Objectives

1. Review the current rates of premature birth in Idaho, as well as the regions of greatest concern and opportunities for improvement in our region.

2. Review the current strategies that have been outlined by the March of Dimes for premature birth prevention.
Why?

More why’s from the brochure
Preterm birth rates

*2015 data are preliminary.
LMP: expected age based on date of mother’s last menstrual period.
OE: obstetric age based on obstetric estimate.
Target: 2020 goal based on 50th percentile age.
Preterm is less than 37 weeks gestation.
Prepared by March of Dimes Perinatal Data Center, June 2016.

2016 PREMATURE BIRTH REPORT CARD

United States 9.6% C

The March of Dimes Prematurity Campaign aims to reduce preterm birth rates across the United States. Premature Birth Report Card grades are assigned by comparing the 2015 preterm birth rate in a state or locality to the March of Dimes goal of 8.1 percent by 2020. The Report Card also provides county and race/ethnicity data to highlight areas of increased burden and elevated risks of prematurity.
Grade | Preterm birth rate range | Scoring criteria
--- | --- | ---
A | Preterm birth rate less than or equal to 8.1% Score less than or equal to 0.0
B | Preterm birth rate of 8.2% to 9.2% Score greater than 0.0, but less than or equal to 1.0
C | Preterm birth rate of 9.3% to 10.3% Score greater than 1.0, but less than or equal to 2.0
D | Preterm birth rate of 10.4% to 11.4% Score greater than 2.0, but less than or equal to 3.0
F | Preterm birth rate greater than or equal to 11.5% Score greater than 3.0
2015 PREMATURE BIRTH REPORT CARD

Idaho

Preterm Birth Rate: 8.1%
Grade: A

The March of Dimes Prematurity Campaign aims to reduce preterm birth rates across the United States. Premature Birth Report Card grades are assigned by comparing the 2014 preterm birth rate in a state or locality to the March of Dimes goal of 8.1 percent by 2020. The Report Card also provides city or county and race/ethnicity data to highlight areas of increased burden and elevated risks of prematurity.

COUNTRIES

Counties with the greatest number of births are graded based on their 2013 preterm birth rates. The status indicator shows whether the 2013 county rate is higher (●), lower (○), or the same (★) as the 2013 state rate (9.2%).

<table>
<thead>
<tr>
<th>County</th>
<th>Preterm birth rate</th>
<th>Grade</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ada</td>
<td>8.6%</td>
<td>B</td>
<td>●</td>
</tr>
<tr>
<td>Canyon</td>
<td>10.1%</td>
<td>C</td>
<td>●</td>
</tr>
<tr>
<td>Bannock</td>
<td>9.7%</td>
<td>C</td>
<td>●</td>
</tr>
<tr>
<td>Kootenai</td>
<td>6.2%</td>
<td>A</td>
<td>●</td>
</tr>
<tr>
<td>Bonner</td>
<td>10.0%</td>
<td>C</td>
<td>●</td>
</tr>
<tr>
<td>Twin Falls</td>
<td>9.8%</td>
<td>C</td>
<td>●</td>
</tr>
</tbody>
</table>

Wrong direction?

2016 PREMATURE BIRTH REPORT CARD

Idaho

Preterm Birth Rate: 8.2%
Grade: B

The March of Dimes Prematurity Campaign aims to reduce preterm birth rates across the United States. Premature Birth Report Card grades are assigned by comparing the 2015 preterm birth rate in a state or locality to the March of Dimes goal of 8.1 percent by 2020. The Report Card also provides county and race/ethnicity data to highlight areas of increased burden and elevated risks of prematurity.
5.5% - Proposed US Preterm Birth Rate Goal For 2030 By March Of Dimes

Fighting for the Next Generation: US Prematurity in 2030

Edward R.B. McCabe, Gerard E. Carrino, Rebecca B. Russell and Jennifer L. Howse

Pediatrics; originally published online November 3, 2014
March of Dimes Board of Trustees Resets Goals

- **8.1%** 2020 preterm birth rate goal for the U.S.
- **7.8%** 2020 preterm birth rate goal for Idaho
- **5.5%** 2030 preterm birth rate goal for the U.S.
- New focus on high volume and high burden areas and racial and ethnic disparities.

What would that mean?

- **Nationally 210,000** fewer babies will be born preterm from 2014-2020, when we meet the 8.1% 2020 goal.
- **1.1 million** fewer babies will be born preterm from 2021-2030, when we meet the 5.5% 2030 goal.
- **1.3 million fewer babies** will be born preterm between 2014 and 2030 when we meet the 5.5% 2030 goal.

March of Dimes Perinatal Data Center. Projected estimates each year based on 2014 live births and incremental declines between 9.6% in 2014 and 5.5% in 2030.

Gestational age determined using obstetric estimate of gestation.
2016 PREMATURE BIRTH REPORT CARD

RACE & ETHNICITY IN THE UNITED STATES

The March of Dimes uses a Disparity Index score to measure and track progress towards the elimination of racial/ethnic disparities in preterm birth. The score represents the average percent difference in the preterm birth rate across all groups compared to the group with the lowest rate in the state. Index scores range from 0 (achievement of equity) to 44 (highest score in 2016).

Percentage of live births in 2012-2014 (average) that are preterm

<table>
<thead>
<tr>
<th>Race/Ethnicity</th>
<th>Disparity index</th>
</tr>
</thead>
<tbody>
<tr>
<td>Asian/Pacific Islander</td>
<td>8.5</td>
</tr>
<tr>
<td>White</td>
<td>9.0</td>
</tr>
<tr>
<td>Hispanic</td>
<td>9.1</td>
</tr>
<tr>
<td>American Indian/Alaska Native</td>
<td>10.4</td>
</tr>
<tr>
<td>Black</td>
<td>13.3</td>
</tr>
</tbody>
</table>

In the United States, the preterm birth rate among black women is 48% higher than the rate among all other women.

RACE & ETHNICITY IN IDAHO

The March of Dimes uses a Disparity Index score to measure and track progress towards the elimination of racial/ethnic disparities in preterm birth. The score represents the average percent difference in the preterm birth rate across all groups compared to the group with the lowest rate in the state. Index scores range from 0 (achievement of equity) to 44 (highest score in 2016).

Percentage of live births in 2012-2014 (average) that are preterm

<table>
<thead>
<tr>
<th>Race/Ethnicity</th>
<th>Disparity index</th>
</tr>
</thead>
<tbody>
<tr>
<td>White</td>
<td>8.4</td>
</tr>
<tr>
<td>Hispanic</td>
<td>9.0</td>
</tr>
<tr>
<td>American Indian/Alaska Native</td>
<td>10.1</td>
</tr>
<tr>
<td>Asian/Pacific Islander</td>
<td>10.3</td>
</tr>
</tbody>
</table>

In Idaho, the preterm birth rate among Asian/Pacific Islander women is 21% higher than the rate among all other women.
Birth Demographics

Birth rate
Idaho, 2010-2013 Average

Rate per 1,000 women 15-44 years
- Over 81.0 (16)
- 71.1-81.0 (14)
- Under 71.1 (10)

Footnotes available in notes section.
Source: National Center for Health Statistics, final natality data. US Census Bureau. Population estimates based on bridged race categories released by the National Center for Health Statistics.
### Birth Demographics

#### IDAHO RESIDENT LIVE BIRTHS

**Fertility Rate and Birth Rates by Age of Mother, 2014**

<table>
<thead>
<tr>
<th>AGE</th>
<th>Total Live Births</th>
<th>Female Population July 1, 2014</th>
<th>Fertility Rate and Age-Specific Birth Rates, 2014</th>
<th>Fertility Rate and Age-Specific Birth Rates, 2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>TOTAL</td>
<td>22,888</td>
<td>314,935</td>
<td>72.7</td>
<td>62.9</td>
</tr>
<tr>
<td>&lt;15</td>
<td>7</td>
<td>59,865</td>
<td>0.1</td>
<td>0.3</td>
</tr>
<tr>
<td>15-19</td>
<td>1,302</td>
<td>56,075</td>
<td>23.2</td>
<td>24.2</td>
</tr>
<tr>
<td>15-17</td>
<td>311</td>
<td>34,410</td>
<td>9.0</td>
<td>10.9</td>
</tr>
<tr>
<td>18-19</td>
<td>901</td>
<td>21,665</td>
<td>45.7</td>
<td>43.8</td>
</tr>
<tr>
<td>20-24</td>
<td>6,146</td>
<td>53,575</td>
<td>114.7</td>
<td>79.0</td>
</tr>
<tr>
<td>25-29</td>
<td>7,225</td>
<td>53,266</td>
<td>136.6</td>
<td>105.8</td>
</tr>
<tr>
<td>30-34</td>
<td>5,473</td>
<td>53,403</td>
<td>102.5</td>
<td>100.8</td>
</tr>
<tr>
<td>35-39</td>
<td>2,262</td>
<td>56,123</td>
<td>45.1</td>
<td>51.0</td>
</tr>
<tr>
<td>40-44</td>
<td>444</td>
<td>48,493</td>
<td>9.2</td>
<td>10.6</td>
</tr>
<tr>
<td>45+</td>
<td>27</td>
<td>47,092</td>
<td>0.6</td>
<td>0.8</td>
</tr>
<tr>
<td>Not stated</td>
<td>1</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
</tr>
</tbody>
</table>

2. Total female population aged 15-44 NOT including women under 15 or over 44.
3. Total number of live births per 1,000 women 15-44 years of age.
4. Total female population aged 10-14; rates for females aged <15 are based on female population 10-14.
5. Total female population aged 45-49; rates for females aged 45+ are based on female population 45-49. NA: Not applicable.

---

#### Birth Demographics

**Birth rates by race/ethnicity**

**Idaho, 2011-2013 Average**

<table>
<thead>
<tr>
<th>Race/Ethnicity</th>
<th>Rate per 1,000 women 15-44 years</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hispanic</td>
<td>83.3</td>
</tr>
<tr>
<td>White</td>
<td>71.2</td>
</tr>
<tr>
<td>Black</td>
<td>68.1</td>
</tr>
<tr>
<td>Native American</td>
<td>77.5</td>
</tr>
<tr>
<td>Asian</td>
<td>64.2</td>
</tr>
<tr>
<td>Total</td>
<td>72.7</td>
</tr>
</tbody>
</table>

Footnotes available in notes section.

Birth Demographics

Percentage of births by race/ethnicity
Idaho, 2011-2013 Average

Preterm birth
Idaho, 2010-2013 Average

Preterm is less than 37 completed weeks gestation. ** Suppressed due to missing data or insufficient numbers.

Preterm is less than 37 completed weeks gestation. ** Suppressed due to missing data or insufficient numbers.
Preterm birth
Idaho, 2003-2013
Percent of live births

Year | Percent
--- | ---
2003 | 10.7
2004 | 11.0
2005 | 11.4
2006 | 11.6
2007 | 10.5
2008 | 9.8
2009 | 10.1
2010 | 10.3
2011 | 10.2
2012 | 10.3
2013 | 10.5

Preterm is less than 37 completed weeks gestation.

Preterm by race/ethnicity
Idaho, 2011-2013 Average
Percent of live births

Race | Percent
--- | ---
Hispanic | 11.6
White | 9.9
Black | 14.5
Native American | 14.7
Asian | 13.0
Total | 10.3

All race categories exclude Hispanics. Preterm is less than 37 completed weeks gestation.
Preterm is less than 37 completed weeks gestation.


**Preterm by maternal age**

**Idaho, 2011-2013 Average**

Percent of live births

<table>
<thead>
<tr>
<th>Group</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;20</td>
<td>13.5</td>
</tr>
<tr>
<td>20-29</td>
<td>9.5</td>
</tr>
<tr>
<td>30-39</td>
<td>10.8</td>
</tr>
<tr>
<td>&gt;=40</td>
<td>15.8</td>
</tr>
<tr>
<td>Total</td>
<td>10.3</td>
</tr>
</tbody>
</table>

Very preterm is less than 32 completed weeks gestation.


**Very preterm birth**

**Idaho, 2003-2013**

Percent of live births

<table>
<thead>
<tr>
<th>Year</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>2003</td>
<td>1.5</td>
</tr>
<tr>
<td>2004</td>
<td>1.5</td>
</tr>
<tr>
<td>2005</td>
<td>1.6</td>
</tr>
<tr>
<td>2006</td>
<td>1.7</td>
</tr>
<tr>
<td>2007</td>
<td>1.4</td>
</tr>
<tr>
<td>2008</td>
<td>1.2</td>
</tr>
<tr>
<td>2009</td>
<td>1.5</td>
</tr>
<tr>
<td>2010</td>
<td>1.4</td>
</tr>
<tr>
<td>2011</td>
<td>1.3</td>
</tr>
<tr>
<td>2012</td>
<td>1.3</td>
</tr>
<tr>
<td>2013</td>
<td>1.6</td>
</tr>
</tbody>
</table>
Late preterm is between 34 and 36 weeks gestation.

Very preterm by race/ethnicity
Idaho, 2011-2013 Average
Percent of live births

All race categories exclude Hispanics. Very preterm is less than 32 completed weeks gestation.
Birth Demographics

Distribution of singletons and multiple births
Idaho, 2013

Preterm is less than 37 completed weeks gestation. Multiple deliveries include twin, triplet and higher
order deliveries.


Preterm Birth Trends

Preterm by plurality
Idaho, 2013

Preterm is less than 37 completed weeks gestation. Multiple deliveries include twin, triplet and higher
order deliveries.

Why has the PTB rate decreased?

- Demographic changes
  - Decrease in teenage pregnancies
  - Decreased in higher order multiple births
- Public Policy Changes
  - Prevent non-medical indicated birth < 39 weeks
  - Smoking Bans
- New Interventions
  - 17-Hydroxyprogesterone Caproate Injections
  - Vaginal Progesterone
  - Cerclage for selected populations

What is the plan?

1. Improve implementation of clinical and public health practices
2. Expanding discovery and accelerating translation and innovation (Research)
3. Aligning multi-level support to improve health equity
   Developing and implementing messages, policy and practice strategies
4. Securing the funding and resources required for success
Themes of Emphasis

- Emphasizing the health of women and adolescents
- Engaging families, communities and other strategic partners across sectors through a collaborative infrastructure
- Optimizing the use of data and evaluation to drive learning and success
Optimize existing interventions

1. Birth spacing and interconception care
2. Elimination of non-medically indicated early elective deliveries
3. Group Prenatal Care
4. Smoking Cessation
5. Access to progesterone shots for women with a previous preterm birth
6. Low dose aspirin to prevent preeclampsia
7. Vaginal progesterone and cerclage for short cervix
8. Reduce multiple births conceived through Assisted Reproductive Technology

Bundle interventions through the Healthy Babies are Worth the wait Community Program

---

Optimizing existing interventions for Idaho

1. Birth Spacing
2. 17- hydroxyprogesterone caproate injectionions
3. Low Dose Aspirin
4. Early Elective Deliveries Before 39 weeks
5. Tobacco use
6. Group Prenatal Care
Spontaneous Preterm birth

- Indicated 25%
- PROM 35%
- PTL 40%
- Spontaneous Preterm birth

For each month that birth spacing was less than 18 months,

- Preterm births increased 1.9%
- Low birthweight increased 3.3%
- Poor intrauterine growth increased 1.5%

Birth Spacing

- **What is Interpregnancy Interval?**
  - The interval from a birth to the next conception
- **Optimal interpregnancy interval?**
  - 18-23 months
- **Improves**
  - Preterm birth
  - Small for gestational age
  - Low birth weight

---

Optimizing Birth Spacing or Interpregnancy Interval

Time between one live birth and conception of next pregnancy.

Birth spacing of less than 18 months increases the risk of preterm birth, low birthweight, and small for gestational age.

33.1% of U.S. births have a short IPI (<18 months).

Risks increase as birth interval decreases, with birth spacing of less than 6 months having the highest risk.
Possible reasons short IPI might contribute to adverse outcomes

• Maternal nutritional depletion hypothesis
• Inadequate time to restore folate levels
• Inflammatory mediators / Intrauterine inflammatory milieu - endometritis, PPROM
• Postpartum changes in vaginal microbiome
• Marker for other social determinants of disease


18 Months: HP 2020 Goal, ACOG Recommendation

Healthy People 2020 birth spacing goal: reduce the proportion of pregnancies conceived within 18 months of a previous birth by 10%, to 29.8%.

ACOG recommends that “women wait at least 18 months after having a baby before trying to get pregnant again in order to have the best health outcomes for both mom and baby.”

ACOG Committee Opinion on Reproductive Life Planning

ACOG “encourages obstetrician-gynecologists and other health care providers to use every patient encounter as an opportunity to talk with patients about their pregnancy intentions and to support initiatives that promote access to and availability of all effective contraceptive methods.”

Birth Spacing

- Long Acting Reversible Contraception (LARC)
  - Intrauterine Device
    - Mirena
    - Paraguard
  - Implantable devices
    - Nexplanon
- California Medicaid patients
  - Every month of contraception coverage odd of preterm birth decreased by 1.1%
Birth Spacing & Interconception Care

Important considerations
- Access to health insurance postpartum
- PP Depression
- Access to contraception postpartum
- Education and support

Missing Data Elements
- Idaho Statistics on Interpregnancy Intervals
  - % with interval less than 18 months
- More recent statistics on intendedness/timing & contraception use and method of
- Percent of women returning for postpartum visit

Progesterone to prevent recurrent PTB

“Spontaneous Preterm Birth”

- Prior preterm birth
  - strongest predictor of recurrent preterm birth
- 17-alpha-hydroxyprogesterone caproate
  - 250 mg IM weekly 16-36 weeks
  - Reduces rates of recurrence of PTB by one third
17 alpha-hydroxyprogesterone caproate (17P)

ACOG Practice Bulletin, October 2012
✓ One of the strongest clinical risk factors for preterm birth is a prior preterm birth.
✓ Maternal history of preterm birth confers a 1.5-fold to 2.0-fold increased risk in a subsequent pregnancy
✓ Synthetic form of progesterone given by injection in the gluteus muscle or anterior thigh
✓ Reduces a woman’s risk of recurrent preterm birth by 33%


NICHD: MFMU Progesterone Trial

• **Aim:** To establish if weekly progesterone injections in women with prior spontaneous preterm delivery (sPTD) reduces the risk of PTD
• **Design:** double-masked, placebo-controlled trial
• **Eligibility criteria:** singleton pregnancy 16-20 wks with documented previous sPTD
• **Intervention:** progesterone or placebo
• **Primary outcome:** delivery at < 37 weeks’
• **Sample:** 463 pregnant women

Progesterone: Rates of Preterm Birth


Progesterone prevents neonatal complications

Protocol for 17P Use

- History of a previous singleton spontaneous preterm birth (20° to 36° weeks)
- Current singleton pregnancy
- Initiate treatment between 16° - 21° weeks gestation*
- Receive 17P injections weekly until 36° weeks gestation or she delivers

Women who delivered multiple infants preterm and/or who are pregnant with multiples are not eligible for treatment

Underutilization of 17P

“Medicaid health plans have covered 17P for many years. However, under-utilization is still broadly acknowledged.” (Medicaid Health Plans of America Report, 2014)

30 percent of women eligible for 17P do not receive it. (AMAG estimates based on distributed units of branded 17P and physician market research data on compounded 17P, 2014)

In Louisiana, just five percent of women who are eligible for 17P receive the drug. (Louisiana Medicaid, 2015)


AMAG Pharmaceuticals (2014). Transformative Acquisition of Lumara Health [Power Point Slides].

Previous Preterm Birth

- Affected 3.8% of U.S. deliveries in 2010
- Accounts for 12% - 16% of maternal deaths
- 15% of preterm births are related to preeclampsia

Perinatal Outcomes of Preeclampsia

Leading cause of:

- Fetal growth restriction
- Indicated preterm delivery
- Maternal and perinatal death and morbidity


Low Dose Aspirin

“Indicated Preterm Birth”

- High Risk patients
  - History of IUGR
  - History of early on set preeclampsia
  - Chronic hypertension
  - Renal disease
  - Autoimmune diseases
Pregnancy Hypertension

Low Dose Aspirin

- Antiplatelet Effect at low doses
  - 80 mg daily
- Improves placental implantation
  - Start before 16 weeks
  - Improves placental blood flow
Efficacy of Aspirin

Reviewed 59 RCTs (37,560 women) to determine benefits of aspirin:

- 17% reduced risk of preeclampsia with low dose aspirin
- 14% reduced risk of stillbirth
- 8% reduced risk of preterm birth

Conclusion: Antiplatelet agents have moderate benefits when used for prevention of preeclampsia.

Cochrane Database of Systematic Reviews 2007, Issue 2. Art. No.: CD004659

ACOG: treatment with low dose aspirin

“For women with a medical history of early-onset preeclampsia and preterm delivery at less than 34 0/7 weeks of gestation or preeclampsia in more than one prior pregnancy, initiating the administration of daily low dose (60 - 80 mg) aspirin beginnin in the late first trimester is suggested.”

Updated guidance-included

Low Dose Aspirin

Benefits both Spontaneous and indicated preterm birth!!

- **Indicated Preterm Birth**
  - Placental diseases - reduced 20%
    - Preeclampsia
    - Fetal Growth Restriction

- **Spontaneous Preterm Birth**
  - Improved placental health
USPSTF Recommendations

<table>
<thead>
<tr>
<th>Population</th>
<th>Asymptomatic pregnant women who are at high risk for preeclampsia</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recommendation</td>
<td>Prescribe low-dose (81 mg/d) aspirin after 12 weeks of gestation. Grade: B</td>
</tr>
<tr>
<td>Risk Assessment</td>
<td>Pregnant women are at high risk for preeclampsia if they have 1 or more of the following risk factors:</td>
</tr>
<tr>
<td></td>
<td>• History of preeclampsia, especially when accompanied by an adverse outcome</td>
</tr>
<tr>
<td></td>
<td>• Multifetal gestation</td>
</tr>
<tr>
<td></td>
<td>• Chronic hypertension</td>
</tr>
<tr>
<td></td>
<td>• Type 1 or 2 diabetes</td>
</tr>
<tr>
<td></td>
<td>• Renal disease</td>
</tr>
<tr>
<td></td>
<td>• Autoimmune disease (i.e., systemic lupus erythematosus, the antiphospholipid syndrome)</td>
</tr>
<tr>
<td>Preventive Medication</td>
<td>Low-dose aspirin (60 to 150 mg/d) initiated between 12 and 28 weeks of gestation reduces the occurrence of preeclampsia, preterm birth, and IUGR in women at increased risk for preeclampsia. The harms of low-dose aspirin in pregnancy are considered to be no greater than small.</td>
</tr>
<tr>
<td>Balance of Benefits and Harms</td>
<td>There is a substantial net benefit of daily low-dose aspirin to reduce the risk for preeclampsia, preterm birth, and IUGR in women at high risk for preeclampsia.</td>
</tr>
<tr>
<td>Other Relevant USPSTF Recommendations</td>
<td>The USPSTF recommends that all women planning or capable of pregnancy take a daily supplement containing 0.4 to 0.8 mg (400 to 800 µg) of folate. This recommendation is available at <a href="http://www.uspreventiveservicestaskforce.org">www.uspreventiveservicestaskforce.org</a>.</td>
</tr>
</tbody>
</table>

For a summary of the evidence systematically reviewed in making this recommendation, the full recommendation statement, and supporting documents, please go to www.uspreventiveservicestaskforce.org. IUGR = intrauterine growth restriction.

Low-Dose Aspirin Use for the Prevention of Morbidity and Mortality From Preeclampsia: U.S. Preventive Services Task Force Recommendation Statement

Group Prenatal Care Structure & Essential Elements

- Groups of 8 to 12 women
- Sessions last 2 hours
- Meet for 10 sessions, continuing through postpartum
- Essential Elements:
  - Health assessment occurs within group space
  - Participants are involved in self-care activities
  - A facilitative leadership style is used
  - Each session has an overall plan
  - Attention is given to the core content; emphasis may vary
  - There is a stability of group leadership
  - The group conduct honors the contribution of each member
  - The group is conducted in a circle and group size is optimal to promote the process
  - The composition of the group is stable, but not rigid
  - Involvement of family support is optional
  - Opportunity for socialization is provided
  - There is on-going evaluation of outcomes
Why Group Prenatal Works

- Health promotion
- Social Support
- Efficiency of care
- Effectiveness of care
- Timeliness
- Culturally appropriate patient-centered care
- More equitable care - power shift
- Self-efficacy

Evidence

Ickovics et al (2007) conducted a multisite randomized controlled trial conducted at two university affiliated-hospital prenatal clinics (Yale and Emory Universities)

Included 1,047 pregnant women randomly assigned to either standard or group care. 14-25 (mean age: 20.4 years), 80% Black

- Significantly less likely to have preterm births compared to those with standard care (9.8% compared with 13.8%), effects were strengthened for African American women (10.0% compared with 15.8%).
- Less likely to have suboptimal prenatal care, had significantly better prenatal knowledge, felt more ready for labor and delivery, and had greater satisfaction with care.
- Breastfeeding initiation was higher in group care
- No differences in birth weight nor in costs associated with prenatal care or delivery
- More likely to attend each prenatal visit
Group Prenatal Care in Idaho

- St. Alphonsus Boise Maternity Care Clinic
  - Margie Widener, CNM
- Kootenai Health Certified Nurse Midwives

http://www.kh.org/site/c.dkLSK7OPLnKaE/b.8771823/k.3273/Certified_Nurse_Midwifery_Care.htm#.V9wtVk3rtYc
Optimizing existing interventions for Idaho 2017

1. Birth Spacing
   • LARC - Long acting reversible contraception

2. 17-hydroxyprogesterone caproate injections
   • Makenna or equivalent

3. Low Dose Aspirin
   • “early and often”

Target geographies and/or racial and ethnic groups with high rates and/or high birth volume

![Bar chart showing percent of live births by race and ethnicity]
Thank You

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