Charting a Course for Perinatal Health in New York State

A Framework for Strategic Planning

By **The Association of Perinatal Networks of New York**

Acknowledgments

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The Association of Perinatal Networks of New York is an informal organization of the original, and currently funded Comprehensive Prenatal Perinatal Services Networks. The intent in forming the Association was to broaden awareness of the continuing need to address and improve maternal and child health services and outcomes in New York State, and to broaden awareness of the improvement in perinatal health that have been evidenced in the regions of the state covered by Perinatal Networks. The Networks attribute the improvements to the increased coordination of services and collaboration among providers that is promoted through the network concept.

The Mission of the Association is:
"To improve perinatal, maternal and child health throughout New York State, and to support the work of the individual Perinatal Networks."

The Association is pleased to have had the opportunity to work with federal and state agencies and their representatives to develop this document.

For more information about the Association of Perinatal Networks, or the Framework document, consult the listing of the perinatal networks (appended) for your nearest network, or:

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Charting a Course for Perinatal Health in New York State

A Framework for Strategic Planning

Overview: *New York State's history as a leader in assessing and supporting medical and ancillary health care services that nurture healthy babies and families is well known. New research and clinical improvements have resulted in an increase in our understanding and ability to provide care, and have led to even better service delivery. In recent years, however, perinatal health has been confronted with challenges related to rapid changes in the delivery and financing of health care and in social welfare policy that impact women and children.*

More startling, and potentially more adverse effects on perinatal health outcomes may unfold in the next few years as New York and the entire country responds to, and repairs the devastation wrought by the terrorist attacks of September 11, 2001. Pregnancy and birth outcomes for women in New York City may be complicated by environmental toxins; stress, depression and grief will likely impact birth outcomes for many women and families throughout the state and country; and the economic effects of these senseless acts will affect the perinatal health system, its providers and its recipients for years to come.

It is, therefore, perhaps more critical than ever before, that we not lose sight of the benefits to be gained by improving services for pregnant women, infants and families. The Association of Perinatal Network supports the following:

Vision for New York State:

Every pregnancy is healthy and wanted, and all women and families receive the support and services they need in a respectful environment.

Preliminary Development:

The goal of developing a unified approach for improving perinatal health outcomes in New York State evolved simultaneously by the Association of Perinatal Networks of New York (APN) and the New York State Department of Health (NYSDOH), Bureau of Women's Health (BWH). Both organizations recognized that due to declining resources and continued fragmentation and gaps in services throughout the state, there was a need for a comprehensive statewide plan. The need to begin developing a statewide plan was reinforced in December 1998, when the five federal Healthy Start projects in New York State expressed an interest in participating in a coordinated planning effort. Guidance from the US Health Resources and Service Administration's (HRSA) Maternal and Child Health Bureau to expand state and federal partnerships-i.e., to build closer links between Healthy Start operations, state health departments and perinatal networks-further reinforced this initiative. APN's partnership with the Healthy Start projects culminated in the facilitation of a state-wide perinatal health symposium.

The September 1999 symposium, *Charting a Course for Perinatal Health in New York State,* was a forum through which the development of a strategic plan for perinatal health for New York was begun. Five health status priorities and seven recommended actions were identified through the active participation of symposium participants and two statewide surveys of over 40 stakeholder groups. The five identified health status priorities were:

- *Reducing disparities in health outcomes between high-risk, under served groups and lower-risk groups;*
- *Reducing the percentage of babies born prematurely or at low birthweight;*
- *Increasing the percentage of women who receive comprehensive prenatal care starting during their first trimester;*
- *Reducing teen pregnancy rates; and*
- *Reducing smoking and other forms of substance use during pregnancy.*

In April 2000, with assistance and input from the NYSDOH, BWH, the APN initiated the development of a Perinatal Strategic Plan for New York State. **The goal was to produce a document that has relevance for the various disciplines and programs that comprise the perinatal health system in New York State.** With no precedent to follow, developing such a plan proved to be an enormous undertaking.

Consultants for the project began by conducting a national search for a model plan, and while a number of states have public health strategic plans specific to maternal and child health services, no state had a template that reflected the public, private and advocacy perspectives on perinatal health. Input was solicited and received from key researchers and government and organizational leaders in the field of maternal and child health at local, state, and federal levels, as well as from clinicians who witness the successes and failures of the current perinatal system on a daily basis.

National documents such as HRSA's *Charting a Course for the Future of Women's and Perinatal Health,* and the National Perinatal Association's *Shaping the Future of Perinatal Care: A Strategic Action Plan,* as well as

numerous well-known and respected books such as the National Institutes of Health's *Caring for Our Future:The Content of Prenatal Care,* were reviewed intensely. Strategic plans for maternal and child health services created by various entities such as: the Maternal Child Health Bureau, HRSA, the Association of Maternal Child Health Programs, various states' maternal/child health programs, and related manuals produced by the March of Dimes and the American College of Obstetricians and Gynecologists, were reviewed and are referenced in this document.

It was evident through this extensive research and review that the goal to develop a plan that would work for both the public and private sectors of perinatal health, as well as at the macro and micro service levels, was very aggressive and perhaps not wholly achievable. Finally, after multiple revisions of the template and content, it was determined that the most successful strategy for engaging all sectors of the perinatal health care system and encouraging endorsement and commitment to a coordinated plan, was to develop a *framework*, rather than an actual strategic plan.

The following document, therefore, through research, review and data analysis, provides an overview of the current system for perinatal health care, background information on specific component issues, and public policies and programs that have been implemented to address one or more issues affecting birth outcomes. **The purpose of *Charting a Course for Perinatal Health in New York State - A Framework for Strategic Planning,* is to identify the issues and to provide the basis for determining how to address them at multiple levels in order to improve perinatal outcomes in New York State.**

Structure

The document is built around three primary goals:

- ***Eliminate Barriers and Health Disparities*** - to improve access to services and eliminate disparities in perinatal health outcomes through the removal of economic, social and cultural barriers.

- ***Assure Quality Care*** -
  a) to enhance the quality of care by engaging women as active and responsible participants in their reproductive health care, and
  b) to assure the highest quality of care through dissemination and implementation of prenatal care standards.

- ***Improve the Health Infrastructure and System*** - to improve health outcomes through the development and improvement of the perinatal health infrastructure, increased availability of data for monitoring and evaluation, dissemination of best practices and improved coordination of services.

Consistent with the adoption of the title - *Charting A Course* - from the MCHB national document, APN members recognized the correlation between the strategic plan objectives identified by MCHB and the health status priorities identified by symposium participants in 1999. Consolidating the priorities under these three goals allowed a more visionary perspective, and helped to make the document more succinct. Additionally, it helped to crystallize the infrastructure as a vital part of the [perinatal health] system and its important role as a part of the solution to the current deficiencies in perinatal health care.

Given the uniqueness of New York's diversity between New York City and Upstate New York, as well as the urban/rural disparities, and the level of racial and ethnic diversity in New York State, the APN has proposed a framework that can be used across the spectrum, and can include providers, service systems, consumers and advocates.

Each community has its own group of perinatal stakeholders, which may include medical professionals, social workers, human service specialists, program and facilities' administrators and line staff. Perinatal stakeholders can also include schools, faith-based organizations, law enforcement and criminal justice, parent organizations, and consumers. Anyone who cares about the health of mothers and babies is *ultimately* a perinatal stakeholder.

Methodology: The current status of perinatal health was measured through the analysis of various perinatal health indicators. The two primary sources of New York State data for secondary data analysis of health indicators documented in the report are: NYSDOH *and* NYC Vital Records and the *Pregnancy Risk Assessment Monitoring System (PRAMS)*. Unique to New York State is the fact that New York City maintains its own vital records, utilizing a separate and distinct birth certificate and database. As evidenced throughout the document, the utilization of two separate data systems for New York compromises the ability to obtain a timely and realistic perspective of maternal and child health for the entire state.

PRAMS is a nationally-designed survey of new moms following the birth of a child. A full description of PRAMS is provided in Section Three *(Infrastructure)*, and is one of the many federal-state partnerships. New York is one of a number of states that actively use the PRAMS survey to assess perinatal health. And while PRAMS information has been useful in helping to identify key issues to be addressed in order to improve perinatal health outcomes, it also is limited by the fact that until 2001, the NYS PRAMS study has been limited to the upstate region.

Other sources of perinatal health indicators used in development of this document include information and data collected through regional and local studies conducted by a number of the perinatal networks, the regional perinatal data systems, and private researchers.

It is important to note that vital statistics data has both power and limitations. Startling data such as high infant mortality rates or racial and ethnic disparity indicators help to highlight the need for policy makers, program managers and providers to authorize funding and initiate new or improved services. The limitations, as indicated by the use of two distinct systems, the lack of state-wide PRAMS information, and the number of sub-objectives for which there are no baseline indicators, are shocking indicators of how much more we must develop in order to identify need and to monitor improvement.

Key Data and examples of its utilization in this document:
In 1998, the most recent year for which statewide vital statistics data is available, there were 413,717 pregnancies recorded in New York State, with 257,748 births recorded (birth rate of 13.8 per 1,000 population). Of the pregnancies, slightly less than one-half (183,667) were to residents living in areas of New York State outside of New York City (230,050/NYC). Following national trends, the overall pregnancy rate has declined since 1993 in New York State (See Table 1).

Perinatal health, however, represents more than just the number of pregnancies or babies born. A more telling statistic is the fertility rate (# of live births/1,000 women, aged 15 - 44) *See figure 1 below.* Both the birth rate and the crude birth rate have declined steadily since 1993, with the exception of a slight increase in the fertility rate between 1997 and 1998 (61.8 to 62.4 respectively).

With fertility as a key factor in perinatal health, monitoring the rates of intended versus unintended pregnancies and related outcomes requires multifaceted approaches to perinatal care, such as public education, outreach, improved access to family planning and prenatal services, and promoting the use of effective contraceptive methods.

How to use this document:
As noted above, *Charting a Course for Perinatal Health in New York State - A Framework for Strategic Planning,* has been designed as a template document to be used by all perinatal health stakeholders and at all levels of the perinatal system. By utilizing the Framework, all components of the system will be able to develop individualized strategic plans that will allow each entity to address specific aspects that fit within their capability and capacity, while building upon a continuum since all sectors will be working toward the same goals. The document is divided into three areas - each focusing on one of the three goals.

Pregnancies in New York State, 1993, 1998

	1993		1998	
Pregnancies	Number	Rate	Number	Rate
NYC	**248,734**	**136.2**	**230,050**	**128.4**
Rest of State	**212,738**	**87.4**	**183,667**	**78.6**
NYS	**461,472**	**108.3**	**413,717**	**100.2**

Table 1
Data Source: NYSDOH, Vital Records. Number of pregnancies is for women of any age. Pregnancy rates are based on female population age 15-44.

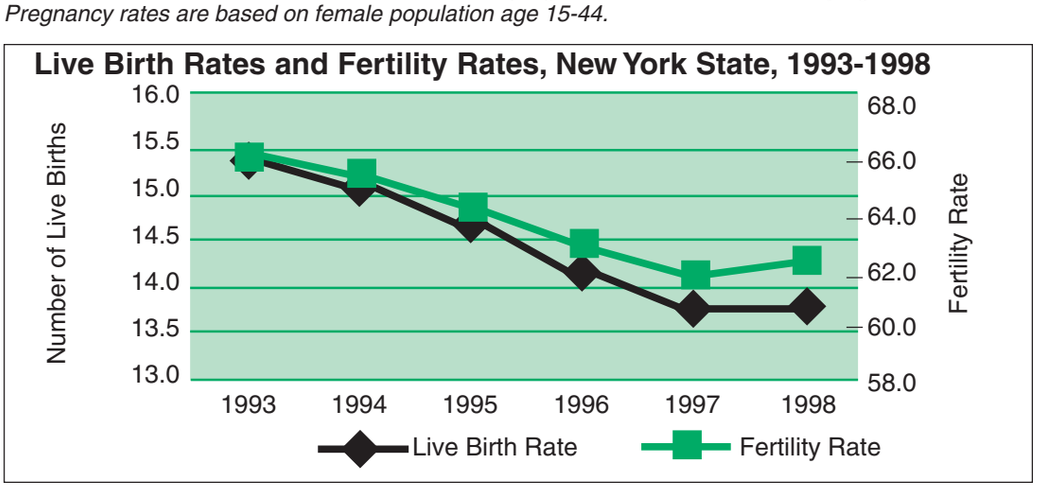

Figure 1
Source: NYSDOH, Vital Records, 1993-1998.

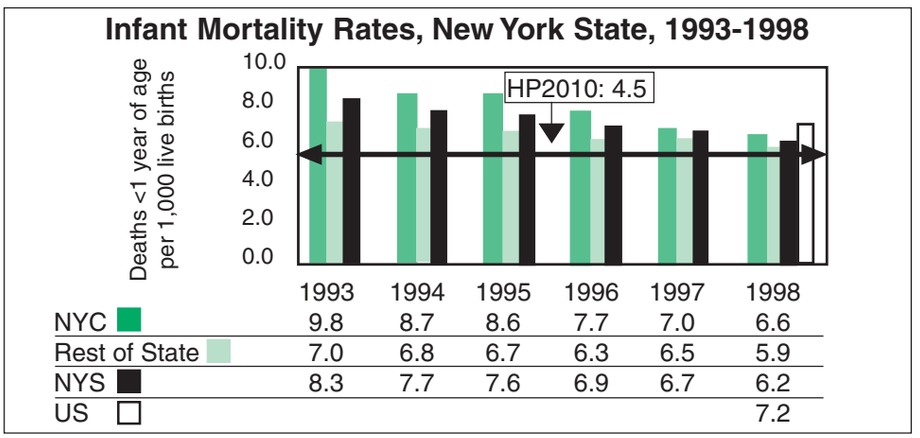

Figure 2
Source:
NYSDOH Vital Records, 1993-1998.

Infant Mortality and Morbidity

Infant mortality is a key measure of a society's health. In 1996, the United States ranked 26th among industrialized nations in infant mortality.[2] New York ranked 19th among states in 1997.[3] In 1998, 1,608 infants died before their first birthday, for a state rate of 6.2 per 1,000 live births (Figure 2). This represents a steady decline from a high of 24.8 in 1950, when infants were four times as likely to die in their first year than in 1998. The *Healthy People 2010 Objective (16-1c)* for infant mortality is 4.5 deaths per 1,000 live births.

Two-thirds of infant deaths occur during the first 28 days of life, the neonatal period. Neonatal deaths are primarily due to birth defects, disorders related to low birthweight and short gestation, respiratory distress syndrome, infections, and maternal complications of pregnancy. The remaining one-third of infant deaths occurs between 29 days and 1 year, the postneonatal period. Sudden Infant Death Syndrome (SIDS) is the leading cause of death during this time.[4]

Birth Defects [5]

Birth defects are the leading cause of death in the first year of life. About 150,000 babies are born each year in the U.S. with birth defects. A birth defect is an abnormality of structure, function or body metabolism present at birth that results in physical or mental disability, or is fatal. There are more than 4,000 known birth defects. While both genetic and environmental factors can cause birth defects, the causes of about 60 percent of birth defects are currently unknown. Birth defects generally are grouped into three major categories: structural/metabolic, congenital infections, and other conditions.

- Structural /Metabolic: Defects of the heart are the most common type of structural birth defect, affecting 1 baby in 125, and remain the leading cause of birth defect-related infant deaths. Spina bifida affects 1 in 2,000 babies who may suffer varying degrees of paralysis, and bladder and bowel problems.

- Congenital Infections: Rubella (German measles) is a well known congenital infection that can cause birth defects. If a pregnant woman contracts rubella in the first trimester, her baby has a one-in-four chance of being born with one or more symptoms of congenital rubella syndrome (deafness, mental retardation, heart defects, blindness). Rubella can also cause stillbirth. The most common congenital viral infection is cytomegalovirus (CMV). About 1 percent (40,000) of all babies born in the U.S. are infected annually, though only about 10 percent of them actually exhibit symptoms which include mental retardation, vision and hearing loss.

- Other Conditions: Malformations - congenital malformation, chromosomal anomaly, or persistent metabolic defect - are the leading cause of infant mortality in the United States. Twenty percent of infant deaths are attributed to congenital malformations. They also are a major cause of morbidity and mortality throughout childhood.[6]

The Healthy People 2010 Objective (16-1f) is to decrease the incidence of all birth defects to 1.1/1,000 live births. While many causes of birth defects are not known, and many are not preventable, there are a number of steps a woman can take to reduce her risk of having a baby with a birth defect. The risk for some birth defects can be detected preconceptionally through genetic testing. Women and their partners can discuss their risks through genetic counseling during the preconception or prenatal period. To reduce the risk of environmentally related birth defects, a woman who is pregnant or planning pregnancy should avoid alcohol, tobacco, and illicit drugs. Any prescription or over-the-counter medication should not be taken without first consulting a health care provider.

The B vitamin, folic acid, has been proven to reduce the risk of certain birth defects of the brain and spine called neural tube defects (NTDs), which occur within the first two weeks of pregnancy. The most common NTDs are

spina bifida and anencephaly. The March of Dimes Birth Defects Foundation, the Centers for Disease Control (CDC) and Prevention and the Institute of Medicine recommend that women who can become pregnant consume 400 micrograms daily of the synthetic form of folic acid, as it is easily absorbed by the body. It is important for a woman to have enough folic acid in her system before pregnancy.

The Healthy People 2010 Objective 16-16a is to increase to 80% the percentage of non-pregnant women aged 15-44 years who consume at least 400 micrograms of folic acid on a daily basis. Since half of all pregnancies are unplanned, community education programs have been established to target all women of childbearing age. The Institute of Medicine also recommends that women should increase the intake of synthetic folic acid to 600 micrograms a day once the pregnancy is confirmed (prenatal vitamins contain at least this amount of folic acid). Among 1998 PRAMS respondents, 80% of White mothers reported having heard or read about the importance of taking folic acid to prevent some birth defects compared with 59.5% of Black mothers. Older women were more knowledgeable about folic acid than younger women - 82% of mothers aged 25-34 and 85.5% of mothers aged 35 or older compared with 50.8% of teen mothers and 64.8% of mothers aged 20-24.

Maternal Mortality and Morbidity

A maternal death is traditionally defined as a pregnancy-related death within six weeks of birth (ICD-9 Codes: 630-676.9). The CDC and the American College of Obstetrics and Gynecology (ACOG) have expanded this traditional definition into "pregnancy-associated deaths" and "pregnancy-related deaths." The latter definition is confined to deaths directly related to pregnancy: "an associated death that results from complications of the pregnancy, the chain of events initiated by pregnancy that led to the death, or the aggravation of an unrelated condition by physiologic or pharmacologic effects of pregnancy that subsequently caused the death." Pregnancy-associated deaths include "the death of a woman, from any cause, while she is pregnant or within one year of termination of pregnancy, regardless of duration and site of the pregnancy." Using these two expanded definitions to analyze maternal death data increases the actual number of deaths surrounding a pregnancy event. There is a growing acknowledgment among states that the traditional definition undercounts maternal deaths, and has been overlooked as a serious public health concern.

Maternal death is a rare event in the United States, with 7.1 deaths per 100,000 live births, or 1 death for every 12,987 births.[7] New York's rate is 9.9 deaths per 100,000 live births, or 1 death for every 10,108 births.[8] *The Healthy People 2010 Objective 16-4* is 3.3 maternal deaths per 100,000 live births. Black women have higher rates of maternal mortality than White women. In fact, the racial disparity in maternal mortality rates is the greatest disparity of all maternal and child health indicators. Nationally, the maternal mortality rate among Black women (17.1 per 100,000 live births) has consistently been three to four times that of White women (5.1).[9] In a recent CDC study,[10] New York ranked highest for maternal mortality among Black women - 28.7/100,000 - compared with 7.6/100,000 for White women.* Race and ethnicity are not necessarily risk factors for maternal mortality, but may be markers of social, economic, and cultural factors as well as health care access, quality of care, and other factors, which may increase the risk of death.[11] It should be noted, however, that even well-educated and non-poor Black women are at an increased risk of maternal death.[12]

The three leading causes of maternal mortality are preeclampsia, hemorrhage, and embolism. Other causes include ectopic pregnancy, pregnancy-induced hypertension and infection.[13] For every maternal death, there are 3,000 cases of serious pregnancy-related morbidity. More than half of all maternal deaths can be prevented through early diagnosis and appropriate medical care of pregnancy complications.[14] Specifically, although Black women have four times the risk of dying from pregnancy complications and childbirth, their risk for developing maternal complications is less than twice that of White women. This suggests an opportunity to target prevention, early diagnosis, and effective treatment through outreach, improved access to and adequate use of health care services.[15]

New York State is one of 25 states with a Maternal Mortality Review Board. It has further refined the definitions to:

- *Direct maternal death* - due to complication of pregnancy, childbirth, or obstetric intervention
- *Indirect maternal death* - due to pregnancy-induced exacerbation of underlying illness
- *Incidental, non-maternal death* - due to condition(s) unrelated to pregnancy.

Since 1997, NYSDOH has conducted in-depth case reviews of maternal deaths. Using the traditional definition and data source (death certificate data) for monitoring maternal mortality, 29 deaths were identified for 1996. Using expanded definitions and matching death certificate data with birth, fetal death, and abortion vital records, 161 'potential' maternal deaths were identified for the same period.[16]

** New York's high rate of maternal mortality is partially a function of better death certificate ascertainment when compared to other areas. Maternal deaths that occur in New York City are found via death certificate data through a referral system with the City's Medical Examiner's office.*

Goal 1: Eliminate Barriers and Health Disparitites

Goal Statement: *To improve access to services and eliminate disparities in perinatal health outcomes through the removal of economic, social and cultural barriers.*

Recommended Objectives to Eliminate Barriers and Health Disparities

Based upon the preceding discussion and the recommendations of key respondents and symposium participants, the following objectives are recommended to improve access to services and eliminate health disparities in perinatal health outcomes, through the removal of economic, social and cultural barriers:

1.1 Expand financial access to prenatal and reproductive health services by increasing Medicaid eligibility for these services to 250% of poverty and advocating for expansion of health supportive services.

Baseline: Financial eligibility for Medicaid for pregnant women increased to 200% FPL (11/00). Financial eligibility for family planning services to 200% of FPL (pending CMS approval)
Data Source: NYSDOH

1.2 Eliminate the disparity between Black and White infant mortality rates.

Baseline: Black 9.8/1,000, White 4.8/1,000 (1998)
Data Source: NYS Vital Records, New York State Department of Health (NYSDOH)

1.3 Increase the percentage of pregnant women receiving prenatal care in the first trimester to 85%.

Baseline: 73.8% for NYS (1998)
Data Source: NYS Vital Records Healthy People 2010 Objective 16-6a: 90%

1.4 Reduce the incidence of low birthweight to 6.5% of live births.

Baseline: 7.8%
Data Source: NYS Vital Records Healthy People 2010 Objective 16-10a: 5%

1.5 Reduce the incidence of preterm birth to 9.5% of live births.

Baseline: 11.0% (1998)
Data Source: NYS Vital Records Healthy People 2010 Objective 16-11a: 7.6%

Building the Framework for a Strategic Plan for Perinatal Health in New York State

The Goal and corresponding Objectives on the preceding page are the basis for the strategic plan framework. In order to ensure a comprehensive state-wide plan, we invite you - ***a perinatal health stakeholder*** - to help identify strategies to ensure achievement of the stated objectives and goals, ***and*** to become part of the state-wide plan by developing your own workplan - using it to direct work within your agency, as well as sending a copy to the Association of Perinatal Networks for inclusion in the state-wide plan (APN Fax: (607) 772-0468, Email: apn@mothersandbabies.org). All entities submitting plans will be invited to participate in the Second Perinatal Health Symposium being planned for Fall 2003.

As a local, regional or state-wide entity, review the objectives to determine which may be applicable to your community and/or agency.

- Select one or more of the objectives - either keeping it as it is, or modifying it (i.e., adjusting the percent for improvement according to your local need);
- Identify some action steps or strategies to which you can commit time and expertise in order to help achieve the objective;
- Set a time frame in which you would expect to achieve part or all of your desired outcome.

Use this worksheet (attaching other pages as necessary) to document your plan.

Agency: _____

Authorized Representative: _____

Address: _____ City: _____ Zip: _____

Phone: _____ Fax: _____ Email: _____

Goal One: Eliminate Barriers and Health Disparities

Selected Objective(s) (1.1, 1.2, 1.3, 1.4, 1.5) (include any modification for your service area)	**Activities (consider activities or action steps in the following domains: surveillance, research, education, outreach, resource development, coordination/partnership, etc.)**	**Time Frame in which progress is expected.**
Example: *Obj 1.2 Eliminate disparity between Black and White infant mortality rates.* **Local adaptation:** *Reduce the incidence of Black infant mortality by 2%.*	**Example:** *Develop a home visiting program to reach pregnant and newly parenting families in targeted neighborhoods; provide information on perinatal nutrition, healthy behaviorial choices and SIDS.*	*18 months from start of program (5/1/02 - 11/1/03)*

Goal 2: Assure Quality of Care

Goal Statement 1: *To enhance the quality of care by engaging women as active and responsible participants in their reproductive health care.*

Goal Statement 2: *To assure the highest quality of care through dissemination and implementation of prenatal care standards*

Recommended Objectives to Assure Quality of Care

Based upon the preceding discussion and the recommendations of key respondents and symposium participants, the following objectives have been identified to enhance the quality of care by engaging women as active and responsible participants in their reproductive health care, and to assure the highest quality of care through dissemination and implementation of prenatal care standards:

2.1 Decrease the proportion of births that result from unintended pregnancies to 30%.
Baseline: 35.3% (1998)
Data Source: PRAMS
Healthy People 2010 Objective 9-1: 70% intended pregnancies

2.2 Increase the percentage of women abstaining from alcohol, tobacco and other drug use during pregnancy by 10%
Baseline: Prenatal alcohol use: 8%; Prenatal tobacco use: 9.8%; Prenatal drug use: unreliable date (1998)
Data Source: PRAMS (upstate only)
Healthy People 2010 Objectives: 16-17a: 94% prenatal abstinence from alcohol; 16-17d: 100% prenatal abstinence from illicit drugs; 16-17c: 99% prenatal abstinence from cigarette smoking

2.3 Increase adherence to prenatal care standards in all prenatal care settings, statewide.
Baseline: Estimated at 40% of prenatal providers using prenatal care standards developed for PCAP
Data Source: NYSDOH

2.4 Assure that comprehensive assessment with appropriate referral is done at the first prenatal visit and throughout the pregnancy and includes:
1. Medical/surgical risk factors
2. Obstetrical history
3. Genetic screening and counseling
4. Nutrition assessment
5. Use of alcohol, tobacco and other drugs
6. Domestic violence and sexual assault history
7. Psychosocial assessment, including: mental health (including prenatal depression), educational level, age, social supports, other children, economic and housing
8. Cultural factors: language spoken, immigration status, health beliefs and practices, religious practices, stage of acculturation

Baseline: Discussed during prenatal care: Smoking: 73%; Alcohol: 75%; Nutrition: 87%
Data Source: PRAMS (upstate NY only), 1998

2.5 Assure that healthcare providers and allied health professionals receive primary and continuing education to increase their capacity to address quality of care issues for women of reproductive age and infants.
Baseline: None.
Data Source: None.

2.6 Increase the percentage of providers that implement cultural competency policies, procedures, and practices to 100%.
Baseline: Unknown
Data Source: Organization Policy Documents

Building the Framework for a Strategic Plan for Perinatal Health in New York State

The Goal and corresponding Objectives on the preceding page are the basis for the strategic plan framework. In order to ensure a comprehensive state-wide plan, we invite you - ***a perinatal health stakeholder*** - to help identify strategies to ensure achievement of the stated objectives and goals, ***and*** to become part of the state-wide plan by developing your own workplan - using it to direct work within your agency, as well as sending a copy to the Association of Perinatal Networks for inclusion in the state-wide plan (APN Fax:(607) 772-0468, Email: apn@mothersandbabies.org.
All entities submitting plans will be invited to participate in the Second Perinatal Health Symposium being planned for Fall 2003.

As a local, regional or state-wide entity, review the objectives to determine which may be applicable to your community and/or agency.

- Select one or more of the objectives - either keeping it as it is, or modifying it (i.e., adjusting the percent for improvement according to your local need);
- Identify some action steps or strategies to which you can commit time and expertise in order to help achieve the objective;
- Set a time frame in which you would expect to achieve part or all of your desired outcome.

Use this worksheet (attaching other pages as necessary) to document your plan.

Agency:

Authorized Representative:

Address: City: Zip:

Phone: Fax: Email:

Goal Two: Assure Quality of Care

Selected Objective(s) (2.1, 2.2, 2.3, 2.4, 2.5, 2.6) (include any modification for your service area)	**Activities (consider activities or action steps in the following domains: surveillance, research, education, outreach, resource development, coordination/partnership, etc.)**	**Time Frame in which progress is expected.**
Example: 2.1: *Decrease the proportion of births that result from unintended pregnancies to 30%.* **Local Adaptation:** *Establish a local baseline to determine the current rate of unintendedness.*	**Example:** *Develop a brief patient survey to query newly pregnant women about their pre-pregnancy planning. Seek agreements with local obstetrical providers to have surveys completed by all new (ob) patients for a three month period.*	*Baseline established within 6 months of project initiation.*

Goal 3: Improve the Health Infrastructure and System

Goal Statement: *To improve health outcomes through the development and improvement of the perinatal health infrastructure, increased availability of data for monitoring and evaluation, dissemination of best practices and improved coordination of services.*

Recommended Objectives to Improve the Health Infrastructure and System

Based upon the preceding discussion and the recommendations of key respondents and symposium participants, the following objectives have been identified to improve health outcomes through the development and improvement of the perinatal health infrastructure, increased availability of data for monitoring and evaluation, dissemination of best practices and improved coordination of service:

3.1 Ensure statewide implementation of the Statewide Perinatal Data System (SPDS), including New York City.
Baseline: Regional data system available in 4 upstate regions (2001)
Data Source: NYSDOH

3.2 Ensure the availability and use of the Pregnancy Risk Assessment Monitoring System (PRAMS) data statewide.
Baseline: Currently available upstate only (2001)
Data Source: NYSDOH and NYCDOH

3.3 Operationalize Regional Perinatal Forums throughout New York State.
Baseline: 5 RPFs (March 2001)
Data Source: NYSDOH

3.4 Strengthen health supportive services by promoting effective program management and replicating best practices.
Baseline: Unknown
Data Source: Unknown

3.5 Ensure coordination of perinatal and related health services throughout New York State by the expansion or establishment of coordinating entities such as Perinatal Networks.
Baseline: 35 counties/boroughs are currently served by comprehensive prenatal services networks (CPPSN)
Data Source: NYSDOH

Building the Framework for a Strategic Plan for Perinatal Health in New York State

The Goal and corresponding Objectives on the preceding page are the basis for the strategic plan framework. In order to ensure a comprehensive state-wide plan, we invite you - ***a perinatal health stakeholder*** - to help identify strategies to ensure achievement of the stated objectives and goals, ***and*** to become part of the state-wide plan by developing your own workplan - using it to direct work within your agency, as well as sending a copy to the Association of Perinatal Networks for inclusion in the state-wide plan (APN Fax: (607) 772-0468, Email:apn@mothersandbabies.org.
All entities submitting plans will be invited to participate in the Second Perinatal Health Symposium being planned for Fall 2003.

As a local, regional or state-wide entity, review the objectives to determine which may be applicable to your community and/or agency.

- Select one or more of the objectives - either keeping it as it is, or modifying it (i.e., adjusting the percent for improvement according to your local need);
- Identify some action steps or strategies to which you can commit time and expertise in order to help achieve the objective;
- Set a time frame in which you would expect to achieve part or all of your desired outcome.

Use this worksheet (attaching other pages as necessary) to document your plan.

Agency:

Authorized Representative:

Address: City: Zip:

Phone: Fax: Email:

Goal Three: Improve the Health Infrastructure and System

Selected Objective(s) (3.1, 3.2, 3.3,.3.4, 3.5) (include any modification for your service area)	**Activities (consider activities or action steps in the following domains: surveillance, research, education, outreach, resource development, coordination/partnership, etc.)**	**Time Frame in which progress is expected.**
Example: *Obj. 3.4: Strengthen health supportive services by promoting effective program management and replicating best practices.* ***Local Adaptation:*** *Increase private provider awareness of community-based health supportive services.*	***Example:*** *1) Produce a resource directory of local health and human services. 2) Identify local funding source to help offset cost of directory production. 3) Distribute copies to all local medical offices.*	*By month 12: Directory produced By month 10: 100% of funds secured. Month 12: Distribution begins.*

Each section includes *issues discussions* which have been developed through extensive research and are backed by related data and an overview of NYS legislation, policies and programs developed to address issues. The purpose for inclusion of both segments is to provide the stakeholder necessary background information and to help reduce the need for individual research before developing and initiating a plan. Following these discussion segments for each goal section are a set of objectives, which were developed through consensus by symposium participants and in conjunction with objectives identified by the Maternal Child Health Bureau (HRSA). It is intended that the objectives will help direct individual energies and steer improvement toward common milestones.

Since it is the intention of the APN that *Charting a Course* be used as a *Framework* document, at the end of each goal section are a set of pages which can be used to record the elements of each stakeholder's strategic plan. Specific strategies, action steps and activities as well as time-limited milestones can be recorded in this section, creating a complete Strategic Plan document, which can be operationalized immediately and revised periodically to maximize its utility.

The development of this document and the invitation for other stakeholders to shape strategic plans in the context to the defined goals and objectives is not intended to compete or presuppose other efforts. Rather, it is intended to build upon the recognition that improving pregnancy and birth outcomes requires a multi-disciplinary effort, and that through collaboration and cooperation we will maximize resources and enable each segment of the perinatal health system to become stronger and more successful in its own initiatives.

Next Steps: Reaching our collective goal to improve the health of women and infants will require determination, coordination, and commitment by all sectors of the perinatal health system. In light of the tragic events of September 11, 2001, staying on course for improved perinatal health will likely become more challenging, rather than more concerted. Government leaders, policy makers and program leaders will be required to re-prioritize in order to address the more immediate needs of rebuilding and protecting American liberty.

As more startling and potentially more adverse effects on perinatal health outcomes unfold in the next few years, it is perhaps more critical now than ever before, that maternal and child health providers and advocates stay focused and committed to ensuring and improving the perinatal health system. The Association of Perinatal Networks is committed to staying on course. We invite every stakeholder who completes the Framework to share their plan with us so that it can be recorded as a component of a statewide effort. (Website, email, address)

Each perinatal network in New York State will take responsibility to introduce the Framework document in its communities, gather input from key stakeholders, and to help individual entities develop their own plans.

A second Perinatal Health Symposium is being planned for Spring 2003. This symposium will showcase the collective New York State plan, highlight key elements and programs, and provide an overview of successes and challenges to date. Additionally, the APN will continue to communicate with federal and other states' leaders, and key maternal and child health national and state organizations to stay abreast of evolving perinatal health issues and strategies. Key elements will also be addressed at the second Symposium.

Reaching a collective goal to improve the perinatal health system in New York State is an exciting and challenging endeavor. We invite you to take part by doing your part to improve the health and well-being of women, infants and families in New York State.

The basis of Charting a Course....

It is frequently noted that the strength of a community, state or country is evidenced by its ability to care for its children: "A singularly important resource to society is the newborn infant, if born with the capacity to function well in our world. In contrast, if born already deprived, unable to function with full equality as a newborn citizen, waste and harm comes to the individual and the community."[1] As has been noted extensively over the past few decades, despite a dramatic decrease in infant mortality, the United States continues to rank poorly when compared to other industrialized countries. Increased technological sophistication has enabled the survival of very young, tiny infants; yet this success has been tempered by the persistence of high rates of low birth weight and premature infants and the continued prevalence of major congenital malformations. Therefore, an appropriate preface to the afore-mentioned goals is a discussion of critical perinatal health indicators.

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