

Office of Disease Prevention and Health Promotion
Healthy People 2020: Who's Leading the Leading Health Indicators?
Maternal, Infant, and Child Health Webinar, March 29, 2012, 12:00 p.m. ET

MODERATOR: Good afternoon, and thank you for registering to the webinar on the leading health indicators. You are now in listen-only mode. Please use the Q&A feature on the right side of your screen to submit any questions and they will be answered at the end of the webinar. I would now like to introduce Dr. Don Wright, Deputy Assistant Secretary for Health Promotion and Disease Prevention at the Department of Health and Human Services.

DR. DON WRIGHT: Thank you. Welcome to the third installment of the monthly series, Who's Leading the Leading Health Indicators. Each month this series will highlight an organization that is using evidence-based approaches to address one of the Healthy People 2020 leading health indicator topics. The series includes a monthly webinar, email bulletin, an active conversation via Twitter and LinkedIn. Our launch on January 25th focused on access to health services, and last month we focused on injury and violence.

All of the webinars will be archived on healthypeople.gov. During today's webinar you will hear from distinguished speakers. Assistant Secretary for Health, Dr. Howard Koh, will introduce this month's LHI topic, maternal, infant and child health. Then, Health and Human Services Deputy Regional Health Administrator of Region IV, Sharon Ricks, will give a snapshot of maternal, infant and child activities in HHS Region IV.

From this month's featured program, Healthy Babies are Worth the Wait, Dr. Ruth Shepherd will discuss how the Kentucky Department for Public Health with the help of national, state and local partners successfully combated rising premature birth rates. For four decades Healthy People has provided a comprehensive set of national, ten-year objectives that have served as a framework for public health activities at all levels and across the public health community.

Often called a roadmap for national health promotion and disease prevention efforts, Healthy People is about understanding where we are now and taking informed actions to get where we want to go over the next decade. Please visit healthypeople.gov for more information. The leading health indicators, the focus of this series, represent critical health issues that, if addressed appropriately, will dramatically reduce the leading causes of preventable death and illnesses. These indicators, or critical health issues, are linked to specific Healthy People objectives.

They've been selected to communicate high priority health issues to the public, along with the actions that can be taken to address them with the overall goal of improving the health of the entire population. The leading health indicators consist of 26 leading health indicators organized under 12 separate topic areas. This month we're focusing on maternal, infant and child health. Healthy People 2020 is committed to improving the health and well-being of women, infants, children and family.

At this time I'd like to turn the podium over to Dr. Howard Koh.

DR. HOWARD KOH: Thank you, Dr. Wright for your leadership, and I want to thank also our Office of Disease Prevention and Health Promotion for putting together this tremendous series. We're very pleased to welcome so many who are attending this webinar. I'd like to give you a brief overview on this month's leading health indicator topic, maternal, infant and child health. If we move on to slide 9, we see that despite major advances in medical care, we still have continued threats to maternal, infant and child health here in the United States.

And we have several drivers of infant death. First, we know that some 12.2 percent of infants are born preterm, and it's defined as before 37 weeks of gestation, and we also still have 8.2 percent of infants born in our country with low birth weight that's defined as a weight under 2500 grams or five pounds and eight ounces. We need to confront these challenges head on because the well-being of mothers, infants and children determines the health of the next generation.

Slide 10 describes the broad framework for the determinants in maternal, infant and child health and reminds us that a broad constellation of determinants effect those outcomes. They include individual behaviors such as smoking during pregnancy, access to services like newborn screening and then this slide also stresses that dimensions like race and ethnicity, socioeconomic status and general health status all have an impact on maternal, infant and child health outcomes.

We are very pleased in this webinar to feature a program, Healthy Babies are Worth the Wait from Kentucky, which addresses these broad determinants in a comprehensive way, and we'll be hearing more from our presenter about how both individual level and population level determinants are addressed through programs such as this one from Kentucky. On slide 11 we review again that infant death and infant mortality is truly a sentinel measure for public health. In Healthy People we are tracking two key indicators; first, infant death or infant mortality, and secondly, preterm birth.

And this slide stresses again that in order to make progress in these two indicators, we need a broad community level approach. Slide 12 shows that the infant mortality rates in our country have changed very little in recent years, and so we note that a Healthy People 2020 baseline level of 6.7 deaths per thousand live births was set and we're aiming for a Healthy People 2020 target of 6.0 deaths over the next decade and beyond. Slide 13 stresses that in this area as in so many other areas of public health we have very significant disparities.

And you can see from this slide that, for example, the rate of black non-Hispanic deaths was almost three times that of Asian and Pacific Islanders. Also, the rate for American Indians and Alaskan Native was almost twice that of Asian and Pacific Islanders, and so these disparities are very striking and persistent over the last decade. Slide 14 looks at the second indicator of total preterm deaths, and this slide shows that for the earlier part of the past decade there was a slide increase in preterm deaths, which has now dropped slightly in recent years.

We have a Healthy People baseline level of 12.7 percent, and we're aiming for a target of some 11.4 percent. Slide 15 shows that there is also great variation by state with respect to percent change and preterm birth rate from 2006 to 2009. We have some states such as those depicted in green where the

decrease is more than 10 percent. You see that there are states like Kentucky that have a decrease from 5.9 percent and on the other hand we have states depicted in light blue that have shown no significant change at all between 2006 and 2009.

So I'm sure people on this webinar are looking at their own particular state and seeing if such data as we're presenting here can help drive strategies for action. Finally, on Slide 16 we have a summary of some federal actions to address, maternal, infant and child health outcomes from a comprehensive social determinants approach. We have a new effort that was just announced by our Health and Human Services Centers for Medicare and Medicaid Innovation called Strong Start, and this is a public-private partnership that features best practices to reduce the rate of early births prior to 39 weeks for all populations.

Through the health reform law we have a new natural prevention strategy that addresses infant mortality and prioritizes this sentinel outcome. We are very pleased that since 2007 our Office of Minority Health has hosted a national campaign called, A Healthy Baby Begins With You that targets the African American community and stresses the importance of free conception peer educators. And then last but certainly not least HRSA, our Health Resources and Services Administration, since 1991 has supported the Healthy Start program to reduce the rate of infant mortality and improve perinatal outcomes through targeted grants to high risk areas.

So we encourage all of you to look at least these four federal actions but of course many, many others in many parts of the country. And now I'm very pleased to turn this over to Sharon Ricks, our Deputy Regional Health Administrator in Region IV.

SHARON RICKS: Thank you, Dr. Koh. Good afternoon, everyone. Region IV is proud and pleased to serve as a co-host for this month's leading health indicator webinar, especially since it features our colleagues and friends at the Department of Public Health in Kentucky and their Healthy Babies are Worth the Wait program. Anyone who's ever held a healthy baby knows that when that new baby is placed in that mother's arms, all of the challenges, obstacles and struggles of the previous nine months fade into the background, and all she sees is that precious beautiful life in front of her.

And at that moment not only does that mother know that it was worth the wait, but that mother also knows it was worth all of the other things she overcame. But when a baby is born too soon or too small and suffers life threatening complications, the impact that it has on an entire family can be devastating. Region IV is a family. We comprise eight states; Alabama, Florida, Georgia, Kentucky, Mississippi, North Carolina, South Carolina and Tennessee, and we are not immune to problems.

We are the largest geographic region with 61 million people. We are most impacted by health disparities. We have the highest ethnic and racial diversity. We have the most poverty and the highest illiteracy rate of any other region. Thirty percent of us are obese, and we are home to 18 percent of the nation's homeless. We also have the most extremely preterm births and carry the unfair and heavy burden of infant mortalities for the entire nation. But I can assure you that since moving here in 2007, I

have never met more committed and caring people at both the state and community level, who are determined to work together to improve the health of their families and their communities.

Just two months ago in January 2012, state health officials, maternal and child health directors and state partners from across Regions IV and VI met to share ideas, strategies and resources to address infant mortality. They talked about implementing state policy changes that would eliminate elective deliveries prior to 39 weeks gestation. They talked about improving access to care for all women of reproductive age, including providing progesterone therapy for those with a clinical indication. They talked about developing and implementing a regional campaign to address other aspects of women's health like smoking cessation, chronic conditions and influenza immunizations that impact the pregnancy.

And they talked about promoting safe sleep for babies. These ideas were shared because they have worked for some states and they may carry promise for others. There are also many local efforts in counties and communities throughout the region. Together, Region IV is addressing this issue as a family, and today you'll hear about one of our success stories with the hopes of inspiring you to take action. I am now pleased to introduce to you my friend and colleague Dr. Ruth Ann Shepherd, the Director of the Division of Maternal and Child Health at the Kentucky Department for Public Health. Dr. Shepherd?

DR. RUTH ANN SHEPHERD: Thank you, Sharon, for those beautiful and inspiring words, and welcome to all of you on the webinar. Now we're going to take a look at an example of how communities can take action in order to affect those maternal and child health indicators. We are pleased to share with you Kentucky's experience with Healthy Babies are Worth the Wait, a community-based approach to prematurity prevention that was developed and piloted in Kentucky from 2007 to 2009.

As you heard from Dr. Koh, the problem of prematurity is a major issue for public health, and particularly, maternal and child health, and as we heard so eloquently from Sharon, it impacts infants, their families and the communities we live in. It is about our future. Prematurity is the leading cause of infant mortality, and in addition, is a major cause of lifelong problems. Prematurity is associated with over half of all the neurodevelopmental disability such as cerebral palsy and mental retardation as well as less severe disabilities such as learning problems and behavior problems.

We now know that there is increased risk for these problems not just in the babies who are born extremely preterm, but even in babies born just a few weeks before their due date. Chronic disease impairs many adults and there's now a lot of national discussion about how to prevent chronic disease, but many studies now have documented that the risk of developing those chronic disease may even begin before birth, the fetal origins of disease. Preterm birth has been linked to increased risk for chronic diseases in adulthood such as heart disease, obesity, diabetes and others, and so prematurity prevention may be one of the first steps in reducing the overall burden of chronic disease.

All these things make the recent rise in preterm birth in the U.S. even more concerning from a public health perspective. Over the last two and a half decades the rate of preterm birth has risen by almost 30 percent in the United States. Well in the Healthy Babies are Worth the Wait initiative, we approve

prematurity as a public health problem, not just a medical issue. After all, prematurity can happen to anyone. You can do everything right and still have a preterm birth.

Prematurity is so common that virtually everyone knows someone who has had a premature baby and that makes it a topic that really engages people and they have an immediate interest in prevention. It's because of that high prevalence from a public health standpoint that prematurity is statistically an easier measure to track and monitor changes than infant mortality, but like infant mortality it serves as an important summary indicator that reflects the social, political, healthcare delivery and outcomes for a geographic area.

So as we work to improve systems of care and support directed toward prematurity prevention, it should also improve infant mortality and should result in savings not just in healthcare cost, but also the emotional, social and financial cost to families and to communities. And while there are certainly opportunities to improve the dissemination of evidence-based practices in the healthcare arena, preventing preterm birth goes beyond what happens in the healthcare provider office or hospital.

To reduce preterm birth and eliminate disparities, like with other health problems, we need to take the more comprehensive approach that includes the multiple determinants of health. This was the multiple determinants of health model that was used nationally at the time we developed Healthy Babies are Worth the Wait, and although there are new versions, what we know is that the context and environment where people live is as important as the medical care in influencing health outcomes.

So we need to implement not just the evidence-based medical interventions for preventing prematurity but also to better define and implement the evidence base for addressing the social, environmental and political determinants of health. That being said, there are still a number of medical interventions, both medical and public health that we know right now can reduce preterm birth. The approach of the Healthy Babies are Worth the Wait initiative was the vision of Dr. Karla Damus, who was then a Senior Scientist at the March of Dimes.

And she asked, what would happen if we took what we know now about preventing preterm birth and tried to implement all of it in a real world setting; could we make a difference? She posed this question to the March of Dimes and Johnson & Johnson Pediatric Institute who had a long standing corporate partnership to address prematurity and they decided to fund a demonstration project to test that question.

The design of the initiative rather than working from the traditional cause and effect paradigm was that community partners would work together to implement bundled interventions known to be effective using both medical and public health interventions in real world settings with the primary target of preventable preterm birth. This multi-level ecological approach was to build systems of care and support that would mediate the psychosocial and contextual factors, as well as promoting the evidence-based medical practices for preterm birth prevention.

Fortunately, national discussions are now going around similar models that focus on building these comprehensive coordinated systems of care that link clinical and public health practices. Hopefully communities will be able to address prematurity through these models and funding will soon follow. The process where Kentucky was selected and chosen to be the third partner and the location for this initiative included elements that many of you would consider in a readiness assessment. A key factor was the data that would drive the focus and direction of the project.

In Kentucky we had a preterm birth rate that was rising more than twice as fast as the national rise. But, Kentucky had also analyzed that data and determined that the driving force of our rising rate was actually the bigger preterm infants as you see in the slide, those 33 to 34 weeks and 35 to 36 weeks both in vaginal births and c-section births. These infants were later categorized in the literature as late preterm infants. But this data fit with the initiative design and the focus on preventable preterm birth as there were indications that many of these babies were being delivered electively, both nationally and in Kentucky.

Kentucky also had a high rate of potentially modifiable risk factors, especially smoking, and another key factor, of course, was leadership. Kentucky had a committed leadership at the state Department for Public Health and an active perinatal association to offer leadership and expertise in support of the initiative. According to the power analysis done by March of Dimes, we needed 12,000 births over the three years, and that would be 6,000 in the intervention sites and 6,000 in comparison sites.

In the intervention sites we would do everything feasible in the real world setting to reduce preterm birth and in the comparison sites do nothing but monitor their trends. Baseline and follow up data including consumer surveys, provider surveys, policy and environmental scans were done at both intervention and comparison sites. Three implementation sites were chosen for strong leadership at both the local hospital and the local health department as we considered them the two health leaders in the community.

The geographic diversity was also intentional. We had two rural settings and one urban setting. We chose three very different practice settings for the intervention. One was a private practice site, one university-based, and one a hospital-based clinic who had started centering. The comparison sites were matched on geographic similarity and similar birth populations. The intent of this model was to have enough flexibility to address issues according to each community's needs and capacity so that when we addressed the issues whether it was oral health or substance abuse or smoking cessation or early elected delivery, it looked different in each of the three sites but it fit their local situation.

The initiative was scheduled for a three year demonstration project and the primary target was to reduce single preterm birth rates by 15 percent in the intervention sites. We also helped to raise awareness of the issue of prematurity among all members of the community and to enhance the ongoing local and national dialogue about preventable preterm birth. As we began to develop this model for possible replication, we identified five core components of Healthy Babies are Worth the Wait that you see here; partnership and collaboration, provider initiatives, patient support, public engagement and progress measures.

Perhaps the most important part of any community-based project is developing strong partnerships. In this project, we are fortunate to have national partners with March of Dimes and Johnson & Johnson who worked side by side with our state and local experts in developing and guiding this project. At each site partnerships were built through local implementation teams which consisted of staff from local hospitals and health departments and included nurses, physicians, administrators, public relations staff, risk managers, health educators, dental hygienists and many others.

For many of these people, even though they were working in the same communities with the same population of patients, they really didn't know each other prior to Healthy Babies are Worth the Wait, and as they established and strengthened their relationships, the benefits accrued to the patients as the services and referral processes were strengthened and improved. We regularly brought representatives from each site together for face to face meetings, conference calls and other venues, and we made a concerted effort to get as many people as possible from the sites to stay in national meetings on prematurity prevention.

This both increased the collaboration among the sites and kept their knowledge base current with the current state of the art. In the other four areas, again, we do not try to work on individual interventions, but on bundling of interventions that would work in their location. Some of these were hospital-based interventions, others were public health interventions and they were bundled according to local needs and local capacity. Through quarterly Grand Rounds presentations and resource centers with current literature, we kept sites up to date on best practices, both in the medical and public health arenas.

And after a Grand Rounds presentation, for example, we would convene the local implementation teams to sit down and discuss how their local practices measured up to the best practices they had just heard and what they could do to improve their processes. These teams were enthusiastic and always anxious to do better, learn from what worked and what didn't and continually built better systems of care for their communities. Our signature education piece was the Brain Card which came out of the focus groups we did at the beginning of a project where we tested messages.

The mothers in those groups told us they needed something concrete to understand why the last few weeks of pregnancy were important. When they saw the picture of the brain at 35 weeks compared to term, they immediately recognized the significant differences and that became a strong and persuasive talking point. Providers requested laminated copies of this to put in every exam room so they could explain to patients who requested early delivery why that was not a good idea.

This Brain Card spoke to all audiences and it's been used widely now with providers, patients and community partners. March of Dimes now has a simplified version available. We worked to keep the message in front of the staff and patients in multiple ways. All of the healthcare agencies and providers in the intervention communities used these materials so patients received the same message whether they were signing up for WIC, being visited by a home visitor, going to the dentist, having an ultrasound at the hospital or seeing their provider in the office.

And just the name of the initiative repeated over and over in different settings reinforced the main messages we were trying to get across. Several original patient education materials were developed, including this brochure of “Every Week Counts”. It talks about the importance of going to full term and emphasizes that if there are no medical problems, it is best for the baby to deliver at 40 weeks which is full term, and should the provider discuss delivering early, you should understand why.

There are now several similar patient education tools available from many sources including March of Dimes. But it was not only the patients that we wanted to get these messages out to. We targeted public education and awareness using this toolkit. The messages you see here were key messages designed so that anyone could use them to talk about prematurity, the risks of delivering early and the importance of brain development in going to full term.

These toolkit materials were provided in English and Spanish and included fact sheets, handouts, a generic PowerPoint presentation on prematurity, sample letters to the editor and many suggestions and ways to spread the message in the community. Staff working on Healthy Babies are Worth the Wait, took these messages to health fairs, to high schools, prisons, beauty shops, businesses, church groups, anywhere they could get an audience. The vision was that all the people in the community around the pregnant woman, grandmothers, aunts, fathers, people you go to church with, coworkers, all of them would know about the importance of brain development in the last few weeks of pregnancy, the risks of delivering early and would encourage that mother to go to full term if at all possible.

So did the bundled multi-level interventions make a difference in our communities? Yes, and in fact, it made a difference in our entire state. We intentionally discussed Healthy Babies are Worth the Wait at every perinatal and professional meeting we could get to once we started the project, and by the end of the second year of the project, Kentucky finally had a drop in our rate of preterm birth, and it was the largest drop of any of our contiguous states. While this is only an association, there were no other initiatives targeting preterm birth going on in the state at the time.

So during the project period from 2007 to 2009, we continued to monitor the rates of preterm birth and late preterm birth, and you can see that by the end of 2009 we knew we were on the right track. The implementation sites were reducing their rates and the comparison sites were not. However, by the end of 2009 when we were up to full speed on the project, those mothers didn't deliver until 2010. Next slide. And so you can see that in 2010, again, these are the deliveries from the moms who were receiving services in 2009.

We did see the maximum impact of the project and we did have a reduction of 15 percent in premature birth at our intervention sites. And the comparison sites took on ... began to implement Healthy Babies are Worth the Wait in January of 2010 at the formal end of the project, and within a year, they were also headed in the right direction. Now this is just one year's data for the comparison sites and we're not willing to call that a trend, but certainly we were pleased to see that it was headed in the right direction. Next slide.

So what went well? Well, certainly building the relationships and partnerships at all levels was one of the strengths of this program. We did have to accept the fact that this integrated concept of bundled multi-level interventions required a different kind of evaluation than what we were used to. We did feel that by comparing best practices with current practices we were able to help these communities identify their gaps and fill them in according to each community's need and move towards better systems of care.

One of the most difficult but rewarding efforts was speeding up the time from research to practice, and so that they were implementing what was in the research within a matter of months, not a matter of years. We did find this topic is one that people easily identify with and really engage and invest their efforts in prematurity prevention and so motivation was not a difficult issue for us and it did help us move the needle in Kentucky on reducing preterm birth.

So what might we have done differently? We might have had a dedicated project coordinator at each site. We were really limited on budget and intentionally didn't pour a lot of money into these sites and so the people who stepped up to coordinate the project were people who already had other full time jobs. We did have physician champions eventually at each site. It was a little bit difficult to get them on board but it's absolutely essential for improving quality of care.

And again, you can never have too much community involvement, and the community engagement really lifts the projects and helps motivate people. Data collection is always a challenge and we encourage ... what we learned was that it's easiest to use data that is already existing and determine how you can use that to measure your progress. And you need to celebrate even the small wins and always look for more opportunities to celebrate and increase the visibility of the project.

So based on our initiative, we think keys to community-based prematurity prevention looks something like this; use your data to drive actions and whenever possible, use existing data, put an emphasis on keeping up with the latest research and discuss how to implement it in the real world. You have to get people in communities out of their silos into building systems of care, but that's doable. Interventions have to go beyond the medical model to comprehensively address multiple determinants of health, and the results will come from building relationships, and therein we think lies the sustainability of this work.

What we learned is that we can do better now with what we know. So moving forward, Kentucky, did implement Healthy Babies are Worth the Wait in our control sites starting 2010. In 2011, we added two additional sites so that we have several sites all across the state now working collaboratively. March of Dimes has adopted Healthy Babies are Worth the Wait as an educational campaign and is also expanding to other program sites in New Jersey and Texas; so more information and materials are available from the March of Dimes. And at this point I think we'll stop and take questions.

DR. DON WRIGHT: Thank you Dr. Koh, Ms. Ricks, and Dr. Shepherd, for your informative presentations. I invite participants who have not already done so to send their questions through the WebEx Q&A feature. Meanwhile, you'll be prompted to fill out a survey about your experience with this webinar.

We encourage you to complete the survey so that we can improve future webinars in our series. Thank you in advance for your feedback. Dr. Shepherd, we have several questions already for you.

As it relates to Healthy Babies are Worth the Wait, we notice that it targets multiple audiences ranging from healthcare providers to pregnant women to the general public. How have you met the challenges of communicating the same message to all these different groups and what's been the most helpful for you in crafting these messages and what didn't work so well?

DR. RUTH ANN SHEPHERD: Well, I think what did work was just the title, Healthy Babies are Worth the Wait. I mean everybody identifies with healthy babies, and everybody does know somebody who has had a preterm birth and any family who has been through that would not wish that on other families even though many of those babies do quite well. The most engaging message was the brain development in those last four to six weeks of pregnancy and the massive amount of development that takes place.

And the Brain Card really was useful. Everybody understands, you know, you can just visually look at that and see the differences in the brain at 35 weeks and at term and much like, you know, brain development was the issue that drove all the new interest in early childhood and creating enriching environments in early childhood, the brain development in those last four to six weeks of pregnancy should be just as important, and we found it was an engaging message for communities at all levels as well as for the patients and the providers.

DR. DON WRIGHT: Thank you, Dr. Shepherd. We have another question for you. You and your team have implemented what sounds like a very robust evaluation process. How has this investment benefited the program to date and are there any additional elements that you wish you had incorporated in your original design?

DR. RUTH ANN SHEPHERD: Well, when we started this project, we knew it would be difficult to evaluate because it's difficult to measure, you know, what's happening from bundled interventions and knowing which intervention did what, so we knew from the beginning it would be a struggle and we basically tried to do all the things that we thought might give us a handle on whether we were having an effect. In retrospect, we probably didn't need all those measures. We did find some evidence that we change provider behavior in the implementation sites that we raised awareness in the implementation sites, but it was probably not worth all the trouble it took to do.

We surveyed literally thousands of people both before and after the project and probably in terms of, you know, getting the most out of those efforts we found that it was probably better to use existing data and local data. You know, everybody tracks their referral numbers to the different programs, and local data was really the most useful in determining what was working well and what was improving in terms of referral numbers and what wasn't.

And then we had a lot of personal stories which were very compelling about people who ... doctors who weren't convinced of this and then delivered a baby early that ended up on ECMO and were convinced

then that it was an issue, so people really were most pleased with the personal stories and that was the most motivating to the people working on this.

DR. DON WRIGHT: Thanks, Dr. Shepherd. A third question here; your collaboration with the March of Dimes and the Johnson & Johnson Pediatric Institute and other public and private partners I think demonstrates clearly how powerful and effective partnerships can be. From your perspective, what's the secret to the success in Kentucky and what advice would you give others looking to foster effective partnerships?

DR. RUTH ANN SHEPHERD: Well I think one of the wins in this was certainly the partnerships, and we had great partners. You know Johnson & Johnson does infant mortality projects literally all around the world and everyone knows the March of Dimes expertise in prematurity prevention, but I think what was most helpful to us is that prematurity prevention is something that everybody thinks is important. You know, we don't want babies to die, we don't want babies to have lifelong disability and so for the people that you call in to be partners, I think they're immediately engaged and involved in this.

And I think that really was the key for this project was to have the right topic that people could engage in and just explaining to them the significance of it. They really bought in very quickly.

DR. DON WRIGHT: Thank you, Dr. Shepherd. Obviously the partnerships were key in the success that you experienced, and thanks for that follow up... Another question...Would you talk a little bit about how you customized the interventions at each different site?

DR. RUTH ANN SHEPHERD: Sure. For instance, with oral health, you know, there is a link between oral health, you know, being a chronic inflammatory disease and preterm birth. We had one site where they couldn't get any local dentist to see a woman on Medicaid, especially a pregnant woman on Medicaid and so what we did there was we had a combined meeting of the dental society and the local ACOG chapter and they had an expert come in and talk to them about oral health in pregnancy and what was safe to do and what wasn't safe to do, and following that, they were able to work out referrals to a number of the local dentists.

In another site, they actually had a dental chair in the women's health center but when the public health department opened up a dental clinic with five chairs they decided they would send their patients over to the dental clinic. It was inside of the hospital. It was less than a block away, but what they found out was the women didn't go. And so what they ended up doing was bringing the dental hygienist and the dentist at specific times back over to the hospital dental chair to see the pregnant women when they were coming in for other things.

DR. DON WRIGHT: Thanks, Dr. Shepherd. There's more questions coming from our audience. The next question, with the improvement of neonatal resources and technology, previous unviable births are now live births. How do you incorporate this phenomenon when determining trends and targets for infant mortality and preterm births?

DR. RUTH ANN SHEPHERD: Well, I think the goal is to prevent those extremely preterm infants as well as the bigger preterm infants, and I think that's one of the places where as we work on social determinants of health, I think we're going to find more impact. Certainly those are a contributor to infant mortality, but the point is that we need to have better systems of care so that we don't have those extremely preterm births and we don't have preterm births at the higher end either. But I think what we found was that working on our systems of care, again, we reduced the overall preterm birth rates even though we talked a lot in the project just about the late preterm births.

But as you call people to work on ACOG guidelines and in the social sector, we call people to get the supports in there that families need, we found that that worked very well to improve both the extreme prematurity and the late prematurity.

DR. DON WRIGHT: Thanks, Dr. Shepherd. The questions continue to come in...Another question...What type of programs work in underinsured and uninsured? How do you get them to change?

DR. RUTH ANN SHEPHERD: Well, my personal opinion is that we don't necessarily need to get them to change. We need to change our systems to fit what their needs are, and so we, again, we didn't have any problem engaging those people. We had centering for some of those folks and they were very active participants in centering. You know, most of the time when they weren't participating in programs it was because the program didn't meet their needs or wasn't presented to them correctly.

We have a home visiting program where we have about 85 percent low income people, although it's not income limited. But we find that overall those who participate do very well.

DR. DON WRIGHT: Thank you, Dr. Shepherd. Another question, budget was considered a factor in the lessons learned. With the same budget and in retrospect, which lessons would you still consider valuable?

DR. RUTH ANN SHEPHERD: Well, I think all the lessons are still valuable and I think it was a good idea to do this without investing huge amounts of money in each of these sites because that's just not going to be feasible these days. The idea was to take what they already had going on and make it better, and I think that was still worthwhile and I still think that that's why, you know, as we continue to monitor these sites they are continuing to show decreases in their preterm birth rates and I think what we've encouraged them and set them up to do is to take what they have and improve it based on current best practices.

DR. DON WRIGHT: Very good. Another question, what performance measures did you use in the evaluation process?

DR. RUTH ANN SHEPHERD: We used a lot of performance measures. We looked at referral numbers, for instance, referrals to the quit line, referrals to smoking cessation, referrals to our home visiting program, just those kinds of service numbers. We looked at preterm birth and late preterm birth. We did not ... we had planned to but ended up not looking at the hospital costs for the babies who were preterm from the project.

We did a lot of surveys of knowledge, attitude and beliefs, and again, those were very labor intensive and the information we got out of them was not particularly useful. So we tried to use existing data whenever possible.

DR. DON WRIGHT: Thank you, Dr. Shepherd, and now a question for Dr. Koh, the Assistant Secretary for Health. Dr. Koh, what is the Healthy People 2020 initiative doing to address this particular health concern?

DR. HOWARD KOH: Well, we've set targets for the prime indicators for our infant deaths and preterm births as we've summarized here, and then we're also trying to make this data available at the state and even local level, if possible, to drive action in those specific areas, so the more we share these data nationally and statewide, the more we share best practices as we've just heard from the state of Kentucky, and this is a very impressive presentation, and thank you very much, Dr. Shepherd for your insights.

And the more we encourage one another we can keep these goals in mind and try to align all of our efforts for healthier futures for the next decade and beyond.

DR. DON WRIGHT: Thank you, Dr. Koh. I think we have time for just one additional question and I will take this question. Several of the attendees have asked about the slides and their access to the slides. All attendees will receive a PDF copy of the webinar and the webinar will also be archived on healthypeople.gov. Well, let me thank you for joining today's webinar. This webinar is part of a series and we hope you'll continue to join us each month. Follow us on Twitter or join the Healthy People 2020 group on LinkedIn to continue the conversation on this LHI topic, maternal, infant, and child health and to learn more about all the leading health indicators.

To receive notices about upcoming events, please sign up for our email announcements on the Healthy People website. That's healthypeople.gov. Also let me say we'll be hosting the 2012 National Health Promotion Summit entitled, Prevention, Promotion, Progress. It'll occur on April 10th and 11th in Washington, D.C., and you can find additional information on our website. On behalf of HHS, I'd like to say thank you to today's presenters and to everyone who's been involved with planning and implementing Healthy People 2020.

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