ALABAMA PERINATAL HEALTH ACT

Annual Progress Report for Fiscal Year (FY) 2014

Plan for FY 2015

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 2014 activities and accomplishments of the State Perinatal Program.

Alabama's infant mortality rate of 8.6 deaths per 1,000 live births in 2013 is lower than the 8.9 deaths per 1,000 live births in 2012. However, when compared to the provisional 2011 national rate of 6.0, we are reminded that the health status of mothers and infants in Alabama continues to be a challenge and that support for the State Perinatal Program is essential to meeting the needs of Alabama citizens.

When addressing infant mortality, it is important that we look at the number of low birth-weight births and subsequently the morbidities that have long-term consequences for families and society. We also need to promote safe sleep practices for infants in Alabama. Additional concerns include disparities in healthcare, spacing pregnancies with at least a two-year interval between pregnancies, reducing elective deliveries less than 39 weeks with no medical indication, encouraging smoking cessation in women of childbearing age, promoting healthy lifestyle choices, and delivering infants at the appropriate facility for medical needs. To this end, the State Perinatal Program developed strategies to address the 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 2014 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 productive members of our society. This report is available at www.adph.org/perinatal.

Due to your continued support, the State Perinatal Program will enable Alabama families to look toward the future with hope and enthusiasm.

Sincerely,

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

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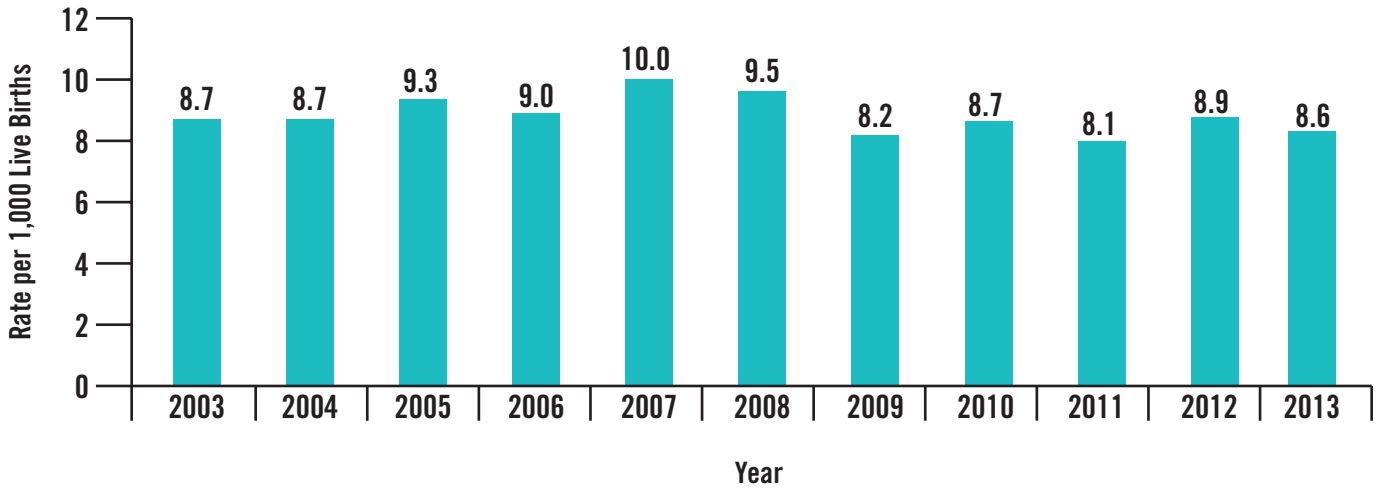
INTRODUCTION

Infant mortality is an indicator used to characterize the health status of communities and states. In 2013, a total of 500 infants died in Alabama before their first birthday. The infant mortality rate (IMR) decreased from 8.9 infant deaths per 1,000 live births in 2012 to 8.6 infant deaths per 1,000 live births in 2013 (Chart 1). The percent of births with adequate prenatal care increased to 76.2 percent in 2013, from 74.1 percent in 2012. At the same time, the number of births with no prenatal care decreased to 875 in 2013 from 926 in 2012. 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, 2003 - 2013[1]



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 68.0 percent of the 2013 infant deaths; however, survivability of these small infants has greatly improved in the past decade. In 2013, 16.4 percent of the births in Alabama were premature. A comparison to the national percentage of 11.6 in 2012 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 43.3 percent more likely to have a premature birth than white mothers. The 2013 percent of prematurity for black infants was 14.9 compared to 10.4 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. 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.

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

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 Committees (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 2014, 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 2009 through 2013 are listed in Table 1.

Table 1. Resident Births and Birth Rates* By Race of Mother, Alabama, 2009-2013

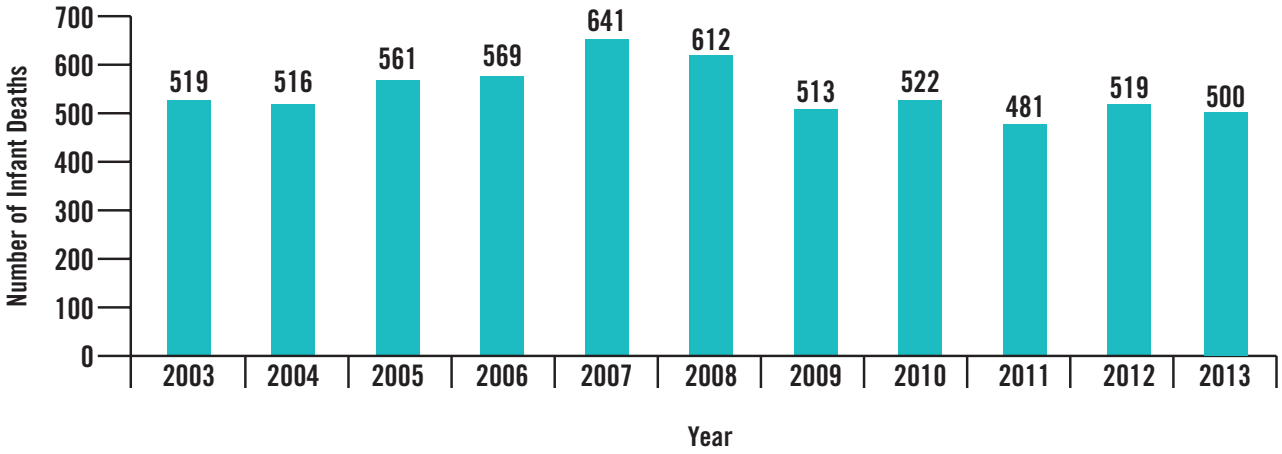
YEAR	TOTAL		WHITE		BLACK AND OTHER	
	NUMBER	RATE*	NUMBER	RATE*	NUMBER	RATE*
2009	62,476	13.3	41,963	12.6	20,513	15.0
2010	59,979	12.5	40,193	12.3	19,786	13.2
2011	59,322	12.4	39,770	11.8	19,552	13.6
2012	58,381	12.1	38,637	11.5	19,744	13.6
2013	58,162	12.0	38,604	11.4	19,558	13.4

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

Infant Mortality Rate

Alabama's 2013 IMR of 8.6 infant deaths per 1,000 live births (500 infant deaths) is a decrease from the 2012 rate of 8.9 (519 infant deaths) (Chart 2). The highest county rate in 2013 was found in Randolph County with a rate of 24.4 deaths per 1,000 live births.

Chart 2. Number of Infant Deaths, Alabama, 2003 – 2013



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 12.6, in 2013, the IMR for blacks decreased from the 14.4 rate of 2012; furthermore, the rate of 12.6 is 82.6 percent higher than the rate for white infants. The IMR for white infants, 6.9 in 2013, increased from the 2012 rate of 6.6.

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 mothers at the time of pregnancy. These factors also have a direct impact on each other.

Low Birthweight

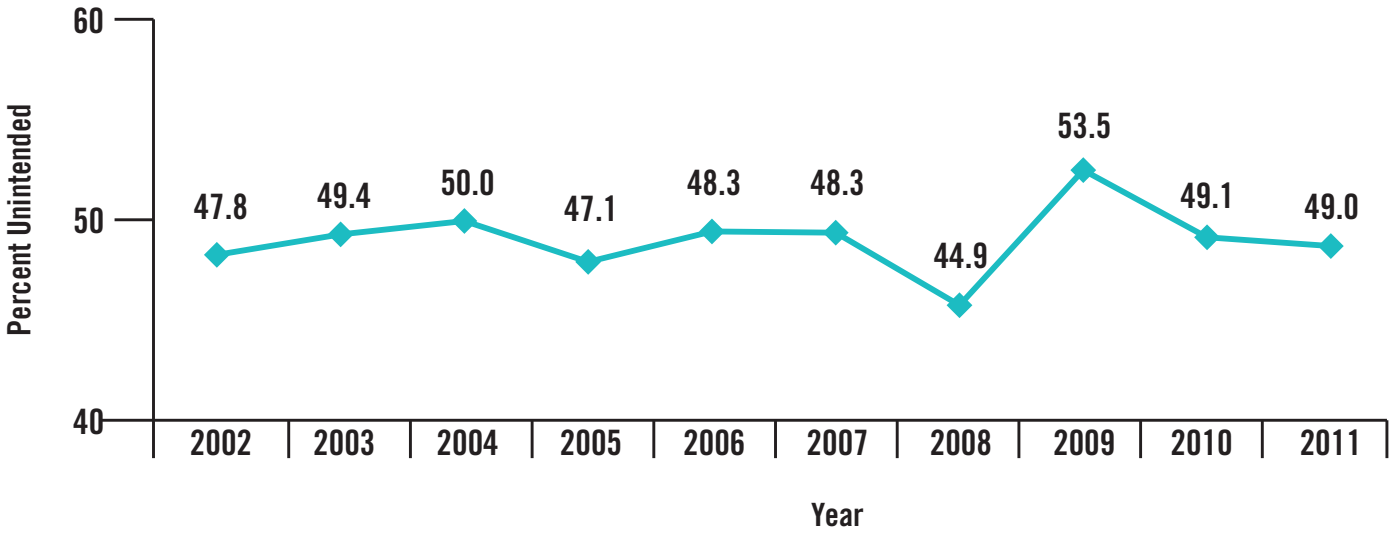
Birthweight is a significant factor directly related to infant morbidity and the IMR. Babies born too soon or too small involve significant risks of serious morbidity. Very low birthweight (VLBW), under 3 lbs. 5 oz., infants accounted for 270 of the 500 infant deaths in 2013. These very small babies 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 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 (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 2002 - 2011[2]



[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 2013 was the lowest in Alabama's history. The numbers of teen births and percent of teen births for residents of Alabama from 2009 to 2013 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 mortality risk for these infants.

Table 2. Percent of Births to Teens by Race of Mother and Marital Status, 2008-2013

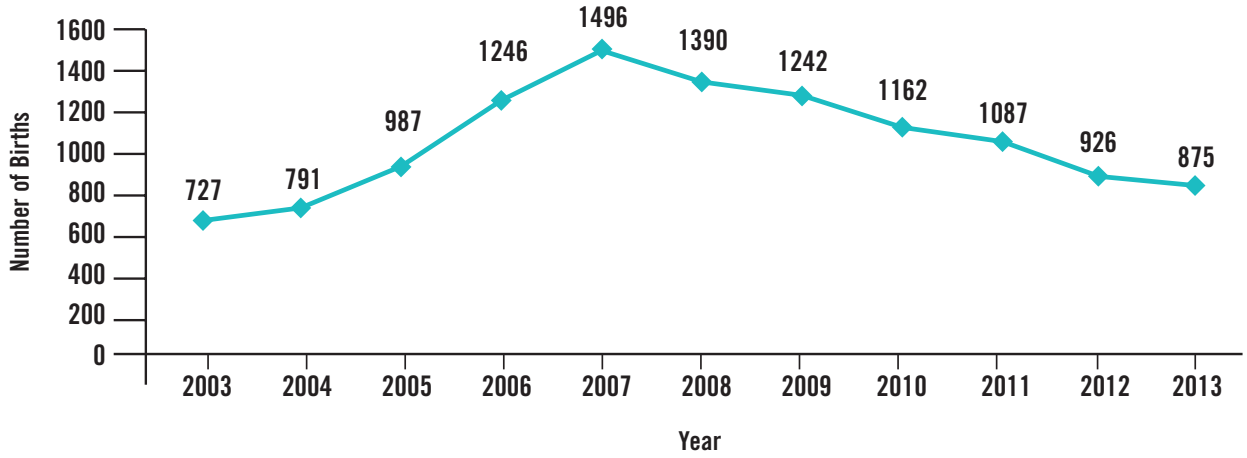
YEAR	TOTAL		WHITE		BLACK AND OTHER		UNMARRIED	
	NUMBER	PERCENT OF BIRTHS	NUMBER	WHITE	NUMBER	BLACK AND OTHER	NUMBER	UNMARRIED
2009	8,365	13.4	4,769	11.4	3,596	17.5	6,616	79.1
2010	7,446	12.4	4,196	10.4	3,250	16.4	6,135	82.4
2011	6,697	11.3	3,799	9.6	2,898	14.8	5,554	82.9
2012	6,236	10.7	3,546	9.2	2,690	13.6	5,202	83.4
2013	5,420	9.3	3,194	8.3	2,226	11.4	4,431	81.8

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, 2003- 2013



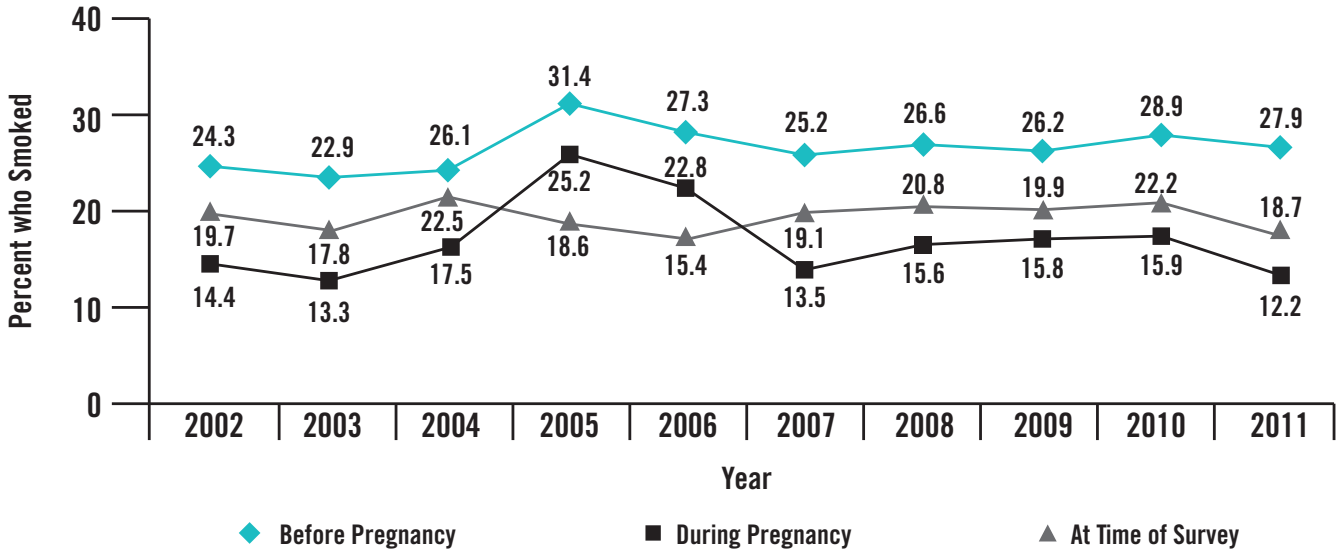
Early and adequate prenatal care to mothers remains a crucial factor in reducing IMRs. The IMR among mothers who received no prenatal care or who initiated care in the third trimester continues to be two times higher than the mothers who received prenatal care in the first trimester. In 2013, only 76.2 percent of the births were to women who had adequate prenatal care. In addition, 875 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 2013, Alabama's statistics indicated babies of mothers who smoked were 67.1 percent more likely to die than infants of nonsmoking mothers, with the rate for smokers being 13.2 per 1,000 live births compared to 7.9 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).

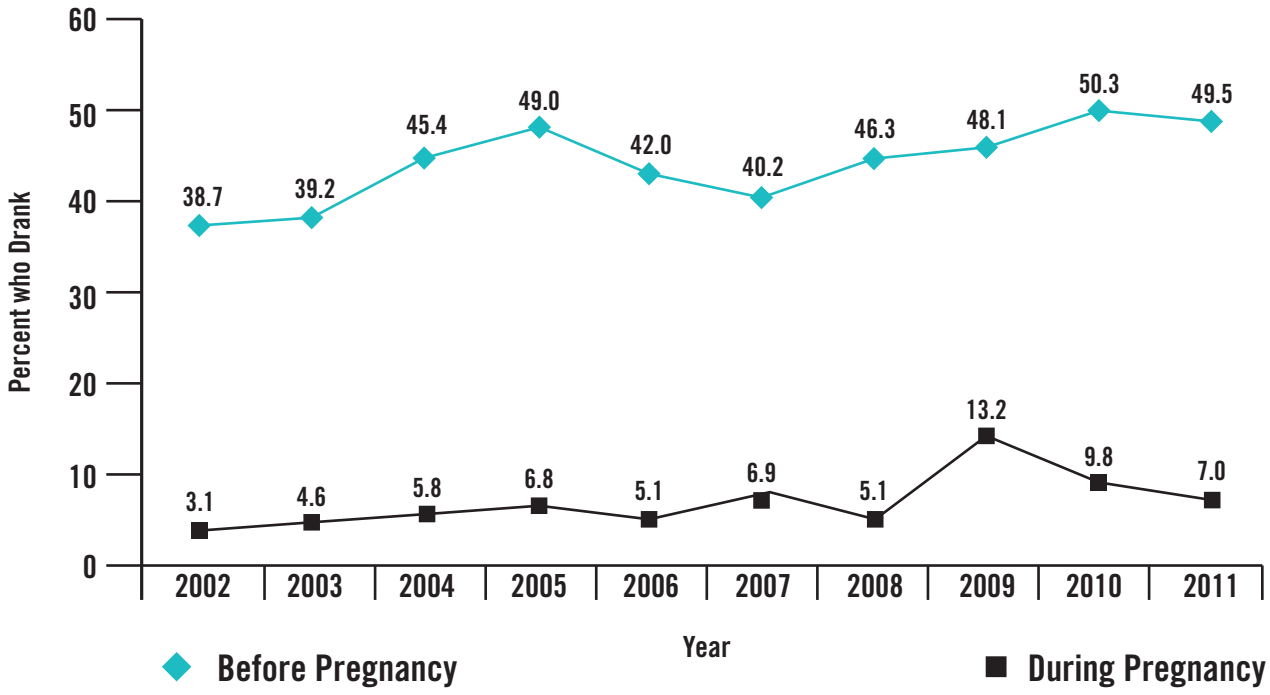
Chart 5. Percent of Mothers Who Smoked, Alabama PRAMS, 2002 - 2011



The percentage of births to teenage women who used tobacco increased to 10.9 in 2013, compared to 10.5 in 2012. During 2013, tobacco use among women, aged 20 or more, increased from 10.7 percent to 10.8 percent. In 2013, white teenage mothers were 9.1 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 that they should 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 significant 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.

Neonatal Abstinence Syndrome (NAS) is a group of problems that occur in a newborn who was exposed to addictive illegal or prescription drugs while in the mother's womb. Symptoms of NAS depend on various factors including the type of drug the mother used, how much of the drug was used, how long the drug was used, and how the drug is metabolized by the mother. NAS is associated with an increased risk of complications in the neonatal period and with higher costs to the healthcare system. NAS has more than doubled in the past four years according to Medicaid claims data, and similar findings can be seen in the privately insured. The total NICU cost for babies diagnosed with NAS from 2010 – 2013 was $23.3 million per a report from the Alabama Medicaid Agency[3]. NAS is a growing problem in Alabama that will require the attention of multiple agencies collaborating together to address.

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 2013, infants of mothers with no insurance coverage and who did not qualify for Medicaid had the highest IMR at 16.0 infant deaths per 1,000 live births. Medicaid babies had a rate of 10.1 infant deaths per 1,000 live births and those whose mothers had private insurance had the lowest IMR at 6.4 infant deaths per 1,000 live births. During 2013, Medicaid paid for 52.6 percent of births.

[3] Obtained from the "Neonatal Abstinence Syndrome (NAS): Adverse Fetal Outcomes in Mothers with Prescribed Opioid Medications Compared to Mothers With No Prescribed Opioid Medications" by the Alabama Medicaid Agency. AMA, 2014.

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, 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. Funding for the perinatal coordinator in Region V was reinstated as of August 1, 2014.

Fetal and Infant Mortality Review Program

The Fetal Infant Mortality Review program 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 2014. However, due to the large number of deaths, the FIMR program focused on a select group of infant deaths for review: those mothers who resided in Madison County (Region I) and Jefferson County (Region III) and all fetal and infant deaths in Region IV. The perinatal staff abstracted data and conducted voluntary 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 coordinator 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 – River Region CAT. The Region V CAT continued to meet quarterly 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 2014 were based on 2013 recommendations. Actions of the CATs included the following:

REGION 1:

RECOMMENDATION: Provide continuing education related to fetal kick counts and fetal movement to pregnant women by prenatal providers, care coordinators, and staff.

ACTIONS: The CAT in Madison County provided educational resources and materials to Medicaid Maternity Care coordinators who enrolled women in their program for maternity care. A number of providers are also educating their patients on utilizing smartphone applications that assist with monitoring fetal movement.

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

ACTIONS: The CAT in Madison County held its fourth 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 175 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: Provide safe sleep education to all parents and family members by all healthcare professionals involved in care.

ACTIONS: The Safety Committee of the Jefferson County Children's Policy Council serves as the CAT team for Region 3/Jefferson County. In conjunction with the committee, safe sleep education was provided to children's groups throughout the county. The Department of Human Resources included safe sleep education with the training provided to foster parents. Children's of Alabama pediatric providers sponsored safe sleep educational opportunities in their associated offices, as well as within the hospitals. Various presentations related to infant and child safety were presented monthly at the University of Alabama at Birmingham School of Public Health. A health fair was held at the Juvenile Justice Center at the Jefferson County Family Court in August 2014. Information provided to the public included preconception/interconception care, safe sleep, shaken baby syndrome, breastfeeding, smoking cessation, and substance abuse.

RECOMMENDATION: Provide smoking cessation and safe sleep education in the community in order to reduce infant mortality related to these causes.

ACTIONS: The Calhoun County CAT elected to address two of the CoIIN initiatives due to no records having been reviewed in that county in 2013-2014. The group chose to provide community education on smoking cessation and safe sleep. Providers and caregivers were provided posters and brochures regarding safe sleep, as well as new smoking cessation posters and information regarding the Alabama QUITLINE. This information was distributed to various physician's offices, maternity care coordinator's offices, and other public and private organizations throughout the county who provide services to young families.

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

ACTIONS: The Mobile County CAT worked with the Infant Mortality Taskforce and the Children's Trust Fund under the Department of Child Abuse and Neglect Prevention to address the high number of infant deaths due to unsafe sleep environments. In Baldwin County, the CAT conducted six safe sleep classes and distributed over 50 cribs to qualifying mothers and their families as a means to provide a safe sleep environment for their infants.

RECOMMENDATION: Provide outreach education to promote breastfeeding.

ACTIONS: The CATs in Baldwin, Escambia, and Mobile County have provided outreach education related to perinatal issues that include, but are not limited to, breastfeeding to hospitals, physicians, and caregivers. The groups have participated in webinars related to safe sleep and breastfeeding and have served as a resource for a breastfeeding conference held at Children's and Women's Hospital in Mobile.

REGION 5:
RECOMMENDATION: Provide resources and grief support for families after the loss of an infant.

ACTIONS: The River Region Community Action Team collaborated with several CAT partners (Health Services, Inc., Counseling Outreach for Pregnancy Emergency [COPE], Faith's Healing Baskets, Threads of Love) to provide funding and resources for four families that experienced the loss of an infant but had limited funds for a proper burial. The River Region Community Action Team also conducted the third annual Pregnancy and Infant Loss Candlelight Memorial with approximately 50 people attending the event.

RECOMMENDATION: Provide safe sleep education to physicians, providers, and caregivers and collaborate with Cribs for Kids® and Gift of Life to provide a safe sleep environment for all infants in Region 5.

ACTIONS: The River Region CAT collaborated with the Department of Child Abuse and Neglect Prevention to provide a crib from the Cribs for Kids® program to a family in Houston County after receiving a call from the infant's grandmother regarding concern that the infant did not have a safe sleep environment. The CAT continues to distribute safe sleep material to hospitals, providers, caregivers, and families in the River Region.

Get a Healthy Life Campaign (GAL)

The FIMR 2009 data identified poor 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 2014. More than 25,000 campaign materials were provided for more than 29 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 1,000 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" in 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. Recently, text4baby added a smart-phone application as an additional way for participants to access key information beyond the character limit of text messages. The free application offers additional content and interactive features that enhance the overall text4baby experience.

ADPH is the lead, outreach state 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 enrollment into the program. Promotional materials to raise awareness of the campaign are provided by HMHB. As of October 25, 2014, approximately 16,311 individuals in Alabama were enrolled in text4baby. More than 2,753 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 2013 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. However, in 2013 that number increased to 16.3 percent, evidence that efforts to decrease preterm birth needs to continue statewide in Alabama.

Collaborative Improvement & Innovation Network to Reduce Infant Mortality (CoIIN)

Alabama created a state team for each of the five strategic action teams and appointed a CoIIN Director to coordinate all CoIIN efforts, both statewide and nationally. The five strategic action teams met monthly or more, as needed, and the statewide team met at least quarterly. Statewide partners include: Alabama Perinatal Excellence Collaborative (APEC); Alabama Medicaid Agency; Alabama Hospital Association (AlaHA); MOD; Association of Women's Health, Obstetric and Neonatal Nurses; UAB; USA; Medicaid Maternity Care Providers; Governor's Office; Alabama Department of Mental Health; Alabama Department of Child Abuse and Neglect Prevention; Alabama Department of Human Resources (DHR); Jefferson County Department of Health; Mobile County Health Department; Alabama Chapter – AAP; health care providers, nurses, and maternal child health advocates. 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 gestation by 3 percent by August 2014.

Alabama's Aim: To reduce non-medically indicated EED less than 39 weeks gestation by 3 percent by August 2014.

2014 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 currently has 30 facilities participating in the HEN; 21 hospitals are delivering facilities and 19 of those facilities have an EED policy in place.
- AlaHA contacted all the delivering hospitals within the state to identify where the facilities were in the process of addressing EED. Next, AlaHA engaged the delivering hospitals through their Quality Task Force Meetings. AlaHA collaborated with MOD and provided the MOD less than 39 weeks toolkit to hospitals. The APEC guidelines were introduced and made available on-line, by mobile application and by QR code reader. AlaHA conducted face-to-face meetings and continues to conduct phone follow-up, as well as collaborate with the hospitals to monitor the number of EED deliveries in their facilities.
- Education provided to physicians regarding requirements by Medicaid to amend Obstetric Delivery Codes to all Medicaid deliveries. These codes consist of:
  - UD – Medically necessary delivery prior to 39 weeks of gestation.
  - U9 – Delivery at 39 weeks of gestation or later.
  - UC – Non-medically necessary delivery prior to 39 weeks of gestation.
- According to AlaHA:
  - Eighty percent of delivering hospitals in Alabama had an EED rate of "0" with the average EED rate of 2.0 percent as of January 2014 (Charts 7 & 8).
  - Twenty-nine of the 48 delivering hospitals in Alabama have a "hard stop" policy in place.
  - Nine of the 48 delivering hospitals have a "soft stop" policy and six of those nine are working on putting a "hard stop" policy in place.
  - One hospital in the state has no policy and has no plan to incorporate a policy because they did not have any EED without medical indication in the past year.

Chart 7. EED Rates in Alabama Hospitals

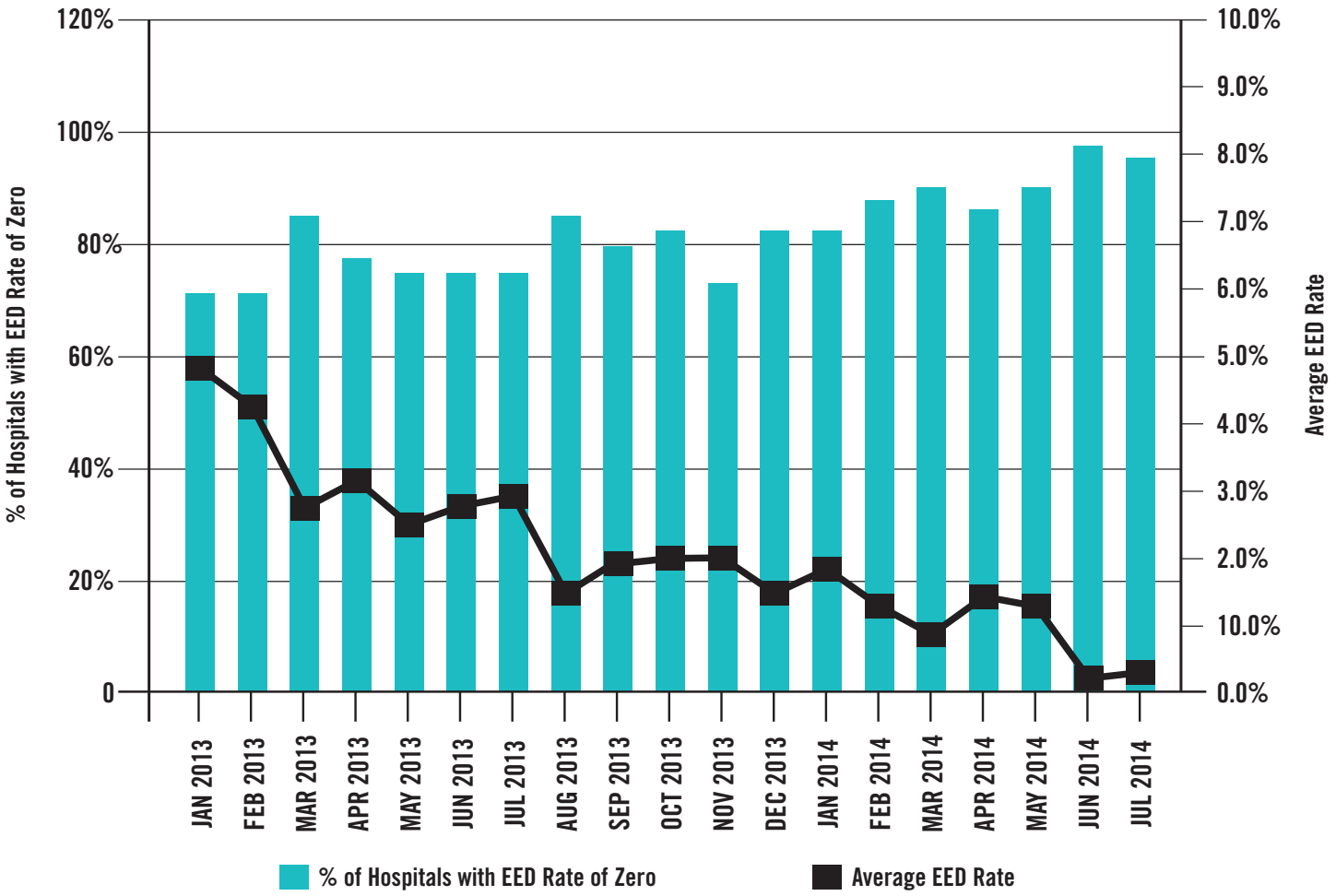


Chart 8. Percent of Hospitals with EED Rate of Zero

	Jan 13	Feb 13	Mar 13	Apr 13	May 13	Jun 13	Jul 13	Aug 13	Sep 13	Oct 13	Nov 13	Dec 13	Jan 14	Feb 14	Mar 14	Apr 14	May 14	Jun 14	Jul 14
% of Hospitals with EED Rate of Zero	69%	69%	84%	78%	76%	76%	76%	84%	80%	82%	73%	82%	82%	89%	90%	87%	89%	97%	95%
Average EED Rate	4.9%	4.3%	2.7%	3.2%	2.4%	2.9%	2.9%	1.5%	2.0%	2.0%	2.0%	1.5%	1.9%	1.2%	0.9%	1.5%	1.3%	0.2%	0.3%
Count	45	45	45	45	45	45	45	45	45	45	45	45	44	44	42	39	38	31	21

* Data in Charts 7 & 8 provided by AlaHA.

Interconception Care (ICC):

National Aim: To modify Medicaid policies and procedures in five to eight southern states by August 2014 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 August 2014 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.

2014 Activities:

- Implementation of an ICC Program for women who remain on Medicaid 60 days after delivery and who had an adverse pregnancy outcome that included: 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 ICC program.
- The following program data is from February 1, 2013, to September 30, 2014:
  - 730 referrals have been received.
  - 620 of the 730 referrals have been contacted.
  - 467 of the 620 women have accepted services.
  - 213 of the 467 that accepted services saw their PMP within 60 days of delivery.
  - 459 of the 482 (95 percent) infants delivered during this time saw their PMP after delivery.
  - 60 of the 482 infants remained in the NICU at time of follow-up.
  - 34 of the 482 infants were fetal or infant deaths with the current pregnancy.

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 August 2014.

Alabama's Aim: To decrease the tobacco smoking rate by 3 percent among pregnant women in Alabama by August 2014. This 3 percent reduction will be a decrease of 254 women smoking during pregnancy in Alabama.

2014 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.
  - Medicaid reimbursement to providers for:
    - Plan First pregnant women who receive smoking cessation medication with a written prescription.
    - Up to four face-to-face counseling sessions in a 12-month period to assist with smoking cessation. The reimbursement period will begin in the prenatal period and continue through the postpartum period.
- The distribution of over 5,000 "How Smoking Affects Your Pregnancy" posters statewide. The posters addressed the long-term effects on the child when a mother smokes during her pregnancy.
- The development of a protocol for all 67 county health departments to provide smoking cessation counseling to women of childbearing age, which includes completing the QUITLINE referral for services and faxing the QUITLINE referral for any women who express the desire to stop smoking.
- According to National CoIIN data:
  - Public Health Regions IV and VI achieved a 6 percent decline in "any smoking" from January 2011 to June 2013.
  - Alabama achieved a 2 percent decline in "any smoking" for the same time period.

Safe Sleep:

National Aim: To increase infant safe sleep practices by 5 percent by August 2014 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 August 2014 among all racial and ethnic groups.

2014 Activities:

- Collaborated with the Department of Child Abuse and Neglect Prevention to provide the Cribs For Kids® Program in Mobile and Baldwin Counties and to supply cribs to families statewide that need a crib in a crisis situation.
- Formed a work-group and developed "Alabama's Collaborative on Safe Sleep: A Position Statement" to encourage providers to discuss safe sleep with patients.
- Facilitated a safe sleep satellite program, "Safe Sleep – You Can Do It, We Can Help!" with over 600 viewers.
- Collaborated with stakeholders to identify consistent messaging educational material to be used statewide.
- Encouraged hospitals to adopt safe sleep policies with annual competencies in their facilities.
- Partnered with AAP to develop a program to have a safe sleep physician champion in each birthing hospital.
- Collaborated with AlaHA and AAP to develop a Blueprint Step-by-Step process for implementing a safe sleep program for hospitals statewide.

Perinatal Regionalization:

National Aim: By August 2014, 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 August 2014, 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.

2014 Activities:

- Collaborated with AlaHA to ensure hospitals were aware of the AAP Levels of Neonatal Care guidelines released in September 2012.
- Formed a workgroup to determine barriers to incorporating the Levels of Neonatal Care guidelines in hospitals. This workgroup addressed barriers such as transportation (especially in rural areas), financial reimbursement, and political climate.
- Collaborated with AlaHA to bring Dr. Wally Carlo, from AAP-Committee on Fetus and Newborn, to discuss facilities' concerns regarding staffing, equipment, and contractual agreements described in the 2012 Levels of Neonatal Care guidelines. Dr. Carlo has agreed to take the concerns back to the AAP-Committee on Fetus and Newborn for clarification in writing for Level I and Level II facilities.

PROGRAMS CONTRIBUTING TO IMPROVED PERINATAL OUTCOMES

Adolescent Pregnancy Prevention Branch

The Adolescent Pregnancy Prevention Branch within the Women and 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 2015 under the Patient Protection and Affordable Care Act of 2010. The purpose of the program is to support decisions to abstain from sexual activity by providing effective and medically accurate abstinence programs. Four community projects are funded through a competitive selection process and provide programs in 22 counties focusing on middle school aged students in classroom settings. The projects incorporated a "Positive Youth Development" approach which utilized 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 2016 under the Patient Protection and Affordable Care Act of 2010. The statute stipulates that a program must educate adolescents on both abstinence and contraception for the prevention of pregnancy and sexually transmitted infections. The program utilizes 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, the subjects include: healthy relationships, adolescent development, and healthy life skills. Five community projects, funded through a competitive selection process, provide 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 on August 5, 1997, under a new Title XXI of the Social Security Act. Alabama's program, known as ALL Kids and in existence since 1998, is administered by the ADPH. The program covers children whose family income is too high to qualify for Medicaid up to 317 percent of the federal poverty level (FPL). Due to Affordable Care Act provisions, Medicaid's income threshold was expanded to 146 percent FPL using CHIP funds. As a result, about 23 thousand ALL Kids' enrollees were transitioned to Medicaid in January of this year. 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 (8.9 percent, according to the U.S. Census Bureau, Current Population Survey, 2013 coverage year) 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. The Alabama newborn screening panel includes 30 disorders recommended by the American College of Medical Genetics and MOD. These disorders include Endocrine Disorders (Congenital Hypothyroidism and Congenital Adrenal Hyperplasia), Cystic Fibrosis, Sickle Cell Disease, Hearing Loss, Critical Congenital Heart Disease, and Metabolic Disorders (Amino, Fatty, and Organic Acids). Every delivering hospital is required to screen all infants for these potentially devastating disorders. The NSP works closely with hospitals to ensure that a satisfactory newborn screening test is collected and submitted to the Bureau of Clinical Laboratories to ensure timely identification and treatment. From January 2014 to September 2014, 85 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 lost to follow-up after failing their initial hearing screen. All 48 birthing facilities in the state screen infants prior to discharge. "Alabama's Listening" follows the guidelines from the Joint Committee on Infant Hearing 2007 Position Statement. Using federal grants, the Alabama system continues to replace outdated screening equipment and provide testing supplies. From January 2014 to September 2014, 13 infants were identified with various forms of hearing loss and referred for continuation of care based on their specific needs. 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 timely diagnosis and intervention, when indicated. In the upcoming year, efforts will include establishing a Memorandum of Understanding with The Alabama Department of Rehabilitation Services, Division of Early Intervention, to ensure that once a diagnosis of hearing loss is identified, infants are entered into a system of intervention by six months of age.

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 2020 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, respectively. According to the CDC "Breastfeeding Report Card" 2014, the percent of infants in the United States initiating breastfeeding is 79.2 percent. Alabama's breastfeeding initiation rate is 67.3 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 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, established in 2005, 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 fiscal year 2014, 46 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 Breastfeeding Peer Counselor 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: A Winning Goal – for Life." The theme asserted the importance of increasing and sustaining the protection, promotion, and support of breastfeeding. 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 is now used in Alabama to further improve both the reporting process and the overall quality of the data collected. All prior data, going back to the beginning of ACDRS, has been cross walked into the new system and is available for concurrent analysis. Annual reports using data from both old and new systems are available along with other original publications on the ACDRS Web site. ACDRS conducted its biennial Statewide Training Conference for ACDRS coordinators and partners throughout the state in 2014 and will plan the next one for 2016.

Alabama Family Planning Program (FPP)

The Alabama FPP 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 women of lower social-economic status are more likely to have unplanned births.

During fiscal year 2014, direct patient services were provided to an estimated 94,147 family planning clients through local health department clinics. Approximately 91 percent of the caseload served was below 150 percent of the FPL. 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 2,512 calls during 2014.

Healthy Child Care Alabama

Healthy Child Care Alabama continued as a collaborative effort between ADPH and the Alabama Department of Human Resources. During FY 2014, 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 to 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 2014, the nurse consultants documented 2,766 health and safety training and educational sessions for 9,455 providers; 2,051 incidents of technical assistance at child care sites; and 6,919 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 21,863 children in the child care setting and developed nine 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 2014, 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 (MCH Epi) Branch staff continued coordinating ongoing needs assessment activities of FHS. In fiscal year 2013, the MCH Epi 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 (2008 to 2013 for characteristics of live births and 2008 to 2013 for risk of infant death) include the following:

- The percentage of infants born to Latino mothers decreased from 8.2 percent in 2008 to 6.9 percent in 2013.
- In the Medicaid-funded group, the prevalence of short (less than 12 months) live birth interval increased slightly from 1.3 percent in 2011 to 1.4 percent in 2013.
- In the White, non-Latino, Medicaid-funded group, the prevalence of tobacco use during pregnancy decreased from 32.1 percent in 2008 to 28.6 percent in 2013.
- The prevalence of inadequate prenatal care, as measured by the Kotelchuck Index, for 2013 was 32.4 percent in the self-pay group, 17.8 percent in the Medicaid-funded group, 5.2 percent in the privately-insured group, and 12.6 percent in the total group. This figure is a slight increase from 2012 when the prevalence for the total groups was 12.3 percent.

In the four-year period of 2010 to 2013, risk of infant (under one year of age) death was 18.7 deaths per 1,000 live births in the self-pay group, 9.7 deaths per 1,000 live births in the Medicaid-funded group, 6.3 deaths per 1,000 live births in the privately-insured group, and 8.4 deaths per 1,000 live births in the total group.

FHS continues to assess the ever-changing needs of Alabama's population and to 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 MCH Epi Branch is planning for the upcoming needs assessment due in FY 2015.

FY 2015 GOALS

1. Create and implement a Strategic Action Plan to reduce infant mortality.

2. Decrease infant morbidity and mortality by identifying the contributing factors and implementing steps to mitigate those factors.

3. 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 2015 OBJECTIVES

1. Through the FIMR Program identify factors that contribute to fetal/infant deaths by reviewing 50 percent of fetal and infant deaths that occur in 2015.

2. Decrease the number of Alabama's unintended births to 46.5 percent (Alabama Baseline: 49.0 percent in 2011; source: ADPH, Center for Health Statistics).

3. Decrease the number of Alabama infants that die before their first birthday from co-sleep and/or unsafe sleep environments to 18 percent of the total infant mortality rate (Alabama Objective; Alabama Baseline: 20 percent of the total infant mortality rate in 2013; source: ADPH, Center for Health Statistics).

4. Decrease the IMR among blacks to no more than 12.2 per 1,000 live births (Alabama and Healthy People [HP] Objective; Alabama Baseline: 12.6 per 1,000 live births in 2013; source: ADPH, Center for Health Statistics).

5. Decrease the percent of non-medically indicated, singleton deliveries before 39 weeks to 9.0 percent (Alabama Baseline: 9.7 percent in 2013; source: ADPH, Center for Health Statistics).

6. Decrease the percent of LBW births to 9.7 percent (Alabama Baseline: 10.0 percent in 2013; source: ADPH, Center for Health Statistics).

7. Decrease the percent of adolescents age 10 to 19 who smoke during pregnancy to 10.5 percent (Alabama and HP Objective; Alabama Baseline: 10.9 percent in 2013; source: ADPH, Center for Health Statistics).

8. Decrease the percent of women who smoke during pregnancy to 10.5 percent (Alabama and HP Objective; Alabama Baseline: 10.8 percent in 2013; source: ADPH, Center for Health Statistics).

9. Increase the percent of births with adequate prenatal care to 77.0 percent; adequacy of care measured using the Kotelchuck Index (Alabama and HP Objective; Alabama Baseline: 76.2 percent in 2013; source: ADPH, Center for Health Statistics).

10. 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 of live births (Alabama Objective; Alabama Baseline: 85.0 percent of live births in 2013; source: ADPH, Center for Health Statistics).

11. Increase the percent of mothers who place their infants on their backs for sleeping to 67.0 percent (Alabama Objective; Alabama Baseline: 65.5 percent in 2011; source: ADPH, Center for Health Statistics).

12. Increase the percent of mothers who initiate breastfeeding to 73 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.

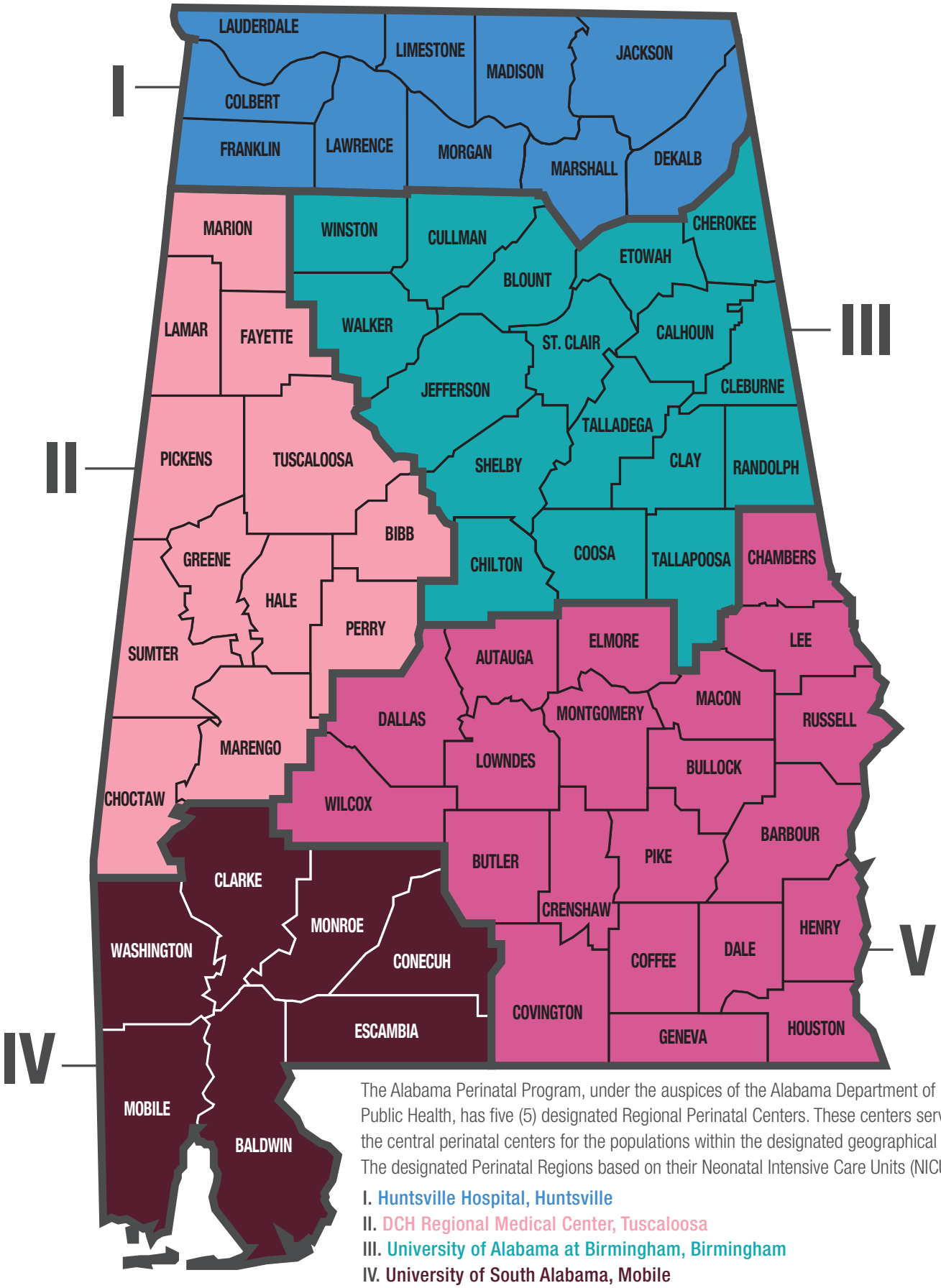
The bureau of maternal and child health under the direction of the state board of health shall annually present a progress report dealing with infant mortality and handicapping conditions to the legislative health and finance committees prior to each regular session of the legislature. No funds of the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