ALABAMA PERINATAL HEALTH ACT

Annual Progress Report for Fiscal Year (FY) 2013

Plan for FY 2014

State and Regional Perinatal Advisory Committee 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

It is my pleasure to present the Alabama Perinatal Progress Report, which describes the fiscal year 2013 activities and accomplishments of the State Perinatal Program.

Alabama's infant mortality rate increased from 8.1 to 8.9 deaths per 1,000 live births in 2012. The increase is evidence that continued support for the State Perinatal Program is needed. Most importantly, we are reminded that the health status of mothers and infants in Alabama continues to be a troubling issue. We must address the increasing number of low birthweight births in Alabama and subsequent infant deaths and morbidities that have long-term consequences for families and society. We also need to decrease elective deliveries less than 39 weeks gestation when there is no medical indication, promote safe sleep practices, and foster smoking cessation. To this end, the State Perinatal Program developed strategies to address factors associated with adverse outcomes of pregnancy. These strategies and the problems they address are described in detail in this report.

Leading perinatal providers in our state met throughout 2013 to guide the State Perinatal Program. I believe the initiatives under development will yield long-term benefits as more infants grow up to become healthy children and contributing adults. This report is available at ***www.adph.org/perinatal***.

Sincerely,

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

The RSA Tower • 201 Monroe Street • Montgomery, AL 36104
P.O. Box 303017 • Montgomery, AL 36130-3017

State Perinatal Advisory Committee (SPAC) Members 2013-2014

REGION I	
Laura Thompson, RN Huntsville	Eileen Dover, RN, CNM Huntsville
REGION II	
James Leeper, PhD Tuscaloosa	Daniel Avery, MD Tuscaloosa
REGION III	
Elaine St. John, MD Birmingham	Martha Wingate, DrPH Birmingham
REGION IV	
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REGION V	
Martha Jinright, MBA Montgomery	Marilyn Rhodes, MSN, RN Montgomery
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University of Alabama at Birmingham Division of Neonatology	Waldemar Carlo, MD – Birmingham
University of South Alabama Department of Obstetrics and Gynecology	David F. Lewis, MD – Mobile
University of South Alabama Division of Neonatology	Michael Zayek, MD – Mobile
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Alabama Department of Human Resources	Carolyn Lapsley, MSW – Montgomery

Joey Biggio, MD, Chairperson
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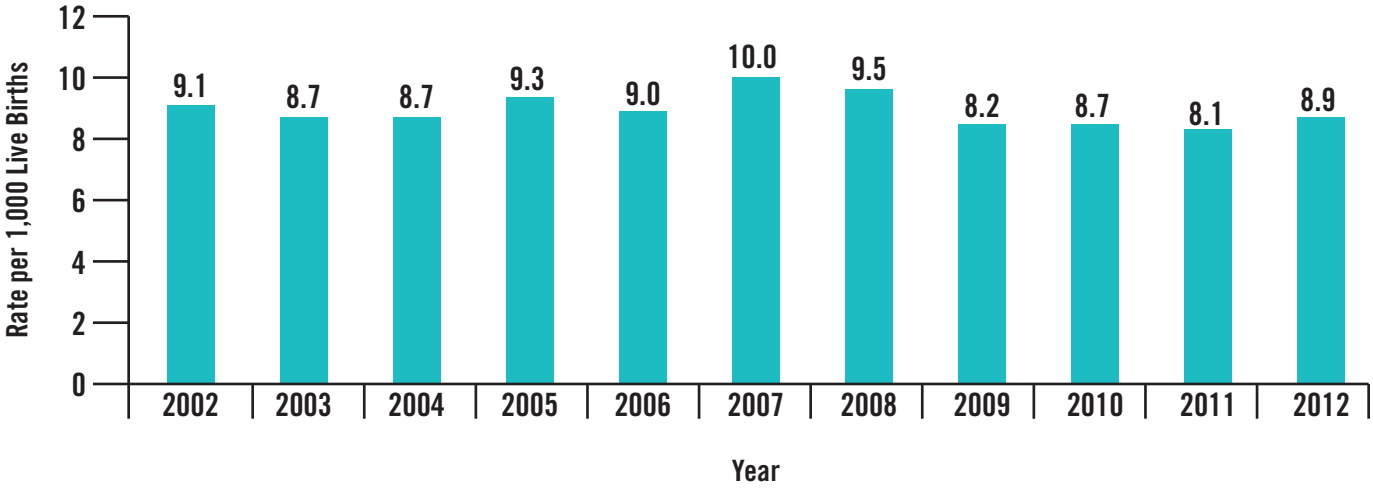
INTRODUCTION

Infant mortality is an indicator used to characterize the health status of communities and states. In 2012, a total of 519 infants died in Alabama before their first birthday. The infant mortality rate (IMR) increased from 8.1 infant deaths per 1,000 live births in 2011 to 8.9 infant deaths per 1,000 live births in 2012 (Chart 1). The percent of births with adequate prenatal care increased to 74.1 percent in 2012, from 71.5 percent in 2011. At the same time, the number of births with no prenatal care decreased to 926 in 2012 from 1,087 in 2011. Alabama's IMR continues to remain among the highest in the nation. The national 2011 provisional IMR rate was 6.0 infant deaths per 1,000 live births.

Chart 1. Infant Mortality Rates Alabama, 2002 - 2012



Factors contributing to infant mortality included maternal chronic health conditions existing prior to pregnancy, short inter-pregnancy intervals, teen pregnancies, previous preterm births and unhealthy lifestyles and behaviors. Low birthweight (LBW) infants accounted for 71.4 percent of the 2012 infant deaths; however, survivability of these small infants has greatly improved in the past decade. In 2012, 14.9 percent of the births in Alabama were premature. A comparison to the national percentage of 12.2 in 2009 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 50.4 percent more likely to have a premature birth than white mothers. The 2012 percent of prematurity for black infants was 19.4 compared to 12.9 for whites.

An important indicator of infant morbidity is the number of newborns being admitted to neonatal intensive care units (NICU). Alabama has seen an increase in NICU admissions since 2008. In 2012, NICU admissions increased to 5,081 compared to 5,049 in 2011. 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 State 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 IMR, 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 Committee (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 served as the framework for the organization of 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 the 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 2013, 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 numbers of live births and birth rates for residents of Alabama from 2008 through 2012 are listed in Table 1.

Table 1. Resident Births and Birth Rates* By Race of Mother, Alabama, 2008-2012

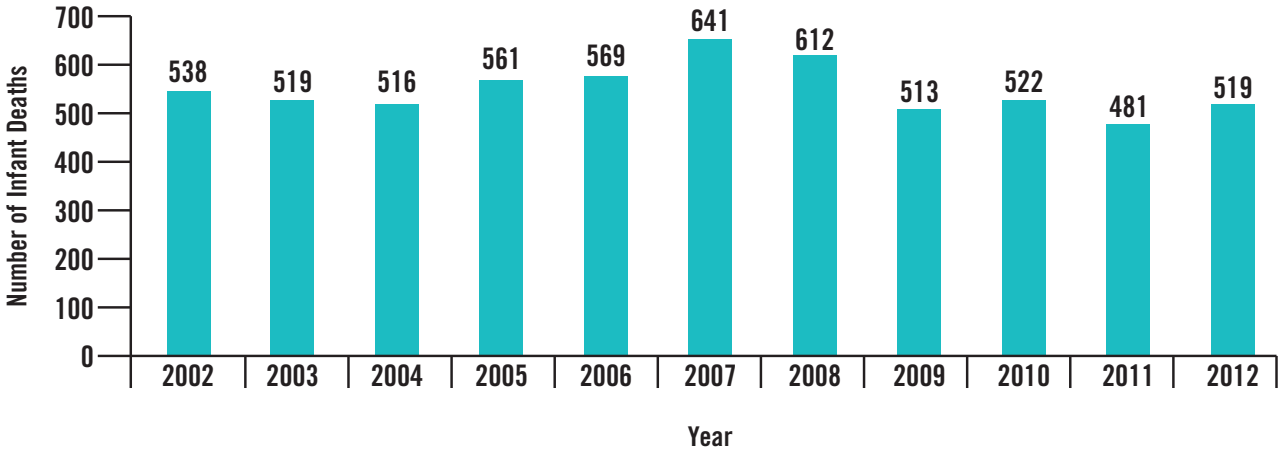
YEAR	TOTAL		WHITE		BLACK AND OTHER	
	NUMBER	RATE*	NUMBER	RATE*	NUMBER	RATE*
2008	64,345	13.8	42,897	13.0	21,448	15.9
2009	62,476	13.3	41,963	12.6	20,513	15.0
2010	59,979	12.5	40,193	12.3	19,786	13.2
2011	59,322	12.4	39,770	11.8	19,552	13.6
2012	58,381	12.1	38,637	11.5	19,744	13.6

***Rate is per 1,000 population for specified group.**

Infant Mortality Rate[1]

Alabama's 2012 IMR of 8.9 (519) infant deaths per 1,000 live births is an increase from the 2011 rate of 8.1 (481) (Chart 2). The highest county rate in 2012 was found in Conecuh County with a rate of 29.0 deaths per 1,000 live births.

Chart 2. Number of Infant Deaths, Alabama, 2002 – 2012



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 14.4, in 2012, the IMR for blacks increased from the 13.0 rate of 2011; furthermore, the rate of 14.4 is 118.2 percent higher than the rate for white infants. The IMR for white infants, 6.6, increased from the 2011 rate of 6.1.

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 that require continued attention from healthcare leaders and policymakers include: **(1)** LBW infants; **(2)** unintended pregnancies; **(3)** teen pregnancies; **(4)** preconception status of mothers; **(5)** substance abuse; 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 IMR. Babies born too soon or too small involve significant risks of serious morbidity. Very low birthweight (VLBW) (under 3 lbs. 5 oz.) infants accounted for 279 of the 519 infant deaths in 2012. 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 a positive impact on neonatal mortality (the first 28 days after birth); however, the VLBW 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).

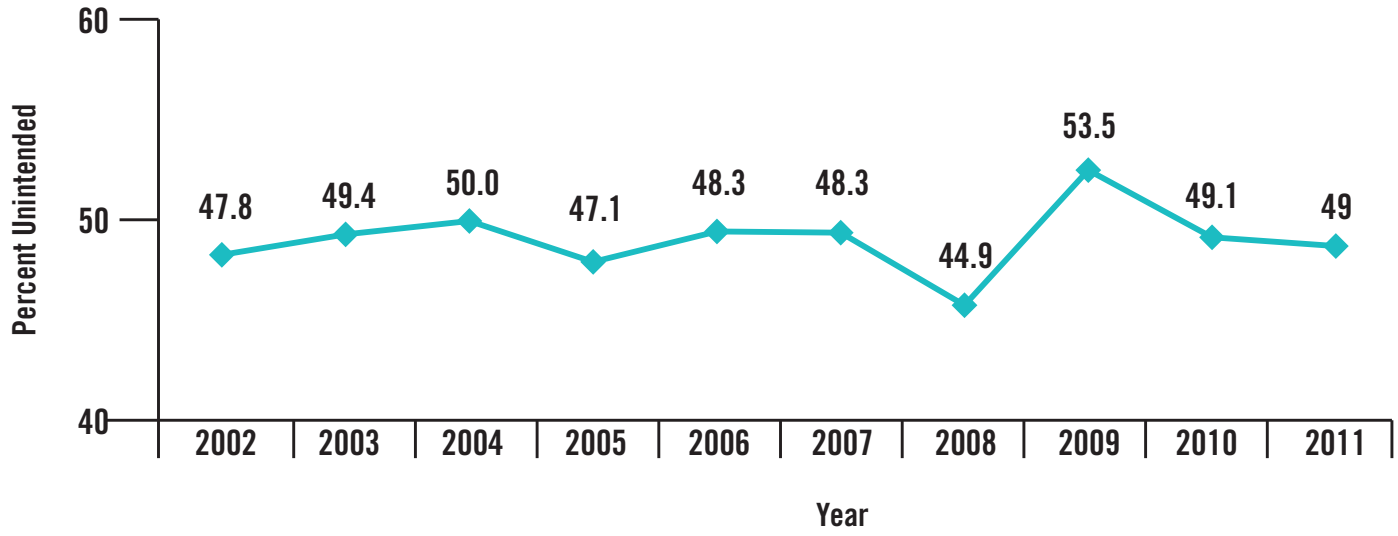
The definitive cause(s) of prematurity remains unknown; however, the increasing magnitude of the problem has gained the attention of medical researchers and scientists. Currently, the one measure that can reduce prematurity is prevention of unintended pregnancies in women who have experienced a previous 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.

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

Unintended Pregnancy

The latest data on unintendedness (2011 data) showed that 49.0 percent of births in Alabama occurred to women who wanted a later pregnancy or to women who did not want to ever become pregnant (Chart 3). 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.

Chart 3. Unintended Births in Alabama, Alabama PRAMS[2] 2002 - 2011



[2] Obtained from the "PRAMS Surveillance Report," The Pregnancy Risk Assessment Management System (PRAMS) by the Center of Health Statistics, ADPH 2011

Teenage Pregnancy

The percent of births to teens in 2012 was the lowest in Alabama's history. The numbers of teen births and percent of teen births for residents of Alabama during 2008 to 2012 are listed in Table 2. Continued focus on efforts to reduce teen childbearing will serve to positively impact Alabama's IMR. Teen births produce multifaceted consequences that impact families and society. Teens are more likely to have VLBW or extremely low birthweight infants and birthweight is the factor most clearly related to infant death. Additionally, the low breastfeeding rate among teen mothers increases the morbidity risk for these infants.

Table 2. Percent of Births to Teens by Race of Mother and Marital Status, 2008-2012

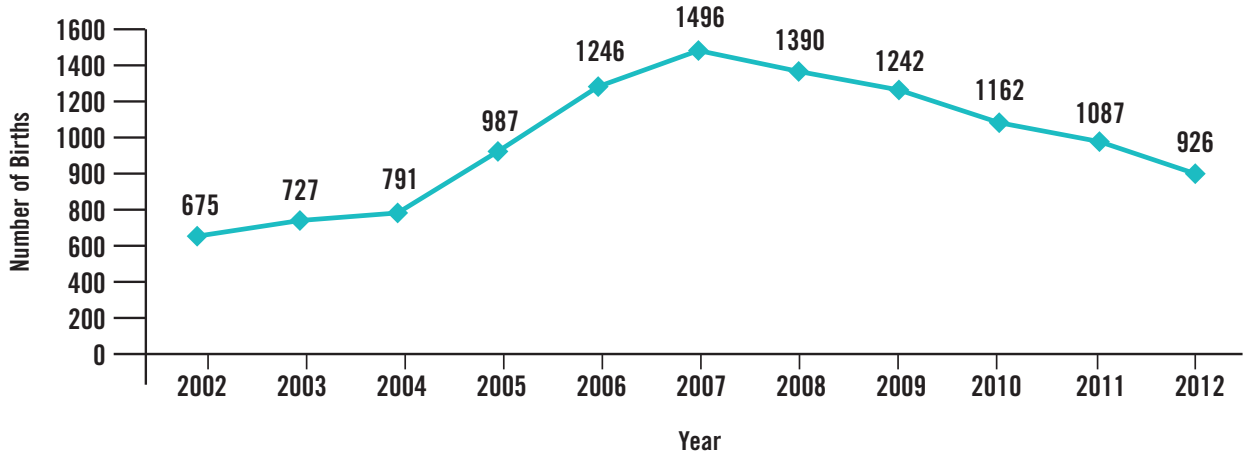
YEAR	Total		White		Black and Other		Unmarried	
	Number	Percent of Births	Number	White	Number	Black and other	Number	Unmarried
2008	8,567	13.3	4,742	11.1	3,825	17.8	6,699	78.2
2009	8,365	13.4	4,769	11.4	3,596	17.5	6,616	79.1
2010	7,446	12.4	4,196	10.4	3,250	16.4	6,135	82.4
2011	6,697	11.3	3,799	9.6	2,898	14.8	5,554	82.9
2012	6,236	10.7	3,546	9.2	2,690	13.6	5,202	83.4

Preconception and Interconception 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 LBW infant than are women who were normal weight before pregnancy. Obesity, along with chronic diseases such as diabetes and hypertension, are major causes of perinatal morbidity.

Prenatal Care

Chart 4. Births with No Prenatal Care, Alabama, 2002 - 2012



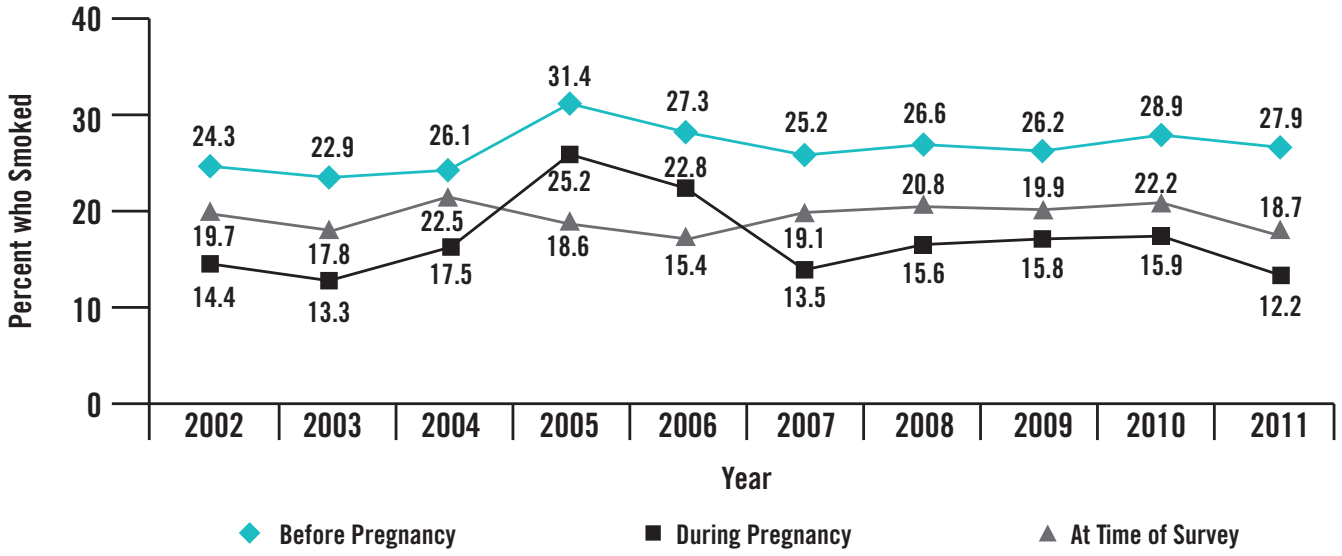
Early and adequate prenatal care to mothers remains a crucial factor in reducing IMRs. The IMR among mothers who received no prenatal care or who initiated care in the third trimester continues to be two times higher than the mothers who received prenatal care in the first trimester. In 2012, only 74.1 percent of the births were to women who had adequate prenatal care. In addition, 926 mothers did not receive any prenatal care (Chart 4).

Substance Abuse

The use of nicotine, alcohol, and drugs during pregnancy is another factor contributing to infant death and LBW. In 2012, Alabama's statistics indicated babies of mothers who smoked are 50.6 percent more likely to die than infants of nonsmoking mothers, with the rate for smokers being 12.5 per 1,000 live births compared to 8.3 for babies of nonsmokers.

One of the objectives of Healthy People 2020 is to increase abstention from cigarette smoking by pregnant women to 98.6 percent. Alabama is not close to achieving this goal. Historically, in Alabama, smoking decreases during pregnancy in the majority of women, only to increase again after the birth of their infants. This pattern was repeated in 2011, although 12.2 percent of Alabama mothers continued to smoke while pregnant. From 2010 to 2011, the decreases in smoking seen during the three time periods (before, during, and after pregnancy) were not statistically significant (Chart 5).

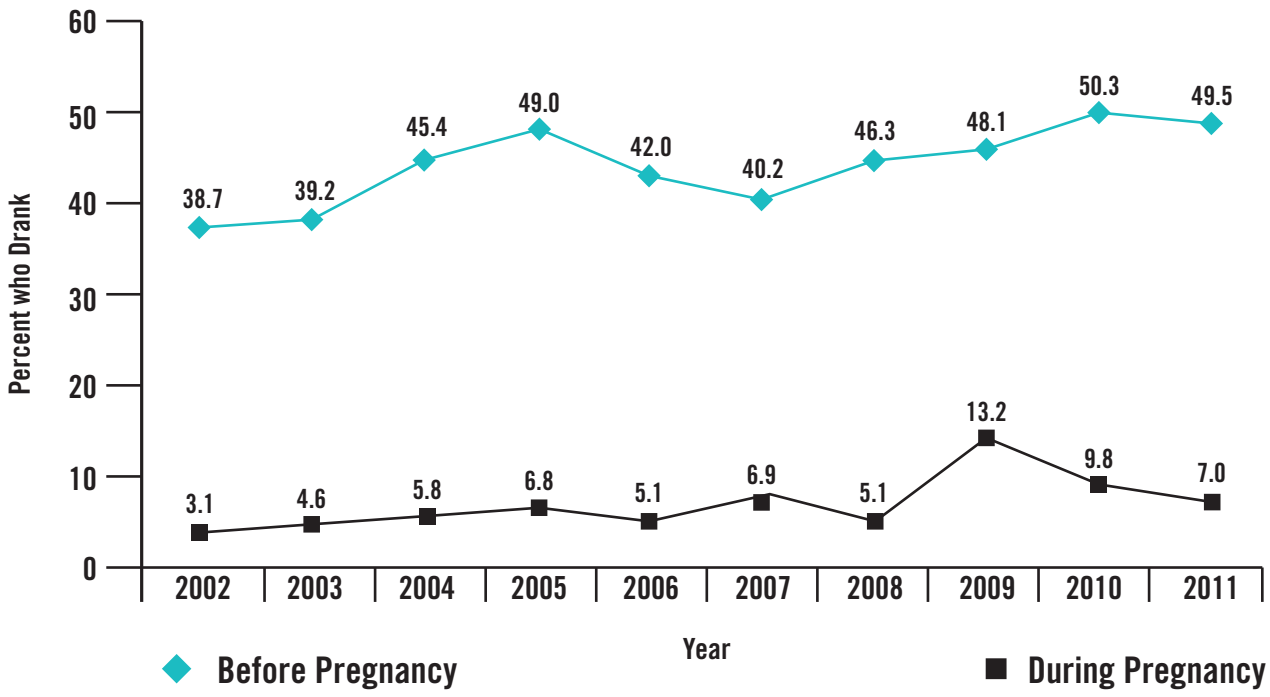
Chart 5. Percent of Mothers Who Smoked, Alabama PRAMS, 2002 - 2011



The percentage of births to teenage women who used tobacco decreased to 10.5 in 2012, compared to 10.8 in 2011. During 2012, tobacco use among women, aged 20 or more, increased from 10.6 percent to 10.7 percent. In 2012, white teenage mothers were 7.3 times more likely to smoke than black teen mothers. Smoking is associated with LBW, 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 2011 data from the PRAMS survey indicated that 49.5 percent of all new mothers indicated they drank in the three months before pregnancy. In the last three months of pregnancy, only 7.0 percent of mothers reported drinking, a decrease of 85.9 percent (Chart 6). Although most mothers apparently realize that drinking during pregnancy can have detrimental effects on their babies and they curtail their consumption of alcohol, mothers of approximately 4,087 babies continued to use alcohol while pregnant. From 2010 to 2011, there was a slight decrease of 1.6 percent in drinking *before* becoming pregnant and a decrease of 28.6 percent in drinking during the last three months of pregnancy reported by Alabama mothers. From 2002 to 2011, there was a signifigant decrease in the number of women who drank *during* their pregnancies compared to their consumption prior to pregnancy.

Chart 6. Percent of Mothers Who Drank Before and During Pregnancy, Alabama PRAMS, 2002 - 2011



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 and Human Immunodeficiency Virus, the virus which causes Acquired Immunodeficiency Syndrome. Pregnant women who use cocaine are at risk of preterm labor and their children are at an increased risk for compromised neurological development. Methamphetamine and methadone are the emerging drugs of choice for many women in Alabama. The effects of these substances to the fetus 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 2012, infants of mothers with no insurance coverage and who did not qualify for Medicaid had the highest IMR at 22.7 infant deaths per 1,000 live births. Medicaid babies had a rate of 9.7 infant deaths per 1,000 live births and those whose mothers had private insurance had the lowest IMR at 6.8 infant deaths per 1,000 live births. During 2012, Medicaid paid for 52.6 percent of births.

STATE PERINATAL PROGRAM ACTIVITIES

Perinatal nurse coordinator 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. Collateral functions of the perinatal program included administering the Fetal and Infant Mortality Review (FIMR) program, raising awareness of the importance of preconception and interconception care via the Get a Healthy Life campaign, coordinating the Collaborative Improvement and Innovation Network (CoIIN) to Reduce Infant Mortality, participating on state and national committees, providing outreach and education to providers and the public, managing the respective RPAC activities and implementing the policies and guidelines of the SPAC. Due to the financial challenges of the state the perinatal coordinators positions were abolished in Regions II and V in FY 2013.

Fetal and Infant Mortality Review Program

FIMR was implemented in 2009 as a statewide initiative to address the state's high IMR. The program's 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 Congress of Obstetricians and Gynecologists (ACOG) in collaboration with the federal Maternal and Child Health Bureau.

The state perinatal program director reviewed all fetal records and birth and death certificates of infant deaths that occurred in 2013. However, due to the large number of deaths, the FIMR program focused on a select group of infant deaths for review: those mothers who consented to a maternal interview in Regions I and III and all fetal and infant deaths in Region IV. The perinatal staff abstracted data and conducted maternal interviews. The de-identified case summaries were presented to the Case Review Teams (CRTs) by the perinatal staff. The RPACs assumed the role of the CRTs. The RPACs met monthly, instead of quarterly, in an effort to review the large number of case summaries in a timely manner. Due to the abolishment of the perinatal coordinators positions in Regions II and V, neither case review, maternal interview, nor data abstraction for fetal and infant deaths occurred in these regions.

The CRTs provided recommendations to the Community Action Teams (CATs) which then developed plans of action and implementation to address the identified, contributing factors at the community level. One CAT is in each perinatal region except Region II, with some regions having more than one CAT. CATs were active in Baldwin County – Babies and Moms (BAM), Calhoun/Cleburne/Talladega Counties, Escambia County, Jefferson County, Madison County, Mobile County – Alabama Baby Coalition (ABC), and Montgomery County – Montgomery River Region. The Region V CAT continued to meet bimonthly to implement 2011 CRT recommendations. The CATs continued to develop and implement plans that led to positive changes within communities throughout the state. Actions implemented in 2013 were based on 2012 recommendations. Actions of the CATs included the following:

REGION 1:
RECOMMENDATION: Provide and increase adequate grief follow-up, referrals/support for women and their families following a fetal or infant loss.

ACTIONS: Madison County CAT: The team held its third annual Pregnancy and Infant Loss Remembrance Day event to commemorate fetal and infant loss in the community with 75 to 100 people attending the event. The event included a local minister speaking; opportunities for families to write a message to their baby, a slideshow, with pictures and poems from families to honor their babies, and a balloon release after the event. Grief support is provided to the families who have experienced a loss in the region, primarily through the "Healing Hearts for Baby Loss of North Alabama" Facebook page and the local Resolve Through Sharing (RTS) grief support group. The Facebook page has approximately 120 friends and is maintained by two of the "friends," one of which is a mother who has experienced a loss. RTS meets monthly and members participate in the annual Pregnancy and Infant Loss Remembrance Day event.

REGION 3:
RECOMMENDATION: Safe sleep education should be provided to all new mothers by all healthcare professionals involved in her care.

ACTIONS: Jefferson County CAT: The team is made up of two subcommittees of the Children's Policy Council for Jefferson County: the Safety Committee and the Reproductive Health Committee. The safety group met six times during the year. The Safety Committee members continued to order and distribute approximately 500 Safe Sleep brochures throughout Jefferson County where services are offered to mothers of newborns. The CAT continued to support the Birmingham Cribs for Kids® Program which distributed 100 cribs to families in the Birmingham area. The Reproductive Health Committee met three times before the committee chair resigned.

RECOMMENDATION: Provide education on the signs and symptoms of preterm labor, premature rupture of membrane, and loss of fetal activity.

ACTIONS: Calhoun County CAT: The team continued to distribute educational materials for patients to hospitals, physicians, and care coordinators regarding signs and symptoms of preterm labor, spontaneous rupture of membranes, and assessment of kick counts. The information was shared with more than 93 physicians, nurses, and maternity care coordinators.

REGION 4:
RECOMMENDATION: Provide safe sleep education to parents to reduce the deaths related to unsafe sleep environments.

ACTIONS: BAM: Team members attended safe sleep training seminars. A total of 100 cribs were donated by the Children's Trust Fund Cribs for Kids® Program. BAM distributed 70 of those cribs in the Baldwin County Area. The team held a safe sleep interview on TV 10 with Devon Walsh to advertise the safe sleep classes. The classes were also advertised on the local radio stations. Eight safe sleep classes were held in the community. Attendance of the safe sleep class is mandatory for mothers to receive a crib. The classes were held at North Baldwin Infirmary in Bay Minette, South Baldwin Medical Center in Foley, and Thomas Medical Center in Daphne. More classes are being scheduled and will be held before December 31, 2013, to distribute the remaining 30 cribs.

RECOMMENDATION: A recommendation has been made for the ABC to partner with the Cribs for Kids® Program and Alabama Children's Trust Fund to provide cribs for those who need them.

ACTIONS: ABC: The team partnered with the Cribs for Kids® Program and provided a Graco® Pack & Play portable crib to teen moms in need of a crib. One hundred cribs were also donated to the ABC by the Children's Trust Fund Cribs for Kids® Program. They have distributed approximately 75 cribs in Mobile County.

REGION 5:
RECOMMENDATION: Provide and increase adequate grief referrals and support for women and their families following a fetal or infant loss.

ACTIONS: Montgomery River Region: The second memorial to commemorate infant loss was held October 15, 2012 on the national Pregnancy and Infant Loss Remembrance Day. Approximately 100 people attended the event. The memorial was held on the terrace of the Montgomery Museum of Fine Arts. The Grief Resource Guide for the River Region that was developed by the CAT in 2012 continued to be disseminated to providers in the region in 2013.

RECOMMENDATION: Provide safe sleep education to every mother who delivers in an Alabama hospital and provide assistance if needed in obtaining a safe sleep environment for an infant.

ACTIONS: The CAT distributed approximately 400 safe sleep posters to physicians, patients, community leaders, and hospitals in Region V. The CAT partnered with the Emergency Medical Services for Children to present a satellite program "Protecting Our Children: Recognizing Child Abuse." The presentation included safe sleep information. More than 1,300 people viewed the program on January 15, 2013. The presentation is available to view on demand on the ADPH Web site.

Get a Healthy Life Campaign

The FIMR 2009 identified preconception health as one of the leading contributing factors to infant death in Alabama. In September 2010, the program received a three-year grant from the Health Resources and Services Administration to raise awareness statewide, through social media, of the importance of preconception and interconception care. The total amount of the award was $1.5 million over the grant period. The goal of the project was to inform the public of the importance of being healthy before pregnancy, promote positive birth outcomes, and ultimately to decrease infant mortality. The program launched a statewide social media campaign to increase awareness of preconception/interconception health, prenatal care, family support, and parenting among first time mothers/new parents. The GAL campaign was implemented through multimedia projects and partnerships with community stakeholders.

The campaign ended August 2012 due to funds no longer being available by the funding agency. However, the campaign's Web site and Facebook page continued to be maintained by ADPH and materials produced by the grant funds continued to be distributed statewide in 2013. More than 45,000 campaign materials were provided for more than 45 events statewide including family planning clinics, health fairs, conferences, health department events, and other activities. For more information, please log on to **www.adph.org/gal.**

Text4baby

Text4baby is an education campaign of the National Healthy Mothers, Healthy Babies (HMHB) Coalition with more than 700 partners. The campaign helps pregnant women and new moms increase their knowledge about caring for their health and giving the best possible start in life to their babies. Text4baby supports moms by providing accurate, text-length health information and resources in a format that is personal and timely, using a channel they know and use. Pregnant women and new mothers who text "BABY" (or "BEBE" for Spanish) to 511411 receive weekly text messages (timed to their due date or their baby's birth date) throughout pregnancy and until the baby's first birthday. The text messages provide information on a variety of topics that are critical to maternal and child health, including developmental milestones, immunization, nutrition, mental health, safety, and more. Text4baby messages also connect women to resources and national hotlines.

APDH is the state lead outreach agency for text4baby in Alabama. As an outreach partner, ADPH spreads the word about text4baby in many different ways and encourages women to sign up for the service. ADPH collaborates with agencies and organizations within the state to promote enrolment into the program. Promotional materials to raise awareness of the campaign are provided by HMHB. As of September 30, 2013, approximately 13,656 individuals in Alabama were enrolled in text4baby. More than 2,756 promotional materials have been distributed within the state.

March of Dimes Collaborative

The State Perinatal Program has partnered with March of Dimes (MOD) since 2004 to address the problem of premature births. The program was a recipient of a 2012 Community Grant from the Alabama Chapter MOD. The grant supported FIMR activities. In March 2012, Dr. Donald Williamson, State Health Officer, signed an agreement with the MOD to commit to decreasing prematurity in Alabama by 8 percent by 2014 using the 2009 rate of 16.7 percent as a baseline. In 2012, the percent of preterm births decreased to a preliminary percentage of 14.6. When comparing this figure to the 2009 baseline of 15.6 percent preterm births, a 6.4 percent decrease occurred from 2009 to preliminary 2012.

Collaborative Improvement & Innovation Network to Reduce Infant Mortality

Alabama created a state team for each of the five strategic action teams and has appointed a CoIIN Director to coordinate all CoIIN efforts, both statewide and nationally. The five strategic action teams met monthly, or as needed, and the statewide team met quarterly. Statewide partners include: Alabama Perinatal Excellence Collaborative (APEC), the Alabama Medicaid Agency, the Alabama Hospital Association (AlaHA), MOD, the Association of Women's Health, Obstetric and Neonatal Nurses, UAB, USA, Medicaid Maternity Care Providers, Governor's Office, Alabama Department of Mental Health, Jefferson County Department of Health, Mobile County Health Department, Alabama Department of Human Resources, Children's Trust Fund in connection with the Alabama Department of Child Abuse and Neglect Prevention, health care providers, nurses, and others. These stakeholders invested time and effort in improving birth outcomes across the state.

Early Elective Delivery (EED):

National Aim: To reduce non-medically indicated, EED less than 39 weeks by 3 percent by December 2013.

Alabama's Aim: To reduce non-medically indicated EED less than 39 weeks by 3 percent by December 2013.

2013 Activities:

- Collaborating with AlaHA, the lead agency for the strategic team. AlaHA received funding from the Centers for Medicare and Medicaid Services to be a Hospital Engagement Network (HEN). AlaHA was assigned 20 delivering facilities within the state. Fourteen out of 20 participating hospitals in AlaHA HEN developed EED policies.
- AlaHA contacted all the delivering hospitals within the state to identify where the hospitals were in the process of addressing EED. Next, AlaHA engaged the delivering hospitals through their Quality Task Force Meetings. During the meetings hospitals who had successfully implemented a "hard stop" policy in their hospital shared their experiences. AlaHA collaborated with MOD and provided the MOD toolkit to hospitals. The APEC guidelines were introduced and made available on-line and later by mobile application. AlaHA conducted face-to-face meetings in hospitals, phone follow-up, and collaborated with the facilities to monitor the number of EED deliveries within their facility.
- According to AlaHA, the activities resulted in the following:
  - Thirty-one of the 50 delivering hospitals in Alabama developed a "hard stop" policy to eliminate non-medically indicated, EEDs.
  - Nine of the 50 delivering hospitals have a "soft stop" policy in place and six of those nine are working on putting a "hard stop" policy in place.
  - Two facilities in the state are not working on policies because they did not have EEDs without medical indication in the past year.
  - A 50 percent decrease in EEDs statewide since the initiative began in May 2012.

Interconception Care (ICC):

National Aim: To modify Medicaid policies and procedures in five to eight southern states by December 2013 in order to improve access to and financing of postpartum visits and inter-conception care case management for women who have experienced a Medicaid financed birth that resulted in an adverse pregnancy outcome.

Alabama's Aim: To modify Medicaid policies and procedures by December 2013 in order to improve access to postpartum visits and interconception care case management for women who have experienced a Medicaid financed birth that resulted in an adverse pregnancy outcome.

2013 Activities:

- The implementation of an ICC Program for women who remain on Medicaid after 60 days after delivery and who had an adverse pregnancy outcome that included: fetal death, VLBW delivery, LBW delivery, infant death, or premature birth.
- Development of a system of referral for the women who enroll in the ICC Program. The program began February 2013.
- APEC developed preconception guidelines that are provided to the primary medical provider (PMP) of women enrolled in the program.
- The following program data is from February 1, 2013 to August 1, 2013:
  - 169 referrals have been received
  - 154 of the 169 referrals have been contacted
  - 104 of the 154 women have accepted services
  - 67 of the 104 that accepted services saw their PMP within 60 days of delivery
  - 109 of the 139 (78 percent) infants delivered during this time saw their PMP after delivery
  - 10 of the 139 infants remained in the NICU at time of follow-up
  - 20 of the 139 infants were fetal or infant deaths

Smoking Cessation:

National Aim: To decrease the tobacco smoking rate by 3 percent among pregnant women in the states of Region IV and VI by December 2013. This 3 percent reduction will be a decrease of 254 women smoking during pregnancy in Alabama.

Alabama's Aim: To decrease the tobacco smoking rate by 3 percent among pregnant women in Alabama by December 2013. This 3 percent reduction will be a decrease of 254 women smoking during pregnancy in Alabama.

2013 Activities:

- Targeted education and training was provided by the State Perinatal Program staff and the Area Tobacco Control Coordinators to providers in the nine counties in Alabama that have greater than 20 percent of women who smoke during pregnancy. The counties were Bibb, Cherokee, Covington, Fayette, Jackson, Lawrence, Marion, Walker, and Winston. Education included:
  - Distribution of educational material regarding 1-800-QUITNOW, "Smoke Free for a Healthy Baby."
  - Access to the "Smoking Cessation During Pregnancy – A Clinician's Guide to Helping Pregnant Women Quit Smoking" an on-line, self instructional guide and tool-kit from ACOG.
  - Education for providers on Medicaid reimbursement capabilities for Plan First pregnant women to receive cessation medication with a written prescription.
- The development of a smoking cessation poster that addressed the long-term effects on the child when a mother smokes during her pregnancy. Approximately 3,500 posters were distributed statewide. The posters were distributed to hospitals, physician's offices, pregnancy test centers, pharmacies, Department of Human Resources offices, Medicaid offices, and local health departments by the State Perinatal Program staff.
- The initiation of a Plan, Do, Study, Act Model for quick analysis in Lawrence County from August 1, 2013, through November 1, 2013. The WIC staff completed and faxed the Quitline referral application to Quitline for women who desired to stop smoking. Quitline contacts the women within 48 hours of receiving the fax to offer services.

Safe Sleep:

National Aim: To increase infant safe sleep practices by 5 percent by December 2013 among all racial and ethnic groups in Region IV and VI states.

Alabama's Aim: To increase infant safe sleep practices by 5 percent by December 2013 among all racial and ethnic groups.

2013 Activities:

- ADPH partnered with the Department of Child Abuse and Neglect Prevention and the Children's Trust Fund to expand the Cribs For Kids® Program in Mobile and Baldwin Counties. Classes were provided at Thomas Medical Center, North Baldwin Hospital, and the Mobile Teen Center. Approximately 100 portable cribs have been distributed since June 2013.
- An on-line survey regarding safe sleep was distributed electronically to the delivering hospitals in Alabama by the team. Ninety-two percent of the hospitals responded to the survey.
- The survey revealed that 64 percent of hospitals do not have an infant safe sleep policy, 68 percent of hospitals do not ask where the infant will sleep once they are taken home, and 94 percent of hospitals would be interested in having a safe sleep program in their facility.
- Safe sleep education has been provided.

Perinatal Regionalization:

National Aim: By December 2013, increase, to 90 percent or by 20 percent above baseline, the number of mothers delivering at appropriate facilities to include infants less than 32 weeks gestation and/or less than 1500 grams.

Alabama's Aim: By December 2013, increase, to 90 percent, the number of mothers delivering at appropriate facilities to include infants less than 32 weeks gestation and/or less than 1500 grams.

Currently in Alabama 86 percent of VLBW infants are delivered at the appropriate level of care facility.

2013 Activities:

- Working with AlaHA to ensure hospitals are aware of the American Academy of Pediatrics (AAP) Levels of Neonatal Care guidelines released in September 2012.
- Identifying the barriers associated with women delivering at the appropriate level of care facility, such as transportation (especially in rural areas), financial reimbursement, and political climate.
- Forming a work group to determine the best way for Alabama to address getting delivering hospitals to declare their appropriate Level of Care based on the availability of their staff, equipment, and contractual agreements.
- In 2013, the State Perinatal Program was awarded the U.S. Department of Health and Human Services – MCH Bureau's "State Systems Development Initiative – Competing Supplement (for states participating in a CoIIN to Reduce Infant Mortality)" grant in the amount of $25,000. The grant enhances the capacity of ADPH to develop and support a data system that assures access to data which allows Alabama to measure progress relative to the five strategies being addressed by the CoIIN to Reduce Infant Mortality.

PROGRAMS CONTRIBUTING TO IMPROVED PERINATAL OUTCOMES

Adolescent Pregnancy Prevention Branch

The Adolescent Pregnancy Prevention Branch within the Children's Health Division of the Bureau of Family Health Services (FHS) 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, funded through the Abstinence Education Grant Program, 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 programs. Four community projects were funded through a competitive selection process and they provide programs in 22 counties focusing on middle school aged students in classroom settings. The projects have incorporated a "Positive Youth Development" approach which utilizes a strength-based rather than a problem-oriented approach to risk reduction activities. High school age youth who are trained as "teen leaders" deliver programming to sixth and seventh grade students.

The Alabama Personal Responsibility Education Program is funded through the Personal Responsibility Education Program, 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 subjects include: healthy relationships, adolescent development, and healthy life skills. Three community projects, funded through a competitive selection process, provided programming to high risk youth (ages 13 to 19) in community settings including juvenile detention facilities, group foster care homes, public housing, and community mentoring programs.

Alabama Children's Health Insurance Program (CHIP)

CHIP 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 ADPH. The program covers children whose family income is too high to qualify for Medicaid up to 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 between ALL Kids and the Alabama Medicaid Agency. Alabama's low uninsured rate for children (8.2 percent, according to the U.S. Census Bureau, Current Population Survey, three year average – 2010 to 2012 coverage 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 NSP is mandated by Statutory Authority Code of Alabama 1975, Section 22-20-3. Every hospital or facility providing delivery services is required to screen all infants for these potentially devastating disorders. The Alabama newborn screening panel includes 30 disorders recommended by the American College of Medical Genetics and MOD. These disorders include Endocrine (Congenital Hypothyroidism and Congenital Adrenal Hyperplasia), Cystic Fibrosis, Sickle Cell Disease, Hearing Loss, and Metabolic Disorders (Amino, Fatty, and Organic Acids). On April 3, 2012, the House of Representatives of the Alabama Legislature passed a resolution commending ADPH and its partners for the efforts made to implement a policy requiring pulse oximetry screening on all newborns for the detection of Critical Congenital Heart Disease (CCHD). CCHD was mandated in June 2013. Through September 2013, 82 infants have been identified with a disorder. All newborns identified with a disorder through the NSP have access to a diagnostic evaluation through medical specialists throughout the state. Medications or changes in diet help prevent most health problems caused by disorders that are identified through newborn screening.

"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 50 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 the number of infants considered lost to follow-up and needing rescreening. Using federal grants, the Alabama system was able to replace outdated screening equipment and to increase services for seven birthing facilities. Reporting methods have also advanced through use of electronic transfer of hearing results. Through September 2013, 27 infants were identified with various forms of hearing loss. The *"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 indicated. In the upcoming year, efforts will include progressing to paperless reporting of screening results while promoting collaborative relationships with Alabama's Early Intervention System and other outpatient providers for infants and children identified with hearing loss.

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 three months and six months are 46.2 percent and 25.5 percent. According to the Centers for Disease Control (CDC) "Breastfeeding Report Card" 2013, the percent of infants in the United States initiating breastfeeding is 77.0 percent. Alabama's breastfeeding initiation rate is 60.4 percent. The AAP 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 breastfeeding provides 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. Studies have shown that infants who are breastfed are less likely to develop diabetes mellitus, obesity, Celiac Disease, asthma, allergies, and 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. During FY 2013, 28 peer counseling sites were available. 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 ADPH and the WIC Program celebrated August as Breastfeeding Awareness Month. This year's theme chosen by the World Alliance for Breastfeeding Action was "Breastfeeding Support: Close to Mothers." The theme highlighted the importance of Breastfeeding Peer Counseling and providing support to families. Many clinics held special receptions for their prenatal and breastfeeding mothers.

Alabama Child Death Review System (ACDRS)

The ACDRS continued 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, including multi-faceted efforts related to Safe Infant Sleep, Child Passenger Safety, and Teen Driving Safety. A web-based national data collection system has been implemented in Alabama to further improve both the reporting process and the overall quality of the data collected; and more than ten years of prior data, going back to the beginnings of ACDRS, has been crosswalked successfully into the new system. The first ACDRS two-year report using data from the new system, a report on completed reviews of 2008 and 2009 deaths, is available along with all past reports and other original publications on the ACDRS Web site. ACDRS conducted its biennial Statewide Training Conference for ACDRS coordinators and partners throughout the state in 2012 and is currently planning the next one for 2014.

Alabama Family Planning Program (FPP)

The Alabama Family Planning Program plays a critical role in ensuring access to family planning and related preventive health services. One of the major goals of the program is to decrease unintended pregnancies. In 2011, 49 percent of Alabama mothers reported their pregnancies as unintended. According to Alabama's PRAMS, from 2009 to 2011, unintended births decreased by 8.2 percent from 53.5 percent (2009) to 49.0 percent (2011). Unintended births among Medicaid patients (62.6 percent) were higher than non-Medicaid births at 33.8 percent which indicates that poorer women are more likely to have unplanned births.

During fiscal year 2013, direct patient services were provided to an estimated 98,862 family planning clients through local health department clinics. Approximately 93 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. The program offers opportunities to individuals to plan and space their pregnancies in order to achieve personal goals and self-sufficiency. Services are targeted to low-income individuals.

Plan First, a joint venture between the Alabama Medicaid Agency and ADPH, continued into its 13th year after being granted a three-year renewal that began in October 2011. This program is an 1115 Medicaid Research and Demonstration Waiver expanding Medicaid eligibility for family planning services for women 19 to 55 years of age. ADPH's Plan First toll-free hotline received 3,637 calls during 2013.

Healthy Child Care Alabama

Healthy Child Care Alabama continued as a collaborative effort between the ADPH and the Alabama Department of Human Resources. During FY 2013, 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 2013, the nurse consultants documented 2,897 health and safety training and educational sessions for 8,909 providers; 2,932 incidents of technical assistance at child care sites; and 7,551 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 24,746 children in the child care setting and developed 22 corrective action plans with providers.

Pregnancy Risk Assessment Monitoring System (PRAMS)

The Alabama PRAMS 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 LBW. The information provided includes topics ranging from obstetrical history and prenatal care to maternal stress factors and pregnancy intentions.

In 2013, 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 LBW as a stratification variable, and rewards are now offered to mothers for completing the survey. The goals of PRAMS include the following: (a) describing maternal behaviors during pregnancy and early infancy; (b) analyzing relationships between behaviors, pregnancy outcomes (i.e., LBW, prematurity, growth retardation, etc.) and early infancy morbidity; (c) serving as a resource for the development and implementation of intervention programs, as well as effectively targeting existing programs; and (d) evaluating intervention efforts.

ASSESSMENT OF THE MATERNAL/INFANT POPULATION

The ADPH, through the Bureau of FHS, continued as the lead agency for assessing needs pertaining to pregnant women, mothers, and infants. The bureau's Maternal and Child Health Epidemiology (MCHEpi) Branch staff continued coordinating ongoing needs assessment activities of FHS. In FY 2013, the MCHEpi Branch provided an update supplementing certain findings on pregnancy and infancy that were reported in Alabama's most recent five-year maternal and child health needs assessment according to source of payment for delivery. The payment groups studied were privately-insured deliveries, Medicaid-funded deliveries, and "self-pay" deliveries. Some notable trends over the surveillance periods (2006 to 2011 for characteristics of live births and 2005 to 2010 for risk of infant death) include the following:

- The percentage of infants born to Latino mothers peaked at 8.3 percent in 2007, then declined slightly each year and was 7.5 percent in 2011, which was the same percentage as in 2006.
- In the Medicaid-funded group, the prevalence of short (less than 12 months) live birth interval declined in each of the last three years studied and was 2.5 percent in 2011.
- In the White, non-Latino, Medicaid-funded group, the prevalence of tobacco use during pregnancy declined but, at 28.3 percent in 2011, remained very high.
- The prevalence of inadequate prenatal care, as measured by the Kotelchuck Index, worsened in the total group, the privately-insured group, and the Medicaid-funded group. In 2011, this prevalence was 38.9 percent in the self-pay group, 18.7 percent in the Medicaid-funded group, 4.7 percent in the privately-insured group, and 13.1 percent in the total group.

Risk of infant, neonatal, and postneonatal death declined. In the three-year period of 2008 to 2010, risk of infant (under one year of age) death was 22.9 deaths per 1,000 live births in the self-pay group, 9.8 deaths per 1,000 live births in the Medicaid-funded group, 6.1 deaths per 1,000 live births in the privately-insured group, and 8.6 deaths per 1,000 live births in the total group. The Medicaid-funded group and the privately-insured group differed notably with respect to causes of infant death. For example, in 2008 to 2010, non-SIDS ill-defined causes accounted for 7.5 percent of infant deaths in the Medicaid-funded group, versus 2.2 percent of infant deaths in the privately-insured group. FHS continues to assess the ever-changing needs of Alabama's population and develop strategies to address these needs. The Statewide Five-Year Maternal and Child Health Needs Assessment for FYs 2009 to 2010 was completed with the final report being submitted to the federal Maternal and Child Health Bureau in September 2010. Currently, the MCHEpi Branch is planning for the upcoming needs assessment due in FY 2015.

FY 2014 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.

3. Implement a state plan to reduce infant mortality.

FY 2014 OBJECTIVES

1. Identify factors that contribute to fetal/infant deaths by reviewing 50 percent of fetal and infant deaths that occur in 2014 through the FIMR Program.

2. Decrease the number of Alabama's unintended births to 46.6 percent (Alabama Baseline: 49.0 percent in 2011; source: ADPH, Center for Health Statistics).

3. Decrease the IMR among blacks to no more than 13.0 per 1,000 live births (Alabama and Healthy People [HP] Objective; Alabama Baseline: 14.4 per 1,000 live births in 2012; source: ADPH, Center for Health Statistics).

4. Decrease the percent of LBW births to 9.7 percent (Alabama Baseline: 10.0 percent in 2012; source: ADPH, Center for Health Statistics).

5. Decrease the percent of non-medically indicated singleton deliveries before 39 weeks to 8.3 percent (Alabama Baseline: 9.3 percent in 2012; source: ADPH, Center for Health Statistics).

6. Decrease the percent of women who smoke during pregnancy to 10.3 percent (Alabama and HP Objective; Alabama Baseline: 10.7 percent in 2012; source: ADPH, Center for Health Statistics).

7. Decrease the percent of adolescents age 10 to 19 who smoke during pregnancy to 9.5 percent (Alabama and HP Objective; Alabama Baseline: 10.5 percent in 2012; source: ADPH, Center for Health Statistics).

8. Increase the percent of infants less than 32 weeks gestation and/or less than 1,500 grams being delivered at an appropriate facility to 88.0 percent (Alabama Objective; Alabama Baseline: 86.0 percent of live births in 2012; source: ADPH, Center for Health Statistics).

9. Increase the percent of births with adequate prenatal care to 75.0 percent, adequacy of care measured using the Kotelchuck Index (Alabama and HP Objective; Alabama Baseline: 74.1 percent in 2012; source: ADPH, Center for Health Statistics).

10. Increase the percent of mothers who place their infants on their backs for sleeping to 70.0 percent (Alabama Objective; Alabama Baseline: 65.5 percent in 2011; source: ADPH, Center for Health Statistics).

11. Increase the percent of mothers who initiate breastfeeding to 73.0 percent (Alabama Objective; Alabama Baseline: 71.6 percent in 2011; source: ADPH Center for Health Statistics).

APPENDICES

APPENDIX A
Alabama Perinatal Healthcare Act (1980)

CHAPTER 12A.

PERINATAL HEALTH CARE.

Sec.

§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 reduce 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 health care services in providing high quality, low cost prevention oriented perinatal care, including optional education programs.

(b) For the purposes of this chapter, the work "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 reduce 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 reduce 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 are, 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 therefor. 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.

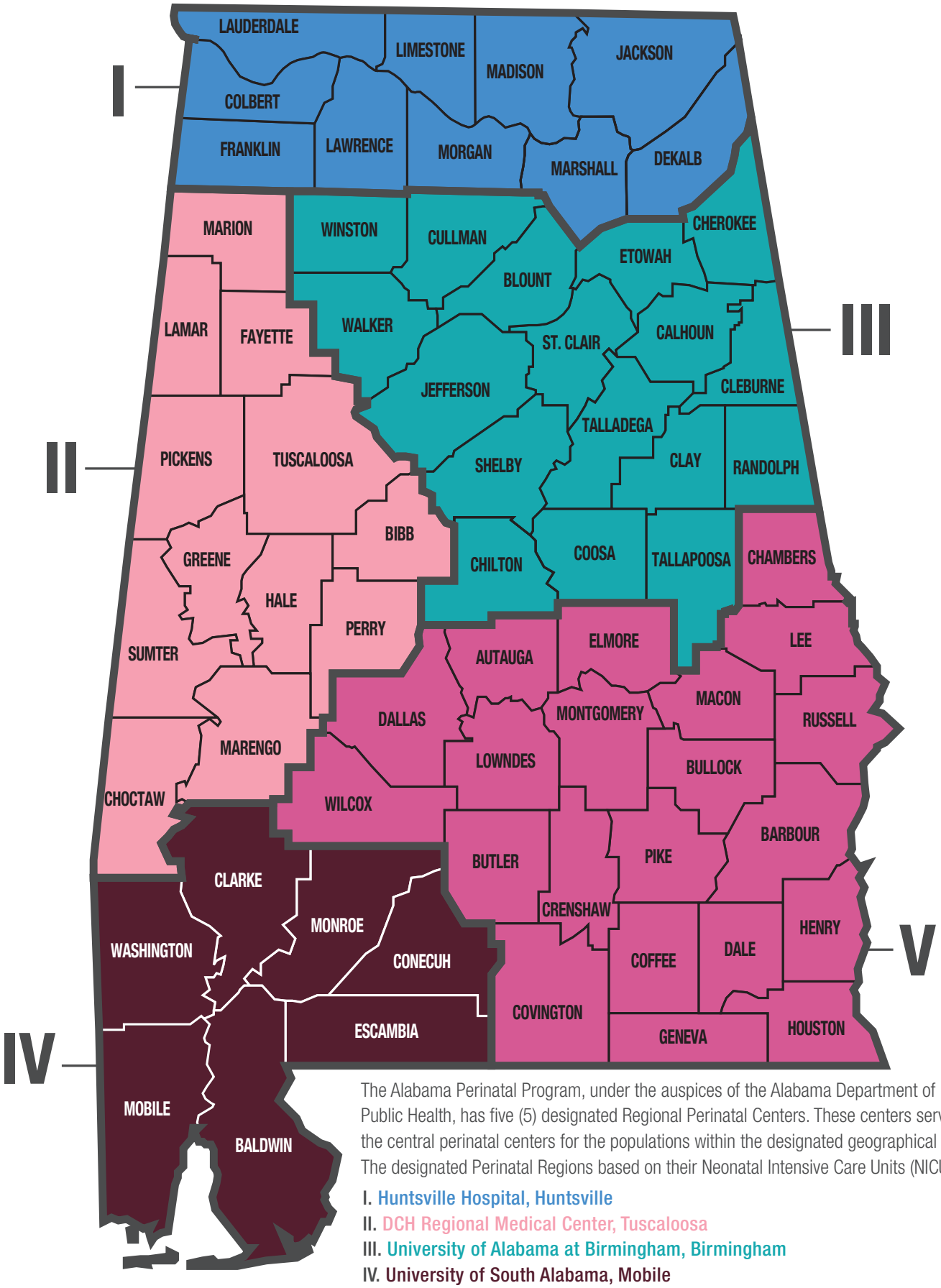
The bureau of maternal and child health under the direction of the state board of health shall annually present a progress report dealing with infant mortality and handicapping conditions to the legislative health and finance committees prior to each regular session of the legislature. No funds of the 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, § 1.)

APPENDIX B
Perinatal Regions Map

Alabama Perinatal Regions Map



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:

I. Huntsville Hospital, Huntsville
II. DCH Regional Medical Center, Tuscaloosa
III. University of Alabama at Birmingham, Birmingham
IV. University of South Alabama, Mobile
V. Baptist Medical Center, Montgomery