Improving Birth Outcomes Policy Statement

POSITION:
ASTHO supports state and territorial health agencies in improving birth outcomes via population health strategies, including policy and comprehensive systemwide changes. Health officials can leverage public health programs, social services, and primary care services to improve care quality and reduce the costs associated with poor birth outcomes across both the healthcare system and among families.

BACKGROUND:
One in 10 infants is born preterm (before 37 weeks gestation).[1] In the United States, the preterm birth rate declined 8 percent between 2007 and 2014 but began to increase again between 2015 and 2017.[2] Preterm infants are at greater risk of developing chronic conditions as adults, such as diabetes and heart disease.[1] Preterm births also bring significant financial costs: the medical, educational, and lost productivity costs associated with preterm births were more than $26 billion in 2005, equaling $51,600 per infant born preterm.[3]

While the U.S. infant mortality rate of 5.9 deaths per 1,000 live births (before age one) is a significant decrease from just 10 years earlier,[4,5] state infant mortality rates range widely between states from nearly zero up to 9.1 deaths per 1,000 births.[6] Preterm birth is a major factor contributing to infant mortality along with birth defects and congenital anomalies, infant sleeping position and location, overheating, and maternal smoking and secondhand smoke exposure.

Summary of Recommendations:

- Develop comprehensive and systematic approaches by prioritizing prevention policies across disciplines and improving state and territorial public health infrastructure.
- Work through state or regional perinatal quality collaboratives.
- Support preconception health and reproductive life planning within existing family planning, educational, and public health settings.
- Provide behavioral and mental health screening.
- Coordinate and collaborate across agencies and sectors to increase payment for, availability of, and access to evidence-based interventions.
- Develop, review, and enhance regionalized maternal and neonatal care systems to ensure access to risk-appropriate care in communities.
- Collaborate, coordinate, and fund a seamless continuum of services to families across public health, social, and medical programs.
- Evaluate the impact of programs using public health surveillance systems and data sources to monitor and track trends in populations.
- Address the social and structural determinants of birth outcomes through a systemic approach.

There are significant racial and ethnic inequities at all economic levels in preterm birth and infant mortality rates. The preterm birth rate for African American women is 49 percent higher than the preterm birth rate for all other racial and ethnic groups.[7] Higher rates of preterm birth and low birth weight babies are a significant part of the reason that African Americans experience an infant mortality rate more than twice the national average (11.3 deaths per 1,000 live births). American Indian and Alaska Native women, who also have an infant mortality rate higher than the national average (8.3 deaths per 1,000 live births), have not experienced the same decreases as other populations during the last decade.[8,9]

RECOMMENDATIONS/EVIDENCE-BASE:

ASTHO recommends the following policy and systemwide changes for improving birth outcomes:

- Develop comprehensive and population health approaches to improve birth outcomes by prioritizing prevention policies across disciplines, enabling and facilitating access to care, and improving state and territorial public health infrastructure, with an emphasis on reducing health disparities and assuring that necessary services are available to high-risk populations.
- Work through state or regional perinatal quality collaboratives (PQCs), which bring together perinatal healthcare providers and public health professionals to improve maternal and perinatal health outcomes by supporting evidence-based clinical practices and processes.[10]
- Ensure access to the full range of contraceptive methods for women of reproductive age and promote preconception health, intrapartum care, healthcare, and reproductive life planning within existing family planning, educational, and public health settings. Providing access to family planning services that include the full range of contraceptive options, counseling, preconception, and interconception care helps women prevent both unplanned and closely spaced pregnancies, both of which are associated with negative birth outcomes.[11]
- Provide behavioral and mental health screening, referral, and treatment for maternal depression and other perinatal mood and anxiety disorders. Work with Medicaid and private insurance to reimburse providers for using screening protocols to detect substance misuse and addiction, maternal depression, and perinatal mood and anxiety disorders early in pregnancy, and to identify adverse outcomes in newborn and infant development. [12] Implement prevention and intervention opportunities with perinatal quality collaboratives and OB/GYN, neonatology, and substance use treatment providers along a continuum of care from the preconception period to early childhood and beyond to help reduce the impact of substance use and addiction on negative birth outcomes.[13,14,15]
- Coordinate and collaborate across agencies and sectors with Medicaid, healthcare providers, professional organizations, and other stakeholders to increase payment for, availability of, and access to evidence-based interventions. Educate providers and patients on evidence-based interventions for improving birth outcomes, including proper use of 17P (injectable progesterone), aspirin, group prenatal care, home visits, and non-medically indicated elective inductions and Cesarean sections.[16,17,18,19,20]
- Develop, review, and enhance regionalized maternal and neonatal care systems in collaboration with healthcare provider organizations, hospitals, and payers to ensure that all pregnant women and newborns have access to risk-appropriate care that is objectively designated to ensure that those likely to need more intensive clinical services receive care at a facility able to support them. [21]
- Collaborate, coordinate, and fund a seamless continuum of services to families across public health, social, and medical programs, including programs such as the Title V Maternal and Child Health (MCH) Block Grant; Special Supplemental Nutritional Program for Women, Infants, and Children (WIC); Title X Family Planning; home visitation programs; and Medicaid. Consider coordinating other public health and medical services, including those for children and youth with special healthcare needs (CYSHCN), HIV, injury and violence prevention, oral health, chronic disease, early learning, substance misuse and addiction, and behavioral health.
- Evaluate the impact of programs using public health surveillance systems to track progress in populations, communities, states, and territories. Data sources for monitoring and assessment include vital statistics, hospital discharge data, electronic health records, and health surveillance systems, such as birth defects surveillance and fetal infant mortality review. Provide continuous

quality improvement training using state and territorial datasets and expand maternal and child health surveys and surveillance projects to every state.

- Address the social and structural determinants of birth outcomes through a systemic approach by ensuring that leadership, infrastructure, policies, and strategies are designed to achieve health equity through social, economic, and political change.[22,23] Eliminate health disparities by incorporating approaches that modify or influence social determinants of health, such as changing the environments in which families live or improving the ability of families to thrive in their environments. This includes mobilizing community health and wellness resources, identifying individuals and communities of greatest need, and using proven practices to engage, inform, and deliver needed health and social services.

APPROVAL DATES

Population Health & Informatics Policy Committee Approval: February 7, 2018
Board of Directors Approval: June 19, 2019
Policy Expires: June 30, 2022

For ASTHO policies and additional publications related to this policy statement, visit www.astho.org/Policy-and-Position-Statements.

ASTHO membership supported the development of this policy, which was subsequently approved by the ASTHO Board of Directors. Be advised that the statements are approved as a general framework on the issue at a point in time. Any given state or territorial health official must interpret the issue within the current context of his/her jurisdiction and therefore may not adhere to all aspects of this Policy Statement.

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