



PULSE

A MONTHLY NEWSLETTER FROM THE ASSOCIATION OF MATERNAL AND CHILD HEALTH PROGRAMS

Infant Mortality September 2011

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From the President

Infant Mortality

By Stephanie Birch, RNC, MPH,
MS, FNP



This issue of *Pulse* focuses on the topic of infant mortality. Infant mortality is the leading worldwide indicator of maternal and infant health status. This indicator is also valuable in assessing the quality and accessibility of primary health care available to pregnant women and infants, and the impact of poor socio-economic conditions on maternal and infant health. The status of infant mortality can be affected by many factors, including the rates of neonatal and post-neonatal death, which have a variety of associated risk factors.

While the United States has made great strides in reducing infant mortality over the last century, our country lags far behind many other developing countries with seven countries having an infant mortality rate that was less than half of the U.S. rate (6.6) in 2008. Disparities continue to exist with some populations, such as Alaska Native/American Indian (8.28 deaths/100 live births) and non-Hispanic black births (13.35 deaths/100 live births), which for the later group is more than double the rate of infants born to non-Hispanic white mothers (Matthews, et al, *Pediatrics*, 2011).

In this issue, you will have an opportunity to read about programs implemented in a variety of states focused on reducing risk factors that contribute to high rates of infant mortality.



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From the CEO An Interview with NHTSA Executive Director Stacey Cunningham

By Michael R. Fraser,
Ph.D., CAE



This month, *Pulse* focuses on Infant Mortality. Infant mortality prevention is a priority of Title V programs nationwide, and states and communities employ a variety of strategies to address this critical maternal and child health (MCH) issue. In addition to the Title V MCH Services Block Grant, the Healthy Start Initiative is another significant federal investment in infant mortality prevention. I caught up with Stacey Cunningham, Executive Director of the National Healthy Start Association (NHTSA) here in Washington, DC, to talk more about the topic of infant mortality and the work of Healthy Start programs and the National Healthy Start Association.

MIKE: *Stacey, thanks for being a part of this month's issue of Pulse on infant mortality. Healthy Start is a major player in addressing this difficult MCH problem. What do you see as some of the key ways that Healthy Start works at the local level to improve birth outcomes?*

STACEY: Thanks Mike, I am so proud to be working with my fellow Healthy Start family to lead the charge on this issue. As you know, this is the 20th anniversary of Healthy Start and for the last two decades, the Initiative has made great strides in improving birth outcomes. For example, at our recent briefing on Capitol Hill we heard how the Central Hillsborough County Healthy Start had a 30 percent reduction in pre-term birth between 2002 and 2007 and how Harlem, because of the Healthy Start project, has seen a significant reduction of its infant mortality rate from 27.7 in 1990 to 6.1 in 2008. Not to mention that in 2007, 13 Healthy Start projects reported no infant deaths and 10 projects reported none in 2008 and 2009. This is fantastic news! We know that Healthy Start's success is largely due to how closely they work with the community to receive guidance on the design of the program, ensuring that the services adequately meet the needs of the individuals being served. Healthy Start also keeps the consumer/client at the core of this work. Projects ensure that the voices of their families are heard and that they are intricately involved with the program. Thus, it is not

From the CEO CONT.

surprising that many return to work or volunteer with the Healthy Start project as a case manager or home visitor. This is what I love most about Healthy Start, the strong commitment to involve families in the programs and services being delivered.

MIKE: That's great news indeed, what a success and these are great examples. Now let's talk about collaboration. What are some ways that Healthy Start programs can best connect with state Title V programs to address the issue of infant mortality?

STACEY: Addressing this problem really does take collaboration between local, state and national partners. Within states, Healthy Start programs are a key resource for state Title V directors in the states that have Healthy Start sites. Our projects and state Title V staff can partner to tailor programs that meet the needs of specific communities, which is really helpful. Although Healthy Start is in 105 communities, we know there are so many more places that need a Healthy Start but do not have one. Title V plays a vital role in addressing infant mortality and can help reach those families in these areas where there is not one. Healthy Start is a great resource on best practices and for what is working in the community and Title V is a great resource for what is happening at the state. Each should continue to tap into these networks to effectively meet the needs of families in this country. We are all striving towards a common goal of reducing infant mortality, so let's work better together to make it happen.

MIKE: Certainly there is a tremendous opportunity for our members to work together. I think it is exciting that we share similar goals and that the work of our members is so complementary. What are some ways that you think AMCHP and NHSA can continue to work together as partners at the national level?

STACEY: Well, as you know, we do so much together here in Washington, Mike. It seems like we are always at the same meetings, aren't we? I think that both of our organizations want to collect and share best practices and innovations that we are learning about in the states and at the community level. Collaboratively, we can share insights from programs that we support together – such as our joint Partnership to End Disparities in Infant Mortality that we work on with CityMatCH and the W. K. Kellogg Foundation. We can continue to encourage our members to attend not just our national conferences, but local and state events where they can learn what is happening in MCH from each

other. And as it pertains to policy and advocacy, I think we have a shared interest in assuring that both of our programs, and the others that address MCH issues, are recognized as essential and supported by Congress. I think there are lots of ways that we can work together – the joint meeting of our Executive Committees and potentially our Boards is another great way to move our shared goals forward. Both of our organizations have a commitment to improving the health and well-being of families and working together can only enhance what we are each aiming to do for states, communities, moms, dads and, of course, the children.

MIKE: I definitely agree that we have started on some great initiatives together. Stacey, thanks for all you do and on behalf of AMCHP please share our thanks with your Board and your members!

STACEY: I definitely will Mike and I truly appreciate the chance to be part of this issue. Thank you for your continued leadership in the field.

Feature

HHS Secretary's Advisory Committee on Infant Mortality Reconvenes

By Lauren Raskin Ramos

Director of Programs, AMCHP

On Aug. 2, the U.S. Department of Health and Human Services (HHS) Secretary's Advisory Committee on Infant Mortality (SACIM) reconvened in Bethesda, MD with new members and a renewed energy/dedication to advancing strategies to reduce infant mortality in the United States. Chaired by Michael Lu, MD, MS, MPH, Associate Professor Department of Obstetrics and Gynecology, David Geffen School of Medicine, at the University of California at Los Angeles and the Department of Community Health Sciences at the School of Public Health, SACIM's purpose is to advise the secretary on HHS programs that are directed at reducing infant mortality and improving the health status of pregnant women and infants. The committee also provides advice on how best to coordinate federal, state, local and private efforts that address the health and social problems impacting infant mortality.

Feature CONT.

HHS Advisory Committee

Among the many prestigious members of the committee are AMCHP members Melinda Sanders, MSN, RN, Administrator, Title V Director, Missouri Department of Health and Senior Services, and Ruth Ann Shepherd, MD, FAAP, Director, Division of Maternal and Child Health, Kentucky Department for Public Health.



In the following interview, Melinda Sanders shares thoughts on the anticipated accomplishments of SACIM and the role of Title V in this important work.

What are you most hopeful that SACIM will achieve?

I would like to see the SACIM develop a national agenda on infant mortality. Looking back through

history, the first half of the 1900s was filled with national “child health campaigns” to improve the health of children. How refreshing it would be to see a renewed interest in the welfare of our nation’s children, with a special emphasis on infant mortality. Assuring each baby reaches their first birthday is a very complex issue. Despite the fact there are many evidence-based interventions proven to prevent infant mortality, the complexity of the issue leads to the need for further research, especially in the understanding and application of the life course perspective. We need to move beyond the knowledge of what “works” for certain populations to what “works” for each child and family.

As a Title V Director on the committee, what messages are you particularly focused on communicating on behalf of state Title V programs?

Data: Coming to state government from the private health care sector, I was amazed at the volume of state, community and often zip-code-level data available to our partners in health and all interested Missourians. I am blessed to work in a state that has a very robust data system accompanied by the best maternal and child health (MCH) epidemiology team! Unfortunately, we have not done a very good job of broadcasting this resource and need to spread the word that the Title V programs offer a wealth of current state-specific maternal and/or child health data (the Block Grant application alone has 73 measures).

Community: If nothing else, the work of the Missouri Title V programs have taught me the value and importance of inclusion of a child/family’s community. While the state

Feature CONT.

HHS Convenes Advisory Committee

staff may be charged with the responsibility of creating opportunities for communities to address the health needs of our children and families, it is the community that carries out the programs/services and knows the faces of those they serve. In my state, we contract with our local public health agencies to provide MCH services in general with a requirement they also focus on the prevention of adverse birth outcomes, tobacco cessation/prevention, obesity prevention or injury prevention. These focus areas are based on their community needs assessment and interventions are based on the Prevention Institute’s Spectrum of Prevention. It is the state-community collaboration that improves the health of Missouri’s mothers and babies.

Is there anything else you want to share with AMCHP members about SACIM?

I am honored to be working with my esteemed colleagues. I have never experienced a more excited, energetic and enthusiastic group of experts more eager to work hard on an issue, find solutions and, most importantly, to save babies! It truly is a humbling experience to be among “greatness” and I thank you for allowing me to represent AMCHP in this work.

Additional information about SACIM, including a membership list can be found at hrsa.gov/advisorycommittees/mchbadvisory/InfantMortality/index.html. AMCHP will continue to communicate information and progress related to SACIM to the membership.

Partnership to Eliminate Disparities in Infant Mortality Shares Lessons Learned

By Katie Brandert

Education & Training Manager, CityMatCH at the University of Nebraska Medical Center

Phyllis George

Program Manager, National Healthy Start Association

Jessica Hawkins

Senior Program Manager, Women’s & Infant Health and Region IV Liaison, AMCHP

To address disparities in infant mortality, CityMatCH, the Association of Maternal & Child Health Programs (AMCHP)

Feature CONT.

Eliminate Infant Mortality Disparities

and the National Healthy Start Association (NHSA) – with funding from the W.K. Kellogg Foundation – created the Partnership to Eliminate Disparities in Infant Mortality. The purpose of this partnership is to eliminate racial inequities contributing to infant mortality within U.S. urban areas. The first activity of the partnership was an 18-month Action Learning Collaborative (ALC) with six sites.

The team-based ALC emphasizes innovative approaches to reducing racial inequities in infant mortality in urban communities, with particular attention paid to the impacts of racism. Throughout the ALC, national partnership staff provides teams with technical assistance, including tools for action planning and evaluation, informational calls with experts in the field, and resources to assist in carrying out selected strategies. ALC teams are encouraged to develop strategies related to any aspect of addressing racism and infant mortality appropriate for their community and state.

Maternal and child health professionals at the local, state and national levels are uniquely positioned to address racism in the United States. Not only do the populations and topics that maternal and child health (MCH) professionals focus on illustrate clear racial health disparities, but research coming out of the MCH field makes it impossible to ignore the role that racism plays in inhibiting health equity. The Infant Mortality and Racism ALC was the first effort of its kind – coordinating efforts across three national MCH organizations; convening professionals from six urban areas in six states; examining the latest research around racism, stress and birth outcomes; and working together to design innovative strategies for implementation at the local and state levels.

The ALC process is a successful approach for tackling a topic as complex and sensitive as racism, with equal attention paid to information and research, personal reflection and growth, and team-building within communities and across all participants of the ALC. The work in each community, and each of the three national organizations, will continue and the experiences and lessons learned will inspire and inform efforts in other communities and states across the nation.

A detailed publication on the experiences and recommendations from the six teams, created/developed to serve as a resource for others interested in addressing racism and its impacts on infant mortality, can be accessed at citymatch.org/downloads/TakingFirstStepBooklet.pdf.

Building upon the successes and lessons learned of the previous collaborative, CityMATCH, AMCHP and NHSA determined there was more need for this important work and have engaged five new state-local teams. The following teams were selected to participate:

- New Haven, CT
- New Orleans, LA
- Boston, MA
- Michigan (working with six metropolitan areas throughout the state)
- Fort Worth, TX

The new cohort of teams will work together through February 2013 and lessons learned will be shared throughout the process.

¹ MacDorman MF, Mathews TJ. Recent Trends in Infant Mortality in the United States.

NCHS data brief, no 9. Hyattsville, MD: National Center for Health Statistics. 2008.

² Ibid

³ Ibid

SUID and SIDS Prevention Efforts: Families at the Center

By Sandra J. Frank, JD, CAE

President, Association of SIDS and Infant Mortality Programs

The American Academy of Pediatrics (AAP) Task Force on SIDS first recommended back sleep for infants in 1992.¹ The national Back to Sleep campaign was initiated in 1994.² The AAP Task Force is expected to issue revised recommendations in October 2011.

Back to Sleep was tremendously successful in the early years. Despite a nearly 50 percent decline in SIDS, the rate has plateaued in the past decade.³ Studies confirm that the decrease in rates has been offset by an increase in other causes of death, e.g., accidental suffocation, asphyxia and undetermined.⁴ New terminology has evolved to describe this phenomenon, including sudden unexpected infant death (SUID) and sleep-related infant death.

There continues to be a significant racial disparity in sleep-related infant deaths.⁵ African-American infants are disproportionately affected by accidental suffocation and strangulation in bed and undetermined deaths, with rates

Feature CONT. SUID/SIDS Prevention Efforts

two to three times that of non-African-American infants. Infants born to African-American mothers still succumb to SIDS at a rate more than twice that in white, non-Hispanic infants.⁶ The extent of the racial disparity has increased.⁷

With the plateau in rates, changing diagnosis and continuing disparities, it is imperative that our intervention strategies are evidence-based, culturally competent and that core maternal and child health (MCH) principles guide our efforts.

Multiple studies provide new insight about factors – social determinants – that influence the choice of infant sleep position and location, and the barriers to accepting the AAP recommendations. Maternal concerns about infant safety, choking and comfort may account for much of the disparity.⁵ Other barriers include the lack of advice and inconsistent or incorrect advice. Another finding is particularly significant as we consider new interventions: **mothers' beliefs about her infant's sleep will influence her decision, no matter how much advice she receives or from whom.**⁸

Focus groups and interviews suggest that mothers did not find the connection between SIDS and safe-sleep recommendations plausible. On the other hand, there was less skepticism about the connection between suffocation and infant death. In terms of interventions, the emphasis on preventability of suffocation may result in acceptance of the recommendations and a decrease in rates of sleep-related infant deaths.⁷

Back to Sleep was a successful public health education campaign. However, infant safe sleep is more complex, multi-factorial and likely to require different approaches to prevention. Social-marketing concepts may be effective in reaching certain populations. The evidence is suggesting that health professionals may need to rethink the way they interact with families – moving away from instruction and toward mutual dialogue.

- What events or family circumstances influence decisions about infant sleep? *What are the unique needs of this family? How can we tailor culturally competent services to meet those needs? Who are the trusted sources of information? Who should we engage to help build trust?*
- What are the family's beliefs and knowledge about infant sleep? *How do we actively listen to the*

reasoning behind infant sleep choices? How can we acknowledge those beliefs and respond in a respectful, non-critical way?

- What are their concerns about safety, choking and comfort? *How do we engage in a sensitive two-way conversation to address those concerns? What resources and tools can help us communicate more effectively?*

As we work together with families to improve acceptance of the safe-sleep recommendations, our challenge is to avoid criticism or blame and to understand the underlying beliefs and address the needs. As professionals and advocates, our efforts should continue to hold true to MCH principles – care that is centered on the family, attuned to the factors influencing behavior and always mindful of the lasting impact we can have.

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2. NICHD/NIH. Back to Sleep campaign. www.nichd.nih.gov/sids/sids.cfm. Date accessed: September 7, 2011
3. Kattwinkle, J., Hauck, F.R., Keenan, M.E., Malloy M.H., Moon, R.Y. (2005). Task Force on Sudden Infant Death Syndrome, American Academy of Pediatrics. The changing concept of sudden infant death syndrome: diagnostic coding shifts, controversies regarding the sleeping environment, and new variables to consider in reducing risk. *Pediatrics*, 116:1245-1255.
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Feature

CDC SUID Case Registry Pilot Program: Grantees Share Success Stories

Atlanta, GA, Aug. 29-30

By Caroline Stampfel, MPH
Senior Epidemiologist, Women's &
Infant Health, AMCHP



The Centers for Disease Control and Prevention (CDC), along with many public/private partners, developed the Sudden Unexpected Infant Death (SUID) Case Registry (CR) Pilot Program to provide more comprehensive data to characterize SUID cases and to determine the factors in the sleep environment that contribute to SUID cases. The program, currently supports seven grantees – Colorado, Georgia, Michigan, New Jersey, New Mexico, New Hampshire and Minnesota, is a state-based surveillance system that supplements current vital, statistics-based surveillance methods building on the National Center for Child Death Review (NCCDR) system funded by the Health Resources and Services Administration Maternal and Child Health Bureau. The SUID-CR relies on multidisciplinary team review of several data sources – reports from death scene investigation, pathology and medical records. This population-based SUID surveillance is critical to researchers, medicolegal investigators and program planners who use this data to improve knowledge about SUID characteristics and risk factors, evaluate case investigation practices and identify high-risk groups to target interventions.

Grantee states shared lessons learned with the assembled partners and Colorado, Georgia, Michigan, New Jersey and New Mexico have completed two years of the project while New Hampshire and Minnesota were new grantees for 2010-2011. Each grantee state was asked to present two lessons learned, which was difficult since so much has been learned through these projects.

In Colorado, the two lessons shared were: utilize more staff time to conduct systematic follow-up with investigators/agencies and streamline the review process. The benefits of utilizing more staff time were to be able to collect more complete information, help build and maintain relationships, increase stakeholder buy-in, provide opportunities to market resources and have timely notification when changes occur. Streamlining the review

process would include identifying new cases using data from vital statistics on a monthly basis and having all data-gathering activities completed before the review. The benefits of streamlining include the ability to review recent deaths with complete records available, having more review time to discuss risk/preventive factors and having more time to implement review-team recommendations.

Georgia shared several lessons learned on how case-registry staff could contribute to reviews, including encouraging, empowering, educating and engaging review teams. The strategies to do this included sending a knowledgeable person to each Child Fatality Review (CFR) team meeting to generate more complete and accurate data reporting from the team; providing Death Scene Investigation (DSI) tools and trainings to investigators to encourage more complete investigations and reports; giving review teams real-time death notifications to assist them in starting the review process in a timely manner; and providing data summaries to local review teams to help them see the products of their work, consider the effects and limitations of poor data quality and identify opportunities and activities.

The Michigan team highlighted quality assurance and utilization/expansion of networks for sharing lessons learned. Under quality assurance, the team has realized that although they proposed to do a random audit of 10 percent of cases, each and every case must be cleaned and prepared to ensure data quality. The team realized that they needed to fully utilize their existing networks, such as newborn screening results, birth records and access to medical examiner files, to obtain data for new variables. In New Jersey, lessons learned centered on meeting preparation and participation. For successful case reviews, the team needed to gather information prior to the meeting from a variety of sources – child protective services, medical records, law enforcement/first responders, medical examiners and birth/death certificates. To ensure a successful review, the team receives records for review at least two weeks prior to the meeting and the coordinator completes a comprehensive review summary. Other keys to success were bringing a medical examiner to the table, including the SIDS Center, tracking missing variables to identify improvement areas, and sponsoring a statewide DSI training to educate/obtain buy-in from first responders.

New Mexico identified lessons learned regarding data integrity and prevention. Keys to success for data integrity

Feature CONT. SUID-CR Pilot Program

include improving communication between the key staff and panel members; streamlining data gathering, entering and auditing processes; increasing panel membership; and providing training and feedback for investigators. Around prevention, the team highlighted developing partnerships and increasing collaboration between government agencies, local communities, hospitals and other stakeholders, as well as increasing advocacy and ownership of prevention recommendations.

The newest grantees shared lessons from their first completed year. Through this project, Minnesota identified instances where case reporting was incomplete and demonstrated a need for structured case definitions, including exclusion and inclusion criteria. The project has also enabled the team to establish contacts with county-level local review teams, channels for retrieving other sources of data and a mechanism to satisfy participants in an interagency data-sharing agreement. New Hampshire has identified key participants who should be invited to case reviews, including representatives from designated areas and local-level providers (law enforcement, EMS, health care providers, home visitors, etc.) who were involved in the case. The team has also realized that the SUID review meetings need to have different components from the existing child fatality reviews, they need to be held more frequently, more cases need to be reviewed per meeting and they need to have a different focus, which includes adherence to the case reporting system form.

For more information, contact Lena Camperlengo RN, MPH, DrPH (c) (770) 488-6322 or gtx6@cdc.gov or visit cdc.gov/sids/CaseRegistry.htm.

Social Media and Technology: How Our Roles are Changing #infantmortality

By **Allan Stamm**
CEO, Go Beyond MCH

Jason Stamm
COO, Go Beyond MCH



There are several factors that we have noticed are changing the way we as maternal and child health (MCH)

Feature CONT. Social Media and Technology

professionals and information technology providers work together and address the landscape of infant mortality. New and better theories for approaching MCH as a whole have emerged; the way communities interact and share information has expanded and the need for more insightful information technology solutions has increased. We hope these changes are leading to more collaboration and higher standards for results in all communities.

In general, the way we view health as a profession and as a society has shifted from treating a symptom to treating root causes. This better understanding and acceptance of the factors that affect health emerged from the Life Course Perspective and continue to resonate within the MCH profession. We now recognize that causes of infant mortality are not simply derived from medical conditions but also from social factors and pressures, nutritional conditions and availability of resources to all populations. MCH professionals are now able to more efficiently develop preventative programs to meet the needs of the population, while the way in which we communicate with the community at risk and the way in which data is tracked has changed significantly.

There is now what seems like an infinite number of ways for a community to reach their targeted population. The emergence of social media, mobile marketing, blogging and more have created new, effective ways to reach at risk populations. These resources can be fairly inexpensive to implement and provide fantastic results as a tool for prevention and awareness. However, with this new media comes a change in mindset and a need to develop a new skill set. We all have to adapt to this constant and transparent media, and understanding that it is here to stay is the first step.

The next step is to brainstorm how this new media can be a research tool for our profession. We have all seen social media play a significant role in Egypt, the UK riots and natural disasters. So, how can we as MCH professionals think outside the box and use this media for issues like infant mortality? Can we monitor the overall health and sentiment of our communities via social media sites? One example is the Centers for Disease Control and Prevention (CDC) use of Twitter to monitor outbreaks, misconceptions and more. Simply using hashtags and searches, the CDC has been able to respond to public health issues with nearly instant turnaround time.

Feature CONT.

Social Media and Technology

Once the communications and new media questions are answered, there is then the question of how to effectively track and monitor each individual as they receive services from multiple programs. The information technology solution needs to be based on integrating multiple programs and users into one software solution modeled around the social model of Life Course. We have modeled our MCH software solutions on the social circles of a community and then created the ability for each individual's care and case management to be tracked and monitored through multiple communities. This allows for a data output that takes into account the path of women, children and families through multiple social services programs.

We invite you to continue the conversation with us online and share your opinions and thoughts on changes affecting the way we as MCH professionals and information technology providers address #infantmortality. Start by watching our exclusive interview with Carol Brady, Executive Director of Northeast Florida Healthy Start, Inc, and Board Member, Reverend Tom Rodgers, as they share their experiences and successes in overcoming challenges and working towards their infant mortality goals. Videos can be viewed by visiting YouTube.com/GoBeyondMCH.

Success Stories

Declining Infant Mortality Rates in Maryland: The Babies Born Healthy Initiative

By Bonnie S. Birkel, CRNP, BSN, MPH

Director, Maryland Center for Maternal and Child Health

As is the case in many states, racial and ethnic disparities exist for 10 of the 14 leading causes of death in Maryland. It is no surprise that infant mortality is among these. In recognition, Gov. O'Malley has made reducing infant mortality (and the racial disparity in infant mortality) one of the 15 strategic goals tracked by the Governor's Delivery Unit (GDU). Fortunately, Maryland experienced a 10 percent decrease in infant mortality rates from 2008 to 2009 and a 7 percent decrease from 2009 to 2010, reducing rates to 6.7 per 1,000 live births (click [here](#)

Success Stories CONT.

Maryland BBH Initiative

for the full report). This success is due in part to efforts spearheaded by the Maryland Center for Maternal and Child Health (CMCH) with many public and private sector partners at the state and local level.

Babies Born Healthy (BBH) is a collaborative, interagency program focused on three primary strategies for improving birth outcomes – healthier women prior to and between pregnancies (i.e. interconception); early enrollment in prenatal care; and post-delivery follow-up for high-risk infants and mothers. Efforts have been targeted to jurisdictions where infant mortality and racial disparities in pregnancy outcomes are highest – Baltimore City, Prince George's County and Somerset County (Dorchester County was added in April 2011).

A new comprehensive women's health model has expanded family planning services to include risk assessment and screening for chronic diseases. Through close partnership with Medicaid, a new Accelerated Certification of Eligibility (ACE) process assures Medicaid-eligible women that they will have access to prenatal care as early as possible and a Quickstart prenatal care visit is offered at health departments in the target jurisdictions. To ensure that high-risk babies and mothers receive post-partum follow-up, a statewide standardized post-partum discharge referral process is being developed and a post-partum Infant and Maternal Referral Form has already been implemented statewide (more information available [here](#)).

Promoting safe sleep has also been an integral component of the program. A safe sleep video developed by the B'More for Healthy Babies program in Baltimore City has been distributed widely around the state (video available [here](#)). Key partners in all of these efforts have been the Department of Health and Mental Hygiene Office of Minority Health and Health Disparities, the Governor's Office on Children, the Maryland Department of Human Resources, the Community Health Resources Commission, the Maryland Patient Safety Center and Carefirst.

For more information on Babies Born Healthy, please contact Maura Dwyer, DrPH, Health Policy Analyst, Maryland Center for Maternal and Child Health, at (410) 767-3702 or mdwyer@dhmh.state.md.us.

Success Stories CONT.

The MIME and DIME Programs: Challenges and Successes of Implementing Interpregnancy Care among High-Risk Mississippi Women

By Juanita Graham, MSN RN

Connie Bish, PhD

Lei Zhang, PhD

Danielle Seale, LCSW

Mississippi State Department of Health

Mississippi has the highest state rate of infant mortality in the United States. Over the past several years, new studies and programs have been implemented to address maternal and infant health. Modeling a program implemented in Georgia, the Mississippi State Department of Health (MSDH) implemented pilot programs in two communities among women who delivered a very low birth weight infant. Very low birth weight accounts for more than half of Mississippi infant deaths each year. The pilot communities are predominantly African American with high rates of poverty, low birth weight (LBW) deliveries, infant mortality and morbidity combined with low rates of health insurance coverage and access to primary care services. The Metropolitan Infant Mortality Elimination (MIME) and Delta Infant Mortality Elimination (DIME) programs give varying perspectives – urban and rural – of implementing interpregnancy care in Mississippi.

The MIME and DIME projects have three aims for program participants: (1) Improve overall health status and optimize child spacing; (2) Reduce subsequent poor pregnancy outcomes; and (3) Share program findings with maternal and child health stakeholders. The projects are highly collaborative, incorporating partnerships and contractual agreements between state, private and community-based resources.

Since recruitment began in February 2009, 110 women have enrolled in the projects. Case studies of success stories and challenges are being documented. A large staff dispersed across a large geographic area in DIME provided unique challenges in case management that the urban MIME program did not experience. Extensive evaluation activities are being implemented to assess both health and financial outcomes. Early data suggest improved outcomes and achievement of adequate child spacing.

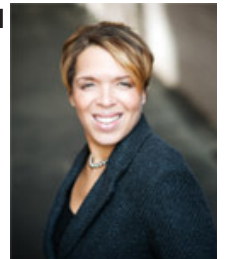
With these successes in mind, the MSDH is implementing expanded access to basic components of the program. The vision for these programs is to provide more women with the knowledge and services needed to be proactive in reproductive health decisions and preconception health.

Generally speaking, healthier mothers have healthier babies. Thus, improving the health of mothers prior to pregnancy could improve outcomes for Mississippi infants and their families. If proven effective, MSDH plans to expand the MIME and DIME programs to other areas of the state upon availability of adequate funding. For more information, contact Juanita Graham, DNPc, MSN, RN, Health Services Chief Nurse, Mississippi State Department of Health at juanita.graham@msdh.state.ms.us.

HRSA MCHB Division of Healthy Start and Perinatal Services Interconception Care Learning Collaborative (ICC LC):

By Stacey D. Cunningham, MSW, MPH

Executive Director, National Healthy Start Association



In 2008, the Division of Healthy Start and Perinatal Services (DHSPS) in the Health Resources and Services Administration (HRSA) Maternal and Child Health Bureau (MCHB) launched one of the largest action learning collaboratives, with over 500 individuals representing the federal Healthy Start Initiative. The ICC LC strives to improve the health and well-being of women and infants served by all 104 Healthy Start grants by advancing the quality and effectiveness of women's health during interconception care in each project. The overarching goal is to apply a quality improvement "learning collaborative" model to improve non-clinical, community-based services in all Healthy Start communities across the country. DHSPS focused on interconception care and the outcomes show how ICC research can be translated into practice. Currently, the projects are completing the third cycle of the collaborative.

The ICC LC uses the Plan-Do-Study-Act (PDSA) model developed by the Institute for Healthcare Improvement

Success Stories CONT.

Healthy Start ICC LC

to integrate evidence-based practice and innovative community-driven interventions to improve care in specific topic areas. Healthy Start grantees were placed in collaborative groups based on their choice of five core content areas from which they chose in each of the three cycles. These areas included case management; family planning/reproductive health; healthy weight; ICC risk screening/assessment; maternal depression; and primary care linkages. Within each core content area, each collaborative selects one of the three change concepts to work on within their individual project area. The three change areas are strengthening partnerships and linkages among community providers; advancing use of evidence-based tools, data collection and performance monitoring; and improving staff training and protocols to improve quality and consistency. A total of 16 collaboratives were formed with the 104 projects.

Each cycle helped grantees move forward in the collaborative process. Cycle I focused on training grantees on the PDSA process; Cycle II focused on creating and implementing measures; and Cycle III currently uses the continued and improved reporting of measures by each collaborative. Each of the 16 collaboratives chose common measures as a small group in Cycle II. The data collected from each collaborative demonstrated improvement and include examples, such as 31 linkages/partnerships were established, reestablished or strengthened; 111 women were screened using selected tools; and 87 Healthy Start community staff were trained on the updated or established protocols.

For more information on the Interconception Care Learning Collaborative, contact DHSPS at (301) 443-0543.

View from Washington

Raising Awareness About Infant Mortality

By Brent Ewig, MHS
Director of Public Policy & Government Affairs, AMCHP



I recently had the honor of representing AMCHP in a congressional briefing, cosponsored by AMCHP and

View from Washington CONT.

organized by our colleagues at the American College of Obstetricians and Gynecologists. The focus was on raising awareness among congressional staff, press and interested organizations about America's standing on infant mortality.

I shared the following three key messages:

- Infant mortality is the sentinel measure of how well society is protecting and promoting the health of women and children, and the lack of significant progress over the past decade should concern us all
- State public health agencies use the Title V Maternal and Child Health Services Block Grant as the foundation for efforts to move the needle on this critical indicator
- Past and projected budget cuts will inhibit progress, we need Congress to help to sustain critical funding

Despite the well-known challenges, the presentation kicked off with a positive, highlighting how the long-term view reveals tremendous progress over the past century. This shows that improvement is possible and helps us remember that, while infant mortality and related disparities have not improved significantly in the past decade and sometimes may seem almost intractable, it has dropped by more than 90 percent in the last century. That is why the Centers for Disease Control and Prevention (CDC) declared healthier mothers and babies as one of the 10 greatest public-health achievements in the 20th century. More recently, states, like South Carolina, Virginia, Delaware, and communities such as Harlem, have shown that dedicated leadership and targeted initiatives can make a difference. I shared the following state highlights:

- [South Carolina reduced its infant mortality by 6 percent](#) from 2007 to 2008 to its lowest rate in 20 years by engaging partners such as the March of Dimes, private physician practices and faith-based organizations to ensure pregnant women have access to needed services.
- [The Virginia infant mortality rate dropped 13 percent](#) from 2007 to 2008. As part of a comprehensive initiative, Virginia distributed grants to local health jurisdictions with the highest infant mortality, increased enrollment in State Children's Health Insurance Program (SCHIP) for pregnant women, and formed partnerships with key organizations and

View from Washington CONT.

community members through a Health Commissioner's Infant Mortality Work Group.

- [Delaware recently reported a 10 percent reduction in their infant mortality rate](#) since 2004 thanks to development of a Healthy Mother and Infant Consortium that implemented programs aimed at decreasing the number of children born prematurely or too small to survive the first year of life. Some of the key components of their comprehensive effort include, embracing preconception care and recognizing the way to healthy infants is through healthy women, and promoting early prenatal care and support for women with previous poor birth outcomes.
- Finally, in central Harlem, the Northern Manhattan Perinatal Partnership – a Healthy Start grantee – developed and executed a community plan that [reduced the infant mortality rate in central Harlem from 27.7 deaths per one thousand live births in 1990 to 6.1 deaths in 2008](#). Their efforts include a Title V supported Comprehensive Prenatal-Perinatal Services Network whose role is to coordinate perinatal services in Northern Manhattan and is committed to providing pre- and post-natal care that is accessible, family-centered, high-quality and addresses the central Harlem community needs.

These examples show that progress is possible, but we know that nationally progress has stalled and disparities are appalling.

How the State Title V MCH Block Grant Makes a Difference

I also shared a brief overview of how Title V is a 76-year-old program that supports a fundamental partnership between the federal government and states to improve maternal and child health (MCH). It provides resources to all states and territories with a fair amount of flexibility but a sets framework for states to deliver services in essentially four standard areas – direct gap filling care, enabling services, population-based programs and infrastructure or systems building. Those familiar with our jargon recognize this as the MCH pyramid.

More specifically to the issue of infant mortality, I highlighted how practically all state MCH programs:

- Link uninsured women to available prenatal services
- Closely coordinate with state Medicaid programs to

improve outreach/enrollment to eligible women

- Assess and work to ensure systems capacity to meet the needs of women and infants in their state
- Develop regionalized systems to care for low birth weight and medically fragile newborns, and support newborn screening and follow-up programs serving nearly all infants
- Ensure data collection/performance monitoring in order to examine/positively impact the incidence of preterm birth, infant mortality, and factors that may contribute to maternal mortality and morbidity
- Increasingly focus on preconception health by working to improve women's health prior to pregnancy in order to improve pregnancy related outcomes

Budget Challenges

I then stated the obvious – that all of this work is endangered by the grim budget outlook.

We used the event to highlight release of the new AMCHP report, [Critical Condition: How Federal and State Budget Cuts are Hurting the Health of Our Nation's Mothers and Children](#), warning that over \$313 million in state cuts, combined with \$74 million in federal cuts, along with record-high poverty and uninsurance rates are creating a perfect storm for the health of moms and kids.

I concluded by asking for the help of everyone in the room to use their voice in the debate on budgets, confronting the myth that we can do more with less.

I talked about how the Title V MCH Block Grant, in our view, represents the best hope for a funding relationship that supports a federal-state-local partnership providing states with the flexibility needed. I highlighted our statutory mandate to address infant mortality, and built-in accountability/performance measures to ensure this is addressed with a system rather than the silo approach.

Yet, the Title V MCH Block Grant has slowly eroded over the past decade. We need your leadership to reinvigorate this core source of state funding and emphasize what is needed to reestablish progress. It is folly to think we can do this on the cheap or absorb the kind of cuts we have beat back so far without losing progress and we need to say so.

I also shared my view that the cost-effectiveness data speak for themselves – when you consider the Institute of Medicine estimates that prematurity costs society \$26

View from Washington CONT.

billion annually, it should not be a hard sell to convince policymakers that investing an incremental percentage to address this will provide a huge pay off. But reality is that this *is* a terrifically hard sell in this environment.

We also ended on a positive, noting that the Health and Human Services Secretary's Advisory Committee on Infant Mortality (SACIM) is reconvening and organizing some of the best minds on this issue to make recommendations. I also highlighted that the Association of State and Territorial Health Officials – who also co-sponsored the briefing – will soon announce an exciting initiative to help raise awareness/catalyze progress.

The presentation ended with this quote from public health hero Bill Foege that captures the need to act now but while also taking in the long-term view:

“One thousand years ago, as tools improved, as building materials improved, we saw new creativity in architecture. At that point resources from churches, royal families and communities, were invested to build cathedrals, some taking hundreds of years to complete. Artisans were assembled who knew they would never see the completed cathedral and yet there is no evidence that it decreased the quality of their work. Likewise you and I are investing in a work for the future.”
- William Foege – Former CDC Director

Thank you for being committed to this work for the future.

Who's New New MCH Leaders

NEW MCH DIRECTORS

Arkansas

David Grimes, MD, MPH
Branch Chief, Family Health Branch
Arkansas Department of Health

Who's New CONT.

NEW TITLE V DIRECTORS

Arkansas

Bradley Planey, MS, MA
Associate Branch Chief, Family Health
Arkansas Department of Health

NEW CYSHCN DIRECTORS

Texas

Carol Labaj, RN, BSN, Unit Manager
CSHCN Director
Texas Department of State Health Services

NEW MCH LEADERS

Violanda Grigorescu, MD, MSPH
Branch Chief
Applied Sciences Branch
Division of Reproductive Health
Centers for Disease Control and Prevention

NEW AMCHP STAFF

Communications

Laura Goodwin joined AMCHP as the Publications and Member Services Manager. In this position, Laura will work on AMCHP publications and newsletters; member renewals/retention and member inquiries; and, in coordination with the Program Manager, Online Media and Information Technology, on social media strategies. Prior to joining AMCHP, she worked for the Air Transport Association on member communication, media relations and online communications. Laura graduated from The George Washington University with a BBA in marketing.

Women's and Infant Health Team Intern

Jess Kim comes to AMCHP as the new Program Intern on the Women's and Infant Health team. She will assist with the AMCHP/NACDD/CDC Gestational Diabetes Collaborative in a variety of ways. Jess has a background in child development with her bachelor's degree in psychology. She is currently a graduate student pursuing her Masters in Public Health at The George Washington University with a focus in maternal and child health. She is very excited to be a part of AMCHP and to partake in all of its wonderful opportunities.

Get Involved

AMCHP is Pleased to Announce the Launch of the Ryan Colburn Scholarship Fund

AMCHP is now accepting applications and will be awarding a scholarship to one youth leader to attend the 2012 AMCHP Annual Conference. The deadline is Friday, Oct. 14 by 8 p.m. ET. For more information, please click here or contact [Michelle Jarvis](#) at (202) 775-1472.

AMCHP Funding Opportunity: Autism Spectrum Disorders and Other Developmental Disabilities

Deadline: Nov. 2

AMCHP, through funding from the Centers for Disease Control and Prevention (CDC) National Center for Birth Defects and Developmental Disabilities (NCBDDD), will provide 10-15 grants of up to \$15,000 each to public health entities (e.g. Title V, WIC, Early Head Start, home-visiting programs, etc.) to integrate "[Learn the Signs. Act Early.](#)" (LTSAE) materials and messages into programs that serve parents of young children, support the collaboration of Act Early State Teams, and evaluate progress. AMCHP will provide ongoing technical assistance, disseminate resource materials, and link grantees to other states and experts in autism spectrum disorders and other developmental disabilities (ASD/DD). The funding announcement can be accessed [here](#) and an informational call for interested applicants will be held in early October 2011 (exact date TBD). For more information, please contact [Treeby Brown](#) or [Melody Cherny](#).

Webinar on the Life Course Perspective

The webinar, "The Life Course Perspective in Promoting Health in Aging," will feature Diana Kuh, PhD, Director of the Unit for Lifelong Health and Ageing at the Medical Research Council (MRC), Director of the MRC National Survey of Health and Development, and Principal investigator for HALCyon, on Oct. 10 from 1 to 2 p.m. EST. Dr. Kuh uses data from the MRC National Survey of Health and Development to study how biological, psychological and social factors at different stages of life, independently, cumulatively or interactively affect adult physical capability and musculoskeletal function and their change with age. She also uses this life course approach to study women's

health, cardiovascular health and well being. To register, visit [here](#).

ASTHO Now Accepting Applications for Environmental Public Health Tracking Fellowship Program

ASTHO announced a call for applications for its fourth round of Environmental Public Health Tracking (EPHT): State-to-State Peer Fellowship Program. The Fellowship is designed to enhance the tracking capacity of non-funded states and territories. For more information on how to apply, please refer to [ASTHO's Fellowship Announcement](#) and use this [application form](#) to apply. All applications must be received by Nov. 21.



Do you have a successful program that has addressed infant mortality in areas such as preconception health, prematurity awareness, infant mortality task forces, SIDS/SUIDS and more?

Consider sharing your program in [Innovation Station](#), AMCHP's searchable database of emerging, promising and best practices in maternal and child health. You'll have a chance to:

- Share successes with your peers
- Enhance the MCH field
- Contribute to program replication
- Get expert feedback from the Review Panel
- Receive national recognition

The online submission process is simple, and applications are accepted on a rolling basis. If you are looking for examples of successful child health programs, be sure to check out the Innovation Station profiles on the [Alaska Childhood Understanding Behaviors Survey \(CUBS\)](#) and [The Boys' Health Advocacy Program](#)!

For more information, contact [Kate Howe](#) at (202) 266-3056 or visit [amchp.org/bestpractices](#).

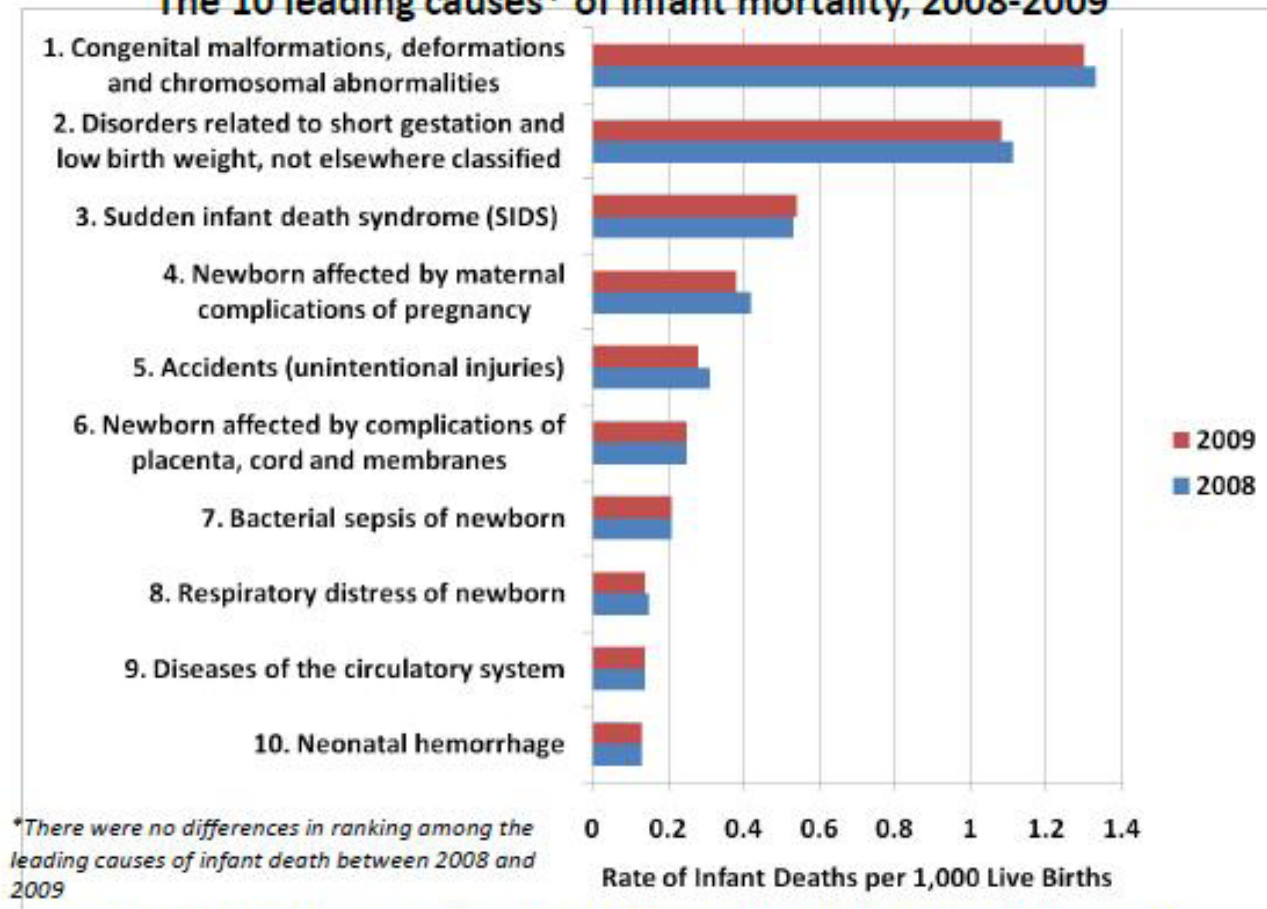
You can also [click here](#) to refer an innovative MCH program that we should know about!

Data and Trends

US Infant Mortality Rate (infant deaths per 1,000 live births)

	2008	2009	Change
Infant Mortality Rate	6.59	6.42	2.6% decrease
Neonatal (< 28 days old)	4.27	4.19	Decrease not significant
Postneonatal (28 days to 364 days)	2.32	2.24	3.4% decrease
White infants	5.54	5.32	4% decrease
Black infants	12.68	12.71	Increase not significant
Black/White ratio	2.3	2.4	Increase not significant

The 10 leading causes* of infant mortality, 2008-2009



Source: National Vital Statistics System, National Vital Statistics Reports, Deaths: Preliminary Data for 2009

Resources

[Association of Maternal & Child Health Programs \(AMCHP\)](#): Offers information and resources about its programs to help state public health agencies and communities address infant mortality.

[Association of SIDS and Infant Mortality Programs \(ASIP\)](#): Hosts information about the [National Sudden and Unexpected Infant/Child Death and Pregnancy Loss Project IMPACT](#), which is part of a national consortium of four centers supported by the [Maternal and Child Health Bureau \(MCHB\)](#) to address infant mortality/pregnancy loss.

[Centers for Disease Control and Prevention \(CDC\)](#): Offers resources and initiatives aimed at reducing infant mortality and pregnancy loss that include:

- [Division of Reproductive Health: Maternal and Infant Health \(CDC\)](#): Contains links to reports, data and other resources about promoting healthy pregnancy and infant health and preventing premature birth and infant illness and mortality, including [SIDS and SUID](#). Recent publications and initiatives include:
 - [CDC's Morbidity & Mortality Weekly Reports \(MMWR\)](#): Presents data based on weekly reports to CDC by state health departments. Recent reports about infant mortality and pregnancy loss include:
 - [QuickStats: Fetal Mortality Rates, by Period of Gestation – United States, 1990-2005](#) (2009): This graph shows fetal mortality rate trends from 1990 - 2005.
 - [QuickStats: Infant, Neonatal and Postneonatal Annual Mortality Rates – United States, 1940-2006](#) (2009): This graph shows infant, neonatal and postneonatal annual mortality rate trends from 1940-2006.
- [CDC's National Center for Health Statistics \(NCHS\)](#): Includes national data about infant mortality and pregnancy loss. Recent publications include:
 - [Deaths: Final Data for 2006](#) (2009): This report includes infant mortality rates and lists leading causes of infant death.
 - [FASTATS: Infant Health \(rev. ed.\)](#) (2009): This fact sheet presents national infant mortality data statistics with links to full reports and data sets.
 - [Fetal and Perinatal Mortality, United States, 2005](#) (2009)
 - [Infant Mortality Statistics from the 2005 Period](#)

[Linked Birth/Infant Death Data Set](#) (2008): This report presents data from the [linked birth/infant death data set](#).

- Also see the NCHS databases: [Data 2010](#), [Health Data Interactive](#) and [VitalStats](#).
- CDC's [Racial and Ethnic Approaches to Community Health Across the U.S. \(REACH U.S.\)](#): Describes this initiative that supports community coalitions in designing, implementing and evaluating community-driven strategies to eliminate health disparities in eight priority areas, one of which is infant mortality.
- Also see CDC's [Pregnancy Risk Assessment Monitoring System \(PRAMS\)](#), the [National Center on Birth Defects and Developmental Disabilities \(NCBDDD\)](#), [publications and brochures](#) addressing folic acid, and diabetes and pregnancy, and NCBDDD's [brochure](#) for health professionals about stillbirths.

[CityMatCH](#): Contains tools and resources for implementing the Perinatal Periods of Risk (PPOR) approach for mobilizing communities to reduce feto-infant mortality in U.S. cities.

[Eunice Kennedy Shriver National Institute of Child Health and Human Development \(NICHD\)](#): Contains research and grant information, publications and other resources for health professionals, researchers and families about pregnancy and infant and child health topics, including pregnancy loss, birth defects, prematurity, and infant mortality. [Reports](#) describe the research and training supported by NICHD's [Pregnancy and Perinatology Branch](#) to improve the outcomes of pregnancy, reduce infant mortality, and minimize maternal and infant morbidities.

[First Candle](#): Hosts information about the [National Sudden and Unexpected Infant/Child Death and Pregnancy Loss Program Support Center](#), which is part of a national consortium of four centers supported by the [Maternal and Child Health Bureau \(MCHB\)](#) to address infant mortality and pregnancy loss. Provides a hotline in English and Spanish for expectant and new parents on ways to help their infants survive and thrive, for parents who have experienced the death of an infant, and for professionals working with families. Also see First Candle's resources about [infant mortality risk reduction](#), [bereavement](#) and [safe sleep environments](#).

Resources CONT.

[Healthy People 2020](#): Offers information and publications about this national health-promotion and disease-prevention initiative. View the [maternal, infant, and child health focus area](#) to learn about the objectives related to infant mortality and pregnancy loss.

[Joint Center for Political and Economic Studies: The Courage to Love Commission](#): Presents [papers](#), [PowerPoint presentations](#), and [fact sheets](#) from this initiative that analyzed racial and ethnic disparities in infant mortality. Papers include:

- [Race, Stress, and Social Support: Addressing the Crisis in Black Infant Mortality](#) (2007): This paper includes information on stress and coping, best practices and policy recommendations regarding black infant mortality.
- [Maternal Nutrition and Infant Mortality in the Context of Relationality](#) (2007): This paper covers infant mortality disparities, nutritional status and behaviors of pregnant women in the United States, prenatal nutrition interventions, relationality over the lifecourse and recommendations.

[March of Dimes \(MOD\)](#): Contains resources for health professionals and [expectant and new parents](#) in English and Spanish about preconceptional and prenatal care, [birth defects](#), [pregnancy loss](#), [prematurity](#), [bereavement](#), and how to get involved in improving infants' health by reducing the incidence of birth defects and infant mortality. Offers [perinatal statistics](#) (including infant mortality rates), continuing-education modules, medical reference information, and video and audio resources.

[Maternal and Child Health Bureau \(MCHB\)](#): Describes MCHB's projects and initiatives on behalf of America's women, infants, children, adolescents and their families. Initiatives include [Healthy Start](#), a program to address factors contributing to infant mortality, low birthweight and other adverse perinatal outcomes in high-risk populations.

[Maternal and Child Health Library at Georgetown University Infant Mortality and Pregnancy Loss Knowledge Path](#): This document links to recent, high-quality resources about infant mortality and pregnancy loss and to factors that contribute to these public health problems, such as birth defects, injuries, prematurity and low birthweight. A section on sleep environment and the prevention of Sudden Infant Death Syndrome is included. A separate

resource on these topics for [families](#) is also available. The MCH Library [website](#) has been redesigned to provide a fresh look and feel and additional resources including pages focusing on professional, family, and school resources and resources on MCH professional education. An enhanced search feature allows users to select display formats and to create their own resource lists by checking off items from materials found in their searches. Please see [here](#) or contact the library at mchgroup@georgetown.edu. To receive notices of new features and information, [subscribe](#) to the weekly MCH Alert.

[National Center for Child Death Review](#): Describes the child death review process for infants, children and adolescents from birth through age 18, offers tools for child death review teams, provides state program information and presents child mortality data by state.

[National Center for Cultural Competence \(NCCC\)](#): Hosts information about the [National Sudden and Unexpected Infant/Child Death and Pregnancy Loss Project](#), which is part of a national consortium of four centers supported by the Maternal and Child Health Bureau (MCHB) to address infant mortality and pregnancy loss. Provides technical assistance and develops resources on cultural and linguistic competence to help programs effectively address racial and ethnic disparities in perinatal, infant and child mortality and pregnancy loss.

[National Fetal and Infant Mortality Review Program \(NFIMR\)](#): Contains a wealth of resources for implementing the fetal and infant mortality review (FIMR) method, including a directory of state and community FIMR projects, program descriptions, data-abstraction forms, sample laws to implement and safeguard FIMR proceedings and an [online discussion group](#). NFIMR is a collaborative effort between the [American College of Obstetricians and Gynecologists \(ACOG\)](#) and the [Maternal and Child Health Bureau \(MCHB\)](#).

[National Healthy Start Association \(NHSA\)](#): Describes the Healthy Start program and provides general information about infant mortality, low-birthweight infants, and racial disparities in perinatal outcomes. Includes a directory of Healthy Start programs nationwide and a [newsletter](#). Funded by the Maternal and Child Health Bureau (MCHB), Healthy Start provides community-based, culturally competent, family-centered, comprehensive perinatal

Resources CONT.

[National Center for Cultural Competence \(NCCC\)](#): Hosts information about the [National Sudden and Unexpected Infant/Child Death and Pregnancy Loss Project](#), which is part of a national consortium of four centers supported by the Maternal and Child Health Bureau (MCHB) to address infant mortality and pregnancy loss. Provides technical assistance and develops resources on cultural and linguistic competence to help programs effectively address racial and ethnic disparities in perinatal, infant and child mortality and pregnancy loss.

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- [National Infant Mortality Awareness Month Toolkit \(2010\)](#): This toolkit aims to help Healthy Start projects promote the effectiveness of programs and efforts to reduce infant deaths, low birthweight, preterm births and disparities in perinatal outcomes.

[National Sudden and Unexpected Infant/Child Death and Pregnancy Loss Resource Center](#): Provides up-to-date information on the prevention of pregnancy loss, SIDS, and sudden unexpected infant and child death; and on bereavement support for families facing losses. Information

on child care and SIDS, first responders, and a safe sleep environment is included, as are a training toolkit, statistics, and multimedia resources.

[Office of Minority Health](#): Infant Health: Contains statistics about infant mortality among racial and ethnic groups and a fact sheet and list of links to publications and websites about infant mortality. Initiatives include:

- [A Healthy Baby Begins with You](#): Presents information about this national print and radio campaign to raise awareness about infant mortality with an emphasis on the African-American community. Includes [campaign materials](#) and infant mortality disparities fact sheets. Also presents information about another phase of the campaign, the Preconception Peer Educators (PPE) Program, which is designed to educate the college-age population about preconception health and care and to train them to serve as ambassadors for their peers who are not attending college.

Databases

The databases listed below are excellent tools for identifying data, additional [literature and research](#), and [programs](#) addressing infant mortality and pregnancy loss. Reproduced with permission from Lorenzo, S. 2010. Infant Mortality and Pregnancy Loss Knowledge Path. Washington, DC: Georgetown University Maternal and Child Health Library.

[Community Health Status Indicators \(CHSI\)](#): Presents county-specific data on health status indicators obtained from a variety of federal agencies including the Department of Health and Human Services, the Environmental Protection Agency, the Census Bureau, and the Department of Labor. Use the indicators to compare a county with counties similar in population composition and selected demographics and to characterize the overall health of a county and its citizens to support health planning. Select a state and county and click on Display Data. Select Measures of Birth and Death to view birth measures and infant mortality rates. CHSI is a service of the [Department of Health and Human Services \(DHHS\)](#).

[Health Data Interactive \(HDI\)](#): Presents interactive online data tables on pregnancy and birth, health conditions and risk factors, health care access and use, and mortality.

Resources CONT.

Infant, neonatal, and postneonatal mortality data and data about preterm birth and low birthweight are presented. HDI is a service of the [National Center for Health Statistics \(NCHS\)](#).

[KIDS COUNT Data Center](#): Contains information about this national and state-by-state effort to track the status of children in the United States. Generate custom graphs, maps, ranked lists, and state-by-state profiles of birth outcomes, among other child health indicators. KIDS COUNT is a project of the [Annie E. Casey Foundation \(AECF\)](#).

[Linked Birth/Infant Death Data Set](#): Contains data about infant births/deaths occurring within the United States to U.S. residents. Data are available by county of mother's residence, infant's age, underlying cause of death, gender, birthweight, birth plurality, birth order, gestational age at birth, period of prenatal care, maternal race and ethnicity, maternal age, maternal education and marital status. This data set is provided by the [National Center for Health Statistics \(NCHS\)](#) via [CDC Wonder](#).

[PeriStats](#): Provides access to maternal and infant health-related data at the national, state, county and city level by aggregating data from several government agencies and organizations. Topics include the timing and frequency of prenatal care, preterm birth, low birthweight, infant mortality, tobacco use and health insurance coverage. Over 60,000 graphs, maps and tables are available, and data are referenced to the relevant source. PeriStats is a service of the [March of Dimes](#).

[Pregnancy Risk Assessment Monitoring System \(PRAMS\)](#): Presents state-specific, population-based data on maternal attitudes and experiences before, during and immediately following pregnancy. PRAMS is a surveillance project of the [Centers for Disease Control and Prevention \(CDC\)](#) and state health departments.

[State Health Facts Online](#): Contains state-level data on more than 500 health topics. View individual state profiles, or compare data for all states by category. For infant mortality data, click on the Health Status category and select one of several subcategories under Infants. For data about low birthweight and prematurity, click on the Health

Status category, and select one of several subcategories under Births. This system is provided by the [Kaiser Family Foundation](#).

[Title V Information System \(TVIS\)](#): Contains data from annual Title V Block Grant applications and reports submitted by all 59 U.S. states and jurisdictions. To identify state efforts to reduce infant mortality, conduct several searches: (1) Select [Program Data](#); scroll to Medicaid/ Non Medicaid Comparison and select Infants deaths per 1,000 live births; select a state and Annual Report Year; and click on Start Search. (2) Select [Measurement and Indicator Data](#); select National Outcome Measures; select Most Recent Year Available or Multi-Year Report; select a state and infant mortality measure; click on Start Search. (3) Select [Measurement and Indicator Data](#); scroll to State Data; select State Priority Needs Keyword Search; select Keyword: Morbidity/Mortality and Population: Infants; click on Start Search. (4) Select [Measurement and Indicator Data](#); scroll to State Data; select State Outcome Measures; select Search By Keyword/Population; select a state and Keyword: Morbidity/Mortality and Population: Infants; click on Start Search. (5) View [State Snapshots of Maternal and Child Health](#) for a summary of each state's infant mortality data. TVIS is a service of the [Maternal and Child Health Bureau \(MCHB\)](#).

[VitalStats](#): Presents tables, data files and reports that allow users to access and examine birth and perinatal mortality data interactively. This system is provided by the [National Center for Health Statistics \(NCHS\)](#).



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Region VIII (2009-2012)
Karen Trierweiler, MS, CNM
Colorado

Region IX (2010-2013)
Les Newman
California

Board of Directors CONT.

Region X (2010-2013)
Maria Nardella, MA, RD, CD
Washington

Director-At-Large (2009-2012)
Annette Phelps, ARNP, MSN
Florida

Director-At-Large (2011-2013)
Debra B. Waldron, MD, MPH, FAAP
Iowa

Family Representative (2009-2012)
Eileen Forlenza
Colorado

Elected Family Representative (2011-2014)
Kris Green
Alaska

AMCHP Staff

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Julio Arguello, Jr., *Program Manager, Online Media and Information Technology*

Joshua Brown, *Senior Manager, Public Policy & Government Affairs*

Treeby Brown, *Senior Program Manager, Children and Youth With Special Health Care Needs*

Tania Carroll, *Office Assistant*

Melody Cherny, *Program Associate, Children and Youth With Special Health Care Needs*

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Jessica Hawkins, MPH, CHES, *Senior Program Manager, Women's and Infant Health*

AMCHP Staff CONT.

Adriana Houk, Associate Director, Organizational Performance and Membership

Kate Howe, MPH, Program Manager, Child Health

Michelle Jarvis, Program Manager, Family Involvement

Jess Kim, Intern, Women's and Infant Health Team

Nora Lam, Executive Assistant

Carolyn D. Mullen, Associate Director, National Center for Health Reform Implementation

Lauren Raskin Ramos, MPH, Director of Programs

Cristina Sciuto, Program Associate, Women's and Infant Health Team

Caroline Stampfel, MPH, Senior Epidemiologist, Women's and Infant Health

Karen VanLandeghem, MPH, Senior Advisor, National Center for Health Reform Implementation

Calendar

AMCHP Conference and Special Events

[AMCHP 2012 Annual Conference](#)

Feb. 11-14, 2012
Washington, DC

[Adolescent and Young Adult Health Institute](#)

Feb. 11, 2012 (during the AMCHP Annual Conference Training Institute)
Washington, DC

[A Life Course Dialogue: Exploring State-Level Implementation](#)

Feb. 12, 2012 (during the AMCHP Annual Conference Training Institute)
Washington, DC

[AMCHP and March of Dimes Third Annual Mini-March for Babies](#)

Feb. 14, 2012 at 10 a.m.
Washington, DC

Calendar CONT.

Partner Events

[Leadership Education in Neurodevelopmental and Related Disabilities \(LEND\) Directors Meetings](#)

Feb. 12, 2012
Washington, DC

[Leadership Education in Adolescent Health \(LEAH\) Directors Meeting](#)

Feb. 12, 2012
Washington, DC

[National Summit on Quality In Home Visiting Programs](#)

Feb. 15-16, 2012
Washington, DC

MCH Events

[Child Health Day](#)

Oct. 3

[NASHP 24th Annual State Health Policy Conference](#)

Oct. 3-5
Kansas City, MO

[American Public Health Association Annual Meeting](#)

Oct. 29-Nov. 2
Washington, DC

[Academy of Breastfeeding Medicine's 16th Annual International Meeting](#)

Nov. 3-6
Miami, FL

[2011 AUCD Conference](#)

Nov. 6-9
Crystal City, VA

[17th Annual MCH Epidemiology Conference](#)

Dec. 14-16
New Orleans, LA

Association of Maternal & Child Health Programs

2030 M Street, NW, Suite 350
Washington, DC 20036
(202) 775-0436
www.amchp.org