are underweight before pregnancy are more likely to have a low birthweight infant than are women who were normal weight before pregnancy. The consequences of obesity, such as diabetes and hypertension, are major causes of perinatal morbidity.

Prenatal Care

Early and adequate prenatal care to mothers remains a crucial factor in reducing infant mortality rates. The IMR among mothers who received no prenatal care or initiated care in the third trimester continues to be two times higher than the mothers who received prenatal care in the first trimester. In 2010, only 73.0 percent of the births were to women who had adequate prenatal care. In addition, there were 1,162 mothers who received no prenatal care. Coverage of the unborn through the expansion of the Alabama Children's Health Insurance Program (CHIP) could provide prenatal care to mothers whose children would be eligible for SOBRA Medicaid or CHIP at birth. The expansion would be a good opportunity to decrease the number of mothers who receive no prenatal care (see "Alabama Children's Health Insurance Program," page 6).

Substance Abuse

The use of nicotine, alcohol and drugs during pregnancy are other factors contributing to infant death and low birthweight. In 2010, Alabama's statistics indicate babies of mothers who smoke are 61.7 percent more likely to die than infants of nonsmoking mothers, with the rate for smokers being 13.1 per 1,000 live births compared to 8.1 for babies of nonsmokers.

The percentage of births to teenage women who used tobacco decreased to 11.6 in 2010, compared to 12.0 in 2009. There was an increase over the year in tobacco use among women aged 20 or more to 11.2 percent from 10.9 percent. In 2010 white teenage mothers were 7.75

times more likely to smoke than black teen mothers. Smoking is associated with low birthweight, Sudden Infant Death Syndrome (SIDS) and respiratory causes of infant deaths.

Alcohol use during pregnancy can cause serious birth defects. Alcohol consumption during pregnancy is a leading cause of mental retardation and developmental delays. The 2009 data from the Pregnancy Risk Assessment Monitoring System (PRAMS)² survey indicated that 48.1 percent of all new mothers indicated they drank in the three months before pregnancy. In the last three months of pregnancy, only 13.2 percent of mothers reported drinking, a decrease of almost 73 percent. Although it appears most mothers realize that drinking during pregnancy can have detrimental effects on their babies and curtail their consumption of alcohol, mothers of approximately 8,247 babies continued to use alcohol.

Illicit drug use during pregnancy can cause long-term health problems for the mother and child. Intravenous drug users and their offspring are at particular risk for contracting Hepatitis B, HIV and AIDS. Pregnant women who use cocaine are at risk of pre-term labor and their children are at an increased risk for neurological development. Methamphetamine and methadone are the emerging drugs of choice for many women in Alabama. The fetal effects of these substances are creating serious challenges for perinatal providers.

Insurance Status

Uninsured pregnant women are less likely than insured women to receive proper health and preventive care. Low income families are most likely to be uninsured. Access to adequate early prenatal care may be determined by the availability of health insurance coverage for the pregnant mother. In 2010 infants of mothers with no insurance coverage and who did not qualify for Medicaid had the highest infant mortality rate at 27.2 infant deaths per 1,000 live births. Medicaid babies had a rate of 9.3 infant deaths per 1,000 live births and those whose mothers had private insurance had the lowest infant mortality rate at 6.9 infant deaths per 1,000 live births. During 2010 Medicaid paid for 52.7 percent of births.

PROGRAMS CONTRIBUTING TO IMPROVED PERINATAL OUTCOMES

Adolescent Pregnancy Prevention Branch

The Adolescent Pregnancy Prevention Branch within the Children's Health Division of the Family Health Services Bureau works to reduce the rate of pregnancies and sexually transmitted infections among teenagers living in Alabama through two federally funded programs.

The Alabama Abstinence Education Program, which was funded through the Abstinence Education Grant Program (AEGP), was extended through Fiscal Year 2014 under the Patient Protection and Affordable Care Act of 2010. The purpose of this program is to support decisions to abstain from sexual activity by providing effective and medically accurate abstinence programming. Four community projects were funded through a competitive selection process. These projects provide programming in 19 counties focusing on middle school aged students in classroom settings. The projects were encouraged to incorporate a "Positive Youth

²Obtained from the "PRAMS Surveillance Report by CHS, ADPH 2011

Development” (PYD) approach which incorporates a strength-based rather than a problem-oriented approach to risk reduction activities. This model works to cultivate opportunities for young people to connect with adults, contribute in their community and gain competence, thus enabling them to resist risky behaviors and transition to adulthood successfully.

The Alabama Personal Responsibility Education Program was awarded funding through the Federal Personal Responsibility Education Program (PREP), a new program funded through Fiscal Year 2014 under the Patient Protection and Affordable Care Act of 2010. This statute stipulates that a program must educate adolescents on both abstinence and contraception for the prevention of pregnancy and sexually transmitted infections. The program must utilize evidence-based models that have been proven on the basis of scientific research to change behavior. The law also requires that adulthood preparation subjects be addressed. In Alabama, these include: healthy relationships, adolescent development, healthy life skills, and parent-child communications. Three community projects were funded through a competitive selection process. The target audience for these grants is high risk youth between 15-19 years of age.

Alabama Children’s Health Insurance Program (CHIP)

The State Children’s Health Insurance Program was established August 5, 1997 under a new Title XXI of the Social Security Act. Alabama’s program, known as ALL Kids, in existence since 1998, is administered by the Alabama Department of Public Health. The program covers children whose family income is too high to qualify for Medicaid and is below 300 percent of the Federal Poverty Level. Alabama has been very successful in reducing the number of uninsured children in the state through coordinated efforts (outreach and simplified application processes) between ALL Kids and the Alabama Medicaid Agency. Alabama’s low uninsured rate for children (7.2 percent U.S. Census Bureau, Current Population Survey, 3 year average – 2008 - 2010 report years), means increased access to healthcare for thousands of children and adolescents in the state. Infants and pregnant teens having health coverage is a critical component for improving perinatal health in Alabama

Alabama Newborn Screening Program (NSP)

The Alabama Newborn Screening Program, in collaboration with birthing hospitals and other healthcare providers, screens for 29 of 31 primary disorders recommended by the Secretary of Health and Human Services’ Advisory Committee on Heritable Disorders in Newborns and Children (SACHDNC) for approximately 60,000 babies born annually. The NSP held a conference in August 2011, to address issues related to collection, disorders, and the family’s perspective. Five families presented their own stories and experiences with the newborn screening process leading up to a diagnosis for their children. Dr. Rebecca Buckley, an expert in the area of Severe Combined Immunodeficiency, was the keynote speaker at the conference. Through November 2011, there have been 79 infants identified with metabolic or other inherited disorders. All newborns identified with a disorder through the NSP have access to a diagnostic evaluation through medical specialists throughout the state. These consultants work closely with the primary care provider in determining needed tests and development of a treatment plan when necessary. The NSP maintains an active advisory board whose members include healthcare professionals, public health professionals, and a parent advocate.

“Alabama’s Listening” Universal Newborn Hearing Screening Program

The Alabama Newborn Hearing Screening Program, “*Alabama’s Listening*”, has made great strides in reducing the number of infants not screened prior to discharge. Currently, all 53 birthing facilities in the state offer hearing screening to all infants. The implementation of the guidelines from the Joint Committee on Infant Hearing 2007 Position Statement has helped in the reduction of numbers of infants considered lost to follow-up and needing rescreening. Using various existing federal grants, the Alabama system was able to replace outdated screening equipment and to increase services for several facilities in smaller, more rural areas. Additional grant money was sought and obtained and will provide funds for even more equipment and service upgrades. To date in 2011, 47 infants were identified with various forms of hearing loss.

Alabama’s Listening Program is constantly exploring new ways to ensure that all infants born in the state receive appropriate hearing screenings at birth, and diagnosis and intervention when needed. In the upcoming year, efforts will include forging stronger reporting relationships with Early Intervention and other outpatient providers.

Breastfeeding Promotion

Breastfeeding is an important public health issue that affects the health of infants and mothers. The United States Department of Health and Human Services has identified breastfeeding as a high priority health objective for the nation for the Year 2020. Healthy People Objectives include that at least 81.9 percent of women will initiate breastfeeding, 60.6 percent of those will breastfeed until the infant is six months old, and at least 34.1 percent will continue breastfeeding for one year. Objectives for exclusive breastfeeding through 3 months and 6 months are 46.2 percent and 25.5 percent. According to the CDC “Breastfeeding Report Card” 2011, the United States national rate for breastfeeding initiation is 74.6 percent. Alabama’s breastfeeding initiation rate is 56.7 percent. The American Academy of Pediatrics recommends breastfeeding for at least one year and beyond. The Alabama Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) supports and promotes breastfeeding as the preferred method of infant feeding.

Research indicates that there are multiple health benefits for babies and mothers. Human milk provides infants with immunological protection against a variety of chronic illnesses and changes to meet the growing infant’s nutritional needs. Infants who are breastfed have reduced incidence and severity of ear infections, pneumonia, diarrhea, urinary tract infections and necrotizing enterocolitis (NEC). Studies have shown that infants who are breastfed are less likely to develop diabetes mellitus, obesity, Celiac Disease, asthma, allergies, and Sudden Infant Death Syndrome (SIDS). Osteoporosis is reduced in mothers who breastfeed. Research indicates that breast, uterine and ovarian cancers are also reduced.

The WIC Breastfeeding Peer Counselor Program continues to provide support and breastfeeding information to pregnant and postpartum mothers. The program employs present or former WIC participants who have breastfed their infants for at least six months. Expansion of the Peer Counselor Program continues statewide. Currently, there are twenty-eight peer counseling sites. Research indicates that Breastfeeding Peer Counselor Programs help increase breastfeeding rates. Alabama WIC Program breastfeeding rates have consistently increased since the program was initiated.

The Alabama Department of Public Health and the Special Supplemental Nutrition

Program for Women, Infants and Children (WIC) Program celebrated August as Breastfeeding Awareness Month. The theme chosen this year by the World Alliance for Breastfeeding Action was “Talk to Me: Breastfeeding –A 3D Experience”. The theme focuses on the importance of connection between mother and baby and on communication at various levels and between various sectors. Many clinics held special receptions for their prenatal and breastfeeding mothers.

Alabama Child Death Review System (ACDRS)

The Alabama Child Death Review System continued in its efforts to prevent unexpected and unexplained child deaths through the study and analysis of all preventable child deaths that occur in Alabama. Program effectiveness was strengthened by strategic partnerships and collaborative efforts with various organizations, including the Children First Foundation, the Alabama Medicaid Agency, and many others. ACDRS continued to develop public education and awareness strategies to prevent child deaths and injuries, especially those related to vehicular deaths and infant sleep-related deaths, the two leading categories of preventable child death in Alabama. ACDRS continued a focused Teen Driving Safety campaign in 2011, which included print materials, web content, and multimedia promotion. Along with the Alabama Department of Forensic Sciences as an essential partner, ACDRS continued to offer Sudden Unexplained Infant Death Investigation (SUIDI) training to Alabama's first-responders, and a new law was passed in 2011 requiring that Coroners, Deputy Coroners, and law enforcement death scene investigators obtain SUIDI training. The operational efficiency of ACDRS also improved in 2011 with continued implementation of a new and improved data collection system. In April of 2011, ACDRS and its staff members were administratively relocated from the Bureau of Family Health Services to the Bureau of Health Promotion and Chronic Disease.

Alabama Family Planning Program (FPP)

One of the major goals of the Alabama Family Planning Program is to decrease unintended pregnancies. According to Alabama's Pregnancy Risk Assessment Monitoring System, from 2008 to 2009, there was a 19.2 percent increase in unintended births in Alabama from 44.9 percent in 2008 to 53.5 percent in 2009. The percent of Medicaid unintended births increased from 57.6 percent in 2008 to 64.3 percent in 2009 while non-Medicaid increased from 32.4 percent in 2008 to 42.2 percent in 2009. Some researchers say this increase may be related to the economy in that more women did not intend to get pregnant. During fiscal year 2011, direct patient services were provided to an estimated 101,454 family planning clients through local health department clinics. Approximately 95 percent of the caseload served was below 150 percent of the federal poverty level. The FPP provides education and counseling, medical examinations, laboratory tests, and contraceptive supplies for individuals of reproductive age. It offers individuals opportunities to plan and space their pregnancies in order to achieve personal goals and self-sufficiency. Services are targeted to low income individuals. Two supplemental Title X funded family planning projects ended during the year in select counties. These included a special populations (Hispanic) project in Limestone and Marshall Counties and a clinic efficiency project in Tuscaloosa County. Plan First, a joint venture between the Alabama Medicaid Agency and the department, continued into its 10th year after being granted a three-year renewal that began in October 2008. This program is an 1115 Medicaid Research and

Demonstration Waiver expanding Medicaid eligibility for family planning services for women 19-55 years of age. In 2011, 93,327 women statewide were enrolled in Plan First. The department's Plan First toll-free hotline received 3,466 calls during 2011. The program has applied for another three-year renewal to begin October 2011.

Healthy Child Care Alabama

Healthy Child Care Alabama continues as a collaborative effort between the Alabama Department of Public Health and the Alabama Department of Human Resources. During fiscal year 2011, the Healthy Child Care Alabama Program continued to provide services in 52 counties through its nine registered nurse consultants. Services offered by the program included providing information on child development, conducting health and safety classes, coordinating community services for low-income and special-needs children, identifying community resources to promote child health and safety, and encouraging routine visits for children to their healthcare providers (medical homes).

The nurse consultants also worked with community agencies and organizations to reduce injuries and illnesses and promote quality child care. The nurse consultants performed health and safety assessments of child care facilities and, if a problem was identified, assisted the child care provider in developing a corrective action plan. During 2011, the nurse consultants documented 2,370 health and safety training and educational sessions for 7,214 providers; 2,131 incidents of technical assistance at child care sites; and 6,526 consultations requiring phone calls, letters, and/or e-mails responding to child care providers' questions and requests. The nurse consultants also provided health and safety programs for 18,758 children in the child care setting.

Pregnancy Risk Assessment Monitoring System (PRAMS)

The Alabama Pregnancy Risk Assessment Monitoring System started collecting data in 1992. It is designed to help state health departments establish and maintain a surveillance system of selected maternal behaviors. The CDC collaborated with Alabama, other states and the District of Columbia to implement the system. PRAMS is an ongoing, population-based surveillance system designed to generate state-specific data for planning and assessing perinatal health programs. Maternal behavior and pregnancy outcomes have been strongly associated, thus the impetus for seeking to improve efforts to understand contributing factors to infant mortality and low birth weight. The information provided includes topics ranging from obstetrical history and prenatal care to maternal stress factors and pregnancy intentions.

In 2011 the project continues to operate as a population-based surveillance system. In an effort to increase response rates, the sampling scheme was modified in early 2007, excluding low birthweight as a stratification variable, and rewards are now offered to mothers for completing the survey. The goals of PRAMS include the following: (a) describe maternal behaviors during pregnancy and early infancy; (b) analyze relationships between behaviors, pregnancy outcomes (i.e., low birth weight, prematurity, growth retardation, etc.) and early infancy morbidity; (c) serve as a resource for the development and implementation of intervention programs, as well as effectively targeting existing programs; and (d) evaluate intervention efforts.

PERINATAL PROGRAM ACTIVITIES

Perinatal nurse coordinator positions were created by ADPH in 2002 for each of the perinatal regions across the state. The positions were designed to strengthen statewide efforts to maximize perinatal health by coordinating a regional system of perinatal care for improved access and quality of services for pregnant women, mothers and infants. The State Perinatal Program has partnered with March of Dimes since 2004 to address the problem of premature births. The perinatal staff has provided education to physicians and their office staff, in addition to maternity hospital staff, regarding preconception, prenatal and infant care patient education to improve perinatal outcomes.

Included in these trainings were: smoking cessation counseling, importance of preconception ideal body weight, effects of alcohol and substance abuse on pregnancy, importance of folic acid supplementation for all women of childbearing age, breastfeeding promotion and support, safe infant sleep environment and newborn screening. Collateral functions of the perinatal staff included managing the respective Regional Perinatal Advisory Council (RPAC) activities and implementing policies and guidelines of the State Perinatal Advisory Council (SPAC).

The Fetal and Infant Mortality Review (FIMR) Program was implemented in 2009 as a statewide initiative to address the state's high infant mortality rate. The purpose is to identify critical community strengths and weaknesses as well as unique health/social issues associated with poor outcomes of pregnancy. The FIMR Program is based on the national model developed by the American College of Obstetricians and Gynecologists in collaboration with the federal Maternal and Child Health Bureau.

The perinatal staff collected data on all fetal and infant deaths that occurred in 2011; however, due to the large number of fetal and infant deaths and the inability to review all of the deaths, the FIMR program focused on a cohort of infant deaths for review. Fetal deaths 24 weeks gestation or greater and 500 grams or greater and selected infant deaths were chosen as the deaths that would be reviewed in 2011. The perinatal staff abstracted all data and conducted the maternal interview. The de-identified case summaries were presented to the Case Review Team (CRT) by the perinatal staff. The RPACs assumed the role of the CRT. The RPACs met monthly, instead of quarterly, in an effort to review the large number of case summaries in a timely manner. Community Action Teams (CATs) were created in each region to implement the CRT recommendations. Community action teams were active in Baldwin, Calhoun, Cleburne, Jefferson, Madison, Mobile, Montgomery, Talladega, and Tuscaloosa Counties. The CATs continue to develop and implement plans that lead to positive changes within the community throughout the state. Actions implemented in 2011 include: 1) providing a perinatal loss conference for hospital staff; 2) collaborating with a summer food program to provide a "Summer Food and Fun Program". The eight-week project was held at the McDonald Hughes Community Center in Tuscaloosa where healthy living and wellness education, physical activity, art and reading enrichment were provided to youth who participated in the program; 3) a specialized prenatal class was implemented just for teens at no cost through a women's mission group at Grace Baptist Church in Oxford; and 4) events were held in several regions to commemorate infant and fetal loss on the National Perinatal and Infant Loss day.

In 2010, the program received a three year grant from the Health Resources and Services Administration. The total amount of the award was \$1.5 million over the grant period. The goal

of the project is to promote positive birth outcomes and ultimately to decrease infant mortality. The program launched a statewide social media campaign to increase awareness of preconception/interconception, prenatal care, family support and parenting among first time mothers/new parents. The *Get a [^]healthy Life Campaign* was implemented through multimedia projects and partnerships with community stakeholders.

The *Get a [^]healthy Life Campaign* partnered with several departments, agencies and organizations to raise awareness. Partnerships included: 1) the Communication and Health Marketing Division that developed the campaign's brand, marketing strategy, Facebook, and webpage; 2) HIV /AIDS Division provided the campaign the opportunity to collaborate and exhibit at Historically Black Colleges and Universities where the division was providing free HIV testing; 3) Family Planning Clinics in Etowah and Calhoun counties were pilot sites for the campaign. The clinics provide assessments, education, and care coordination to women that were high risk for having an unplanned pregnancy; 4) the FOCUS Program, a peer to peer education program that promotes school and community partnerships for the prevention of HIV/AIDS and other adolescent risk behaviors, provided the opportunity to provide education to high school students; 5) two pregnancy testing sites provided GAL materials and education regarding the importance of being healthy prior to becoming pregnant to mothers whose pregnancy test were negative; 6) Medicaid Maternity Care Contractors were provided GAL educational materials to give to their mothers at their postpartum visit; and 7) WIC was provided educational materials to distribute to the clients.

ASSESSMENT OF THE MATERNAL/INFANT POPULATION

ADPH, through the Bureau of Family Health Services (BFHS), continued as the lead agency for assessing needs pertaining to pregnant women, mothers and infants. The bureau's Maternal and Child Health Epidemiology Branch staff continued coordinating BFHS's needs assessment activities. One major change in the state's demographics has been an increase in Hispanic births. Based on birth certificate data, the number of live births to Hispanic residents increased more than 15-fold in 17 years, from 344 in 1990 to 5,342 in 2007. This number then declined to 5,258 in 2008 and 5,066 in 2009 and 4,831 in 2010. Comparing 2008 to 2003, the number of live births to Hispanic residents increased by a factor of 1.8: from 2,972 in 2003 to 5,258 in 2008. The rise in the Hispanic population is impacting the services being provided to families by ADPH. Translators, bilingual staff and appropriate written literature are factors that must be addressed. BFHS continues to assess the ever-changing needs of Alabama's population and develop strategies to address these needs. The Fiscal Years 2009-10 Statewide 5-Year Maternal and Child Health Needs Assessment was completed with the final report being submitted to the federal Maternal and Child Health Bureau in September 2010.

FY 2012 GOALS

1. Decrease infant morbidity and mortality by identifying the contributing factors and implementing steps to mitigate those factors.
2. Improve healthcare services for mothers and infants through facilitation of state, regional and local/community collaboration, interest and action regarding healthcare needs and services.

FY 2012 OBJECTIVES

1. Identify factors that contribute to fetal and infant deaths by reviewing 50.0 percent of infant deaths that occur in 2011 through the FIMR Program.
2. Decrease the number of Alabama unintended births to 50.0 percent (Alabama Baseline: 53.5 percent in 2009; source ADPH, Center for Health Statistics).
3. Decrease the infant mortality rate among blacks to no more than 13.0 per 1,000 live births (AL & Healthy People [HP] Objective, Alabama Baseline: 13.7 per 1,000 live births in 2010; source ADPH, Center for Health Statistics).
4. Decrease the incidence of low birth weight births to no more than 10 per 1,000 live births (AL & HP Objective, Alabama Baseline: 10.3 per 1,000 live births in 2010; source ADPH, Center for Health Statistics).
5. Decrease the percent of women who smoke during pregnancy to 12.8 percent (AL & HP Objective, Alabama Baseline: 13.1 percent in 2010; source ADPH, Center for Health Statistics).
6. Decrease the percent of adolescents age 10 – 19 who smoke during pregnancy to 11.0 percent (AL & HP Objective, Alabama Baseline: 11.6 percent in 2010; source ADPH, Center for Health Statistics).
7. Decrease pregnancies among adolescents age 10 – 19 to no more than 12.0 percent of live births (AL Objective, Alabama Baseline: 12.4 percent of live births in 2010; source ADPH, Center for Health Statistics).
8. Increase the percent of births with adequate prenatal care to 74.0 percent, adequacy of care measured using the Kotelchuck index (AL & HP Objective, Alabama Baseline: 73.0 percent in 2009; source ADPH, Center for Health Statistics).
9. Increase the percent of mothers who place their infants on their backs for sleeping to 70.0 percent (AL Objective, Alabama Baseline: 62.2 percent in 2009; source ADPH, Center for Health Statistics).

10. Increase the percent of mothers who initiate breastfeeding to 70.0 percent (AL Objective, Alabama Baseline 64.8 percent in 2009; source ADPH Center for Health Statistics).

APPENDICES

APPENDIX A

Alabama Perinatal Healthcare Act (1980)

**CHAPTER 12A.
PERINATAL HEALTHCARE.**

Sec.
22-12A-1. Short title.
22-12A-2. Legislative intent; "perinatal" defined.
22-12A-3. Plan to Decrease infant mortality and handicapping conditions; procedure, contents, etc.
22-12A-4. Bureau of maternal and child

Sec.
health to develop priorities, guidelines, etc.
22.12A-5. Bureau to present report to legislative committee; public health funds not to be used.
22.12A-6. Use of funds generally.

§22-12A-1. Short title.

This chapter may be cited as the Alabama Perinatal Health Act. (Acts 1980, No.80-761, p. 1586, § 1.)

§22-12A-2. Legislative intent; "perinatal" defined.

(a) It is the legislative intent to effect a program in this state of:

(1) Perinatal care in order to Decrease infant mortality and handicapping conditions;

(2) Administering such policy by supporting quality perinatal care at the most appropriate level in the closest proximity to the patients' residences and based on the levels of care concept of regionalization; and

(3) Encouraging the closest cooperation between various state and local agencies and private healthcare services in providing high quality, low cost prevention oriented perinatal care, including optional educational programs.

(b) For the purposes of this chapter, the word "perinatal" shall include that period from conception to one year post delivery. (Acts 1980, No.80-761, p. 1586, § 2; Acts 1981, 3rd Ex. Sess., No.81-1140, p. 417, § 1.)

§ 22-12A-3. Plan to Decrease infant mortality and handicapping conditions; procedure, contents, etc.

The bureau of maternal and child health under the direction of the state board of health shall, in coordination with the state health planning and development agency, the state health coordinating council, the Alabama council on maternal and infant health and the regional and state perinatal advisory committees, annually prepare a plan, consistent with the legislative intent of section 22-12A-2, to Decrease infant mortality and handicapping conditions to be presented to legislative health and finance committees prior to each regular session of the legislature. Such a plan shall include: primary care, hospital and prenatal; secondary and tertiary levels of care both in hospital and on an out-patient basis; transportation of patients for medical services and care and follow-up and evaluation of infants through the first year of life; and optional educational programs, including pupils in schools at appropriate ages, for good perinatal care covered pursuant to the provisions of this chapter. All recommendations for expenditure of funds shall be in accord with provisions of this plan. (Acts 1980, No.80-761, p. 1586, § 3; Acts 1981, 3rd Ex. Sess., No.81-1140, p. 417, § 1.)

§ 22-12A-4. Bureau of maternal and child health to develop priorities, guidelines, etc.

The bureau of maternal and child health under the direction of the state board of health, and the state perinatal advisory committee representing the regional perinatal advisory committees, shall develop priorities, guidelines and administrative procedures for the expenditures of funds therefore. Such priorities, guidelines and procedures shall be subject to the approval of the state board of health. (Acts 1980, No. 80-761, p. 1586, § 4.)

§ 22-12A-5. Bureau to present report to legislative committee; public health funds not to be used.

The bureau of maternal and child health under the direction of the state board of health shall annually present a progress report dealing with infant mortality and handicapping conditions to the legislative health and finance committees prior to each regular session of the legislature. No funds of the state department of public health shall be used for the cost of any reports or any function of any of the committees named in section 22-12A-3. (Acts 1980, No. 80-761, p. 1586, § 5.)

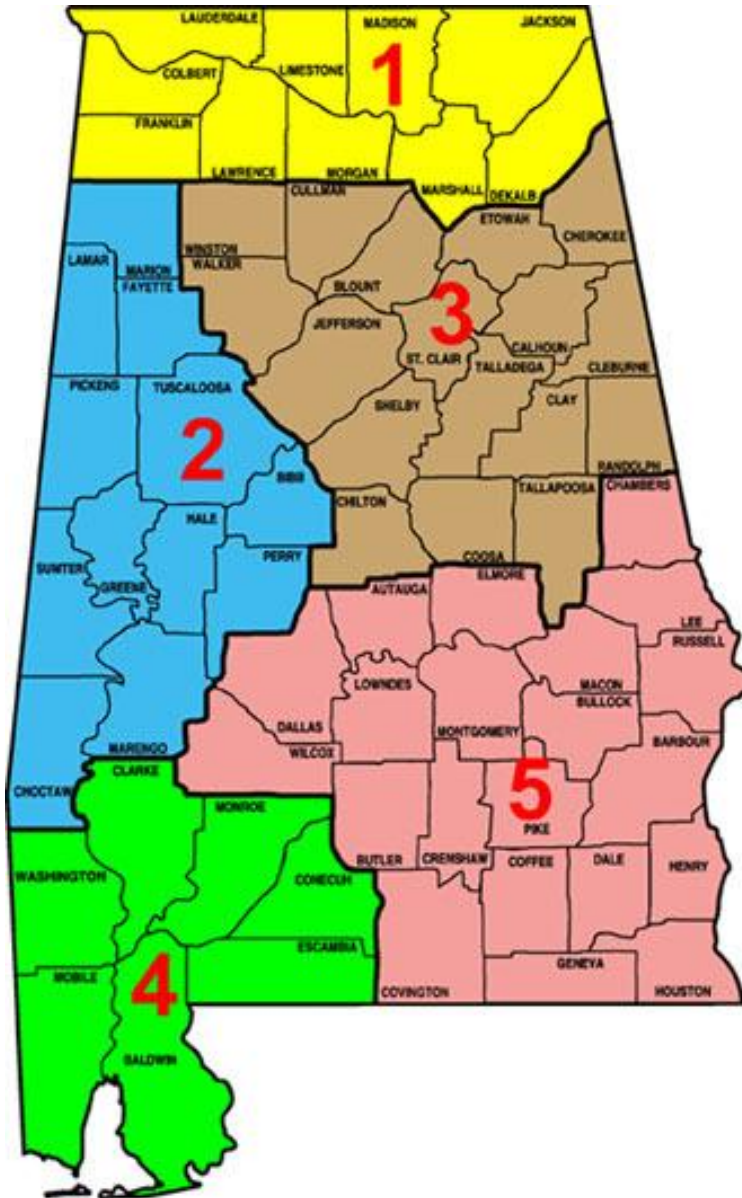
§ 22-12A-6. Use of funds generally.

Available funds will be expended in each geographic area based on provisions within the plan developed in accordance with section 22- 12A-3. Funds when available will be used to support medical care and transportation for women and infants at high risk for infant mortality or major handicapping conditions who are unable to pay for appropriate care. Funds will only be used to provide prenatal care, transportation, hospital care for high risk mothers and infants, outpatient care in the first year of life and educational services to improve such care, including optional educational programs, for pupils in schools at appropriate ages but subject to review and approval by the local school boards involved on an annual basis. (Acts 1980, No.80-761, p. 1586, § 6; Acts 1981, 3rd Ex. Sess., No.81-1140. p. 417, § I.)

APPENDIX B

Perinatal Regions Map

Perinatal Regions



The Alabama Perinatal Program, under the auspices of the Alabama Department of Public Health, has five (5) designated Regional Perinatal Centers. These centers serve as the central perinatal centers for the populations within the designated geographical areas. The designated Perinatal Regions based on their Neonatal Intensive Care Units (NICUs) are:



- (1) Huntsville Hospital, Madison
- (2) DCH Regional Medical Center, Tuscaloosa
- (3) University of Alabama at Birmingham, Jefferson
- (4) University of South Alabama, Mobile
- (5) Baptist Medical Center, Montgomery