State policymakers are increasingly realizing that beyond the importance of early childhood development lies its foundation, a healthy birth outcome for parents and their newborns.

The phrase “healthy birth outcome” can encompass numerous initiatives — safe-sleep education to reduce incidents of Sudden Infant Death Syndrome, mentoring and support for new and expectant mothers to combat child and infant mortality, and even the somber task of collecting child and infant mortality data.

It can also include public education campaigns to raise awareness of not-always-apparent health hazards (such as congenital cytomegalovirus) and to reduce stress on new parents and parents-to-be.

This year, Iowa Sen. Janet Petersen, chair of the Midwestern Legislative Conference, aims to put a yearlong spotlight on the role of states in ensuring healthy birth outcomes. That issue is her MLC chair’s initiative for 2017. (CSG Midwest provides staff support for the MLC, a nonpartisan association of all legislators from 11 states and four affiliate provinces.)

“I’m hoping for dialogue where legislators can learn from each other and get some best practices going,” Petersen says. “So that if you’re having a baby in Iowa or in North Dakota or wherever you live, you don’t have to worry that you won’t have a better chance for your baby’s survival in one state or another because we don’t share best practices.”

It’s a personal mission for Petersen. In 2003, she had a stillborn daughter, due to a true knot in her umbilical cord — a rare occurrence, according to her doctor. But when Petersen learned soon thereafter that (at the time) one in 160 pregnancies were ending in stillbirths, she decided to turn personal tragedy into motivation.

“It’s not an issue I’m willing to give up on, and if one should experience the heart-wrenching loss of delivering a full-term baby who was otherwise healthy but has died, you just wouldn’t wish that on anyone,” she says. “So I think I carry Grace in my heart as a way to try and prevent other families from experiencing the heartache of having something go wrong with their pregnancy.”

She led an effort to make Iowa the first state to expand its birth-defects registry to include stillbirths. And in 2009, she and four other Iowa women founded Healthy Birth Day, a nonprofit that launched the “Count the Kicks” public awareness campaign encouraging expectant mothers to monitor their baby’s in utero kicks, because decreased fetal movement could indicate a problem.

Since then, Iowa has gone from 33rd worst in the country for the number of stillbirths to third-best.

**Simple steps to big gains**

Another unheralded threat to fetal health that concerns Sen. Petersen is congenital cytomegalovirus. Per the U.S. Centers for Disease Control and Prevention, CMV is a common virus that infects almost a third of children by the time they hit 5 years of age, and half of adults by age 40. It’s transmitted via direct contact with bodily fluids including saliva, breast milk and urine.

Most people show no symptoms, but it can hurt people with weakened immune systems or babies in utero, who can get it via the mother’s blood passing through the placenta. For those babies, congenital CMV can cause premature births or even a pregnancy loss, as well as lung, liver and spleen problems, seizures or small head or birth sizes.

So, Peterson asks, why not educate pregnant women now about CMV and simple techniques to prevent its transmission, to prevent higher health costs later?
“Very simple things, like when a baby drops a pacifier, don’t just pick it up and wipe it off and put it back in your baby’s mouth because she may have just picked up the virus,” she says. “Don’t kiss your child on the mouth — little things like that. Be very vigilant in how you wash your hands. And screening the baby’s blood to see if they have CMV.

“If we could help prevent the spread of CMV, we could greatly reduce the number of babies born with health or clinical disabilities including hearing loss.”

**Home visits help expectant parents**

States (on their own and with assistance from the federal government) fund home visit programs to help achieve healthy birth outcomes. Most, like Kansas’ Maternal and Child Health Program’s Healthy Start Home Visitor services [4], are offered to all pregnant women and families with a baby under one year of age. South Dakota’s Bright Start [5] program, however, focuses on first-time mothers with limited economic, social or health resources from pregnancy until the child is 3 years old. The Nebraska-Maternal, Infant and Early Childhood Visiting Program [6] is available to pregnant women and families with children up to age 5.

Illinois has programs aimed at specific groups For example:

- **Family Case Management** [7], which provides income-eligible clients access to medical care, pediatric health education and counseling, developmental screening, and referrals to other community services as needed; and
- **Better Birth Outcomes** [8], an intensive prenatal case management program in communities with higher-than-average Medicaid costs associated with poor birth outcomes, and higher-than-average numbers of women delivering premature infants.

Michigan has four targeted programs:

- the **Maternal Infant Health Program** [9], which is for Medicaid-eligible pregnant women and infants and includes services from a licensed social worker and a registered nurse, as well as mental health specialists and dietitians in some instances;
- the **Nurse Family Partnership** [10], in which expectant “vulnerable” mothers are partnered early in their pregnancy with a registered nurse and receive ongoing nurse visits through the child’s second birthday;
- **Parents as Teachers** [11], in which trained professionals go into the homes during the child’s early years to help a family have their child “develop optimally” during these crucial years of life; and
- **Infant Mental Health** [12], which focuses on social, emotional, behavioral and cognitive development.

Nebraska’s general fund budget includes $1.1 million in each fiscal year for “evidence-based early intervention home visitation programs.” (The “evidence-based” language was added in 2014.) Likewise for Kansas’ Senator Stan Clark Pregnancy Maintenance Initiative [13], which awards grants to not-for-profit organizations that provide services for women which enable them to carry their pregnancies to term.

**Impact, implications of the Affordable Care Act**

The Affordable Care Act mandates health insurance coverage of maternity care for all plans created since the law was signed by President Obama (“grandfathered” plans, those in existence before the ACA was signed into law, don’t necessarily have the same coverage).[16]

Before the ACA, only 12 percent of health insurance policies nationwide included maternity coverage, according to the National Women’s Law Center [14]. In the Midwest, only Illinois, Michigan and Minnesota required maternity coverage, or the offer of coverage, according to a Kaiser Family Foundation report [15]— Illinois required HMOs to cover it or offer coverage in individual markets; Michigan and Minnesota required coverage or the offer in small-group markets.

According to HealthCare.gov [16], under the ACA, all health insurance plans must cover outpatient services including pre- and post-natal doctor visits, medications, lab studies and gestational diabetes screenings; inpatient services including hospitalization and physician fees; and newborn baby care and lactation consulting, including breast pump rentals. Additionally, all plans must let women see an obstetrician/gynecologist without referral from another doctor and cover the following:

- For pregnant women: Folic acid supplements and screenings for Rh incompatibility, iron deficiency anemia and various
infections.

- For newborns and young children: Immunizations, vision and hearing screenings, iron supplements for those at risk of anemia, oral health risk assessments, tuberculosis testing, and screenings for various infections and diseases, autism and lead poisoning.

**When the worst happens**

Every child or infant death is a personal tragedy. But if patterns can be found in those deaths that can be remedied by public policy or education campaigns, then that information can be used to fix problems, whether they are local environmental condition or gaps in medical and/or public health systems.

All states have established Child Death Review (CDR) programs to examine deaths of children age 18 and younger; 26 states — including Illinois, Indiana, Michigan, Nebraska, South Dakota and Wisconsin — also have Fetal and Infant Mortality Review (FIMR) programs to track data specific to perinatal babies and infants under the age of 1, according to the National Center for the Review and Prevention of Child Deaths (17).

CDR and FIMR teams identify the causes of, and ways to prevent, such fatalities; improve communication between relevant state and local agencies and the medical community; improve agencies’ responses to child deaths; and provide information for policymakers to consider legislation for mitigating the number of such deaths, according to the national center.

While most CDR programs are state-level, most FIMR programs are local, says Rosemary Fournier, the center’s FIMR director.

Only Michigan, Indiana, Ohio and Wisconsin provide state-level coordination or financial and/or technical support (including training). At a minimum, states should help facilitate regular meetings of local teams to exchange data and ideas, she says.

“It’s a really great surveillance system. It is core public health surveillance,” Fournier says.

Over time, the work of these state and local research teams has led to legislative action, including graduated driver’s-license laws, bicycle helmet and all-terrain vehicle safety rules, and improved death-investigation protocols. Research has also informed efforts to expand home visitation and safe-sleep programs, improve mandatory reporting laws (and training requirements) regarding child abuse, and pass “Safe Haven” laws, which allow parents to leave newborn infants in designated safe places.

Minnesota may soon join these states. In 2015, its Maternal & Child Health Advisory Task Force (18) released part one of its “Infant Mortality Reduction Plan for Minnesota.” Among its recommendations: assuring “a comprehensive statewide system that monitors infant mortality.”

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**Q&A with Iowa Sen. Janet Petersen on her MLC Chair’s Initiative**

Every year, the leader of CSG Midwest’s Midwestern Legislative Conference chooses a policy issue as her MLC chair’s initiative. That decision helps guide the session topics for the MLC Annual Meeting and the research done by CSG Midwest on behalf of the region’s state legislators.

Sen. Petersen explains here why her MLC chair’s initiative is focusing on policies that promote healthy birth outcomes, and why — after experiencing the loss of her daughter Grace, stillborn in 2003 — this subject area is so personal.

**Q: What do you hope to accomplish by focusing the Chair’s Initiative on healthy birth outcomes?**

A: I hope that we’ll be able to open some eyes to the issues facing maternal health care in the United States, and give people kind of an idea of where the U.S. stacks up compared to the rest of the world in caring for pregnant women. There are a lot of things we could be doing in the United States to improve birth outcomes and get babies started off on healthier lives. My goal would be to open up the Midwest region’s eyes to see that there are a lot of policy issues we should be trying to tackle to make the Midwest one of the safest places in the country to have a
baby. That was my goal all along in Iowa — to make Iowa a safer place to have a baby. That is my goal in every piece of maternal health legislation that I’ve worked on.

**Q: What is the role of state legislatures in working to improve healthy birth outcomes?**

A: There are a lot of things that state legislators and legislatures can do if they have a better understanding of just how costly it is for our country when we don’t have healthy pregnancies and healthy birth outcomes, and try to come up with policies to improve birth outcomes. Plus, healthier babies and infants decrease costs in a number of fronts — everything from Medicaid to child health insurance to health in the workforce.

Once people see just how costly [unhealthy birth outcomes can be], not only financially but in terms of our future, it’s an important issue that we need to spend more time addressing.

**Q: How do you attempt to draw attention to this subject in your own legislature?**

A: I try to sponsor a number of bills that would help improve birth outcomes to try and elevate the conversation, to get people to talk about it. If you don’t sponsor legislation and don’t have the conversation going, then [it behooves us] to step back and realize that when we are spending a lot of money on pregnancies and poor birth outcomes, then maybe we need to ... ask what could we be doing differently.

That’s one of the reasons I selected my Chair’s Initiative — because the United States is not doing well in terms of maternal health care compared to other countries. We should up our game. You’ve got to start the conversation somewhere.

**Q: How does your personal experience help amplify your voice on the issue of healthy birth outcomes?**

A: I think it’s certainly made me a more passionate advocate because I have experienced the best of maternal health care and the worst of maternal health care in our country. And I believe that our daughter Grace would have been here if I had known more about stillbirth and stillbirth prevention when I was pregnant with her.

It’s not an issue I’m willing to give up on, and if one should experience the heart-wrenching loss of delivering a full-term baby who was otherwise healthy but has died, you just wouldn’t wish that on anyone. So I think I carry Grace in my heart as a way to try and prevent other families from experiencing the heartache of having something go wrong with their pregnancy.

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