



## Place Matters: Preventive Health Programs to Reach Rural Women

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This is the second issue of our current volume on the challenges and solutions of delivering public health interventions to women and children living in rural and frontier communities. The [first issue](#) focused primarily on children and their families; this issue focuses on women.

The Affordable Care Act has increased the availability of preventive health screenings for women; however, as Sabrina Matoff-Stepp and Michelle Berlin point out in their editorial, women living in rural areas may have a hard time accessing these screenings. The authors list federal resources available to states to increase access to cervical cancer screenings.

Renee Bouvion and Jesus Reyna explore factors that affect migrant women's health and programs established to address their needs. The authors highlight the exciting possibilities of promotoras or community health worker programs as a way to provide health information to these women. Margo Young urges health professionals working with rural families to recognize environmental hazards and understand the connection between those hazards and health.

Adelaida Magallanes, a student with the University of Washington School of Medicine, describes her Rural/Underserved Opportunities Program (R/UOP) project to increase rural, young Latinas' awareness of emergency contraception. Maria Campanaro, a student with the University of Washington Maternal and Child Health Program describes several telehealth programs in rural states.

Gina Legaz gives an overview of the March of Dimes "Healthy Babies Are Worth the Wait" campaign. While the goal of the campaign is to reduce elective deliveries prior to 39 weeks, she points out that in rural areas early elective deliveries may be a rational approach to avoid uncertainties associated with having to travel long distances. The states of Alaska, Idaho, Oregon, and Washington report on their efforts to reduce early term and preterm births. The reader may find useful the glossary of terms on page 15 used to categorize gestational age to clarify terminology used in the state reports. The reader is also encouraged to read the reports closely and consider, as the Alaska and Idaho reports note, the limitation of using birth certificate data to define elective early term birth and the need to differentiate "early term" (37 to 38 completed weeks) and "preterm" (less than 37 weeks gestation) in prevention goals. Individual, provider, and system-level interventions to limit elective early term birth are likely to be very different from efforts to reduce preterm births.

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## Updates

Welcome Cheryl Alto, Colleen Huebner, and Melissa Schiff to the editorial board of the *Northwest Bulletin*. Cheryl is with the Oregon WIC Program, Oregon Health Authority. She is the new Oregon State representative to the editorial board, replacing Nurit Fischler. Colleen Huebner, Director of the Maternal and Child Public Health Leadership Training Program and Professor, Department of Health Services, is now faculty lead on the editorial board, replacing Jane Rees. Melissa Schiff is Co-Director of the Maternal and Child Public Health Leadership Training Program and Professor, Department of Epidemiology.

Congratulations to Dieuwke Disney-Spencer on her promotion to Deputy Administrator for the Division of Public Health at the Idaho Department of Health and Welfare. Idaho will greatly benefit from your leadership and understanding of maternal and child health issues.

## Reader Information

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Editorial . . .

# Preventive Health Screenings:

## Making the Connection for Rural Women

Sabrina Matoff-Stepp  
Michelle Berlin<sup>1</sup>

**A**mong women, longevity is associated with geographic location, higher education, health insurance, and access to care, including preventive health exams, such as blood pressure and cancer screenings. Prevention is key to women's health across the life course—but women living in rural communities may have a particularly hard time accessing preventive health screenings.(1, 2)

### Affordable Care Act and Preventive Health Screening

Beginning September 23, 2010, women, including pregnant women, with private health insurance coverage are eligible for [many preventive health screenings and services](#), including cervical cancer screenings, without a copayment or deductible under the Patient Protection and Affordable Care Act (ACA, PL 111-148). These services have been evaluated by the United States Preventive Services Task Force and determined to be of moderate to substantial benefit.

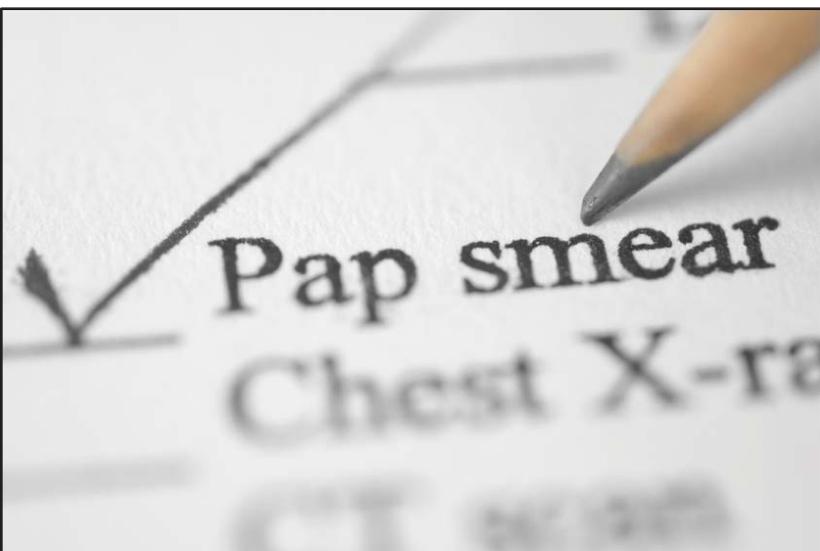
Eight additional services were added effective August 1, 2012, including well-woman visits and high-risk human papillomavirus (HPV) DNA testing every three years for women, aged 30 years or older, with normal cytology results. Health care providers are encouraged to offer or provide these services in their clinical practice.(3)

### Helping Women Access Cervical Cancer Screenings

According to data from the 2010 Behavioral Risk Factor Surveillance System, a notable percentage of women living in Region X—Alaska, Idaho, Oregon and Washington—are not receiving recommended cervical cancer screenings. (See table on page 4.) Additional disparities can be seen between racial and ethnic groups within a state.

One objective of [Healthy People 2020](#) (Objective C-15) is to increase the proportion of women, aged 21-65 years, who receive a cervical cancer screening from 84.5% in 2008 to 93% in 2020. Cervical cancer screening is also one of the Health Resources and Services Administration's current priority quality care indicators.

There are federal resources to assist states in



increasing the number of women living in rural areas who receive cervical cancer screening. In FY12, a select number of health centers received a one-time, supplemental funding from the Health Resources and Services Administration to focus on cervical cancer screening within a patient-centered medical home model.

The Centers for Disease Control and Prevention’s [National Breast and Cervical Cancer Early Detection Program](#) offers cervical cancer screening to uninsured and underinsured women, aged 64 years and under. This program reaches all 50 states, as well as the District of Columbia, United States territories, and American Indian and Alaska Native tribes.

In addition, intervention research is exploring novel ways to help women living in rural areas better understand the importance of cancer screening and connect them to sources of care and support, including the use of lay health workers and social media.(5,6,7)

**Conclusion**

While challenges exist to accessing preventive health services in rural communities, there are resources that can provide no-cost and low-cost cancer screenings for women. Lay health workers and social media can also link women to sources of care and support. ☺

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<sup>1</sup>Disclaimer: The viewpoints in this article are those of the authors and do not necessarily represent the official positions of the US Department of Health and Human Services or the Health Resources and Services Administration.

Table. Percent of women, aged 18 years and older, who in 2010 reported having had a Pap smear in the last three years.

| United States | Alaska | Idaho | Oregon | Washington | Healthy People 2020 Target |
|---------------|--------|-------|--------|------------|----------------------------|
| 80.9%         | 81.1%  | 76.2% | 74.9%  | 80.7%      | 93%                        |

Source: Centers for Disease Control and Prevention (4)

# Cervical Cancer Screening Updates

Michelle Berlin  
Sabrina Matoff- Stepp

Cervical cancer screening is an important preventive health test for women, aged 21-64 years. Updated guidelines have been released by the American Cancer Society, the American Society for Colposcopy and Cervical Pathology, and the American Society for Clinical Pathology (1) and the United States Preventive Services Task Force (2). (See table.)

These new guidelines differ from prior recommendations. First, initiation of Pap screening is recommended only for women 21 years and older. Previous guidelines suggested beginning Pap screening at 18 years of age or three years after the onset of vaginal intercourse. This change reflects current knowledge that: a) the rate of new cancers in these women is very low and unchanged by Pap testing, and b) false positive results can lead to unnecessary evaluation and overtreatment. Second, the interval for Pap testing is now uniform for all women, aged 21-65 years. Previous guidelines suggested a shorter interval for women, aged 21-29 years. Third, a new option for cervical cancer screening has been introduced for women, aged 30 years and older. This option pairs high-risk human papillomavirus (HPV) DNA testing

with Pap testing ( called “co- testing”).

Three other points, unchanged in the new guidelines, are worth emphasizing. Cervical cancer screening can be discontinued for women, aged 65 years and older, who do not have a history of abnormal Paps and have had sufficient testing in the recent past. Women who have undergone a hysterectomy that included removal of the cervix and do not have a history of abnormal Paps do not need Pap screening. Finally, women who have received the full HPV immunization series need to continue Pap screening. While HPV immunization decreases the number of future cervical cancer cases, it will not eliminate them entirely. ☺

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Table: A Comparison of 2012 Pap Screening Guidelines

|  | ACS-ASCCP-ASCP <sup>1</sup>  | USPSTF <sup>2</sup>                                   |
|--|--|---|
| Age to start screening   | 21 years   | 21 years  |
| Testing frequency for those between the ages of 21 and 29 years (Pap alone)          | Every 3 years  | Every 3 years   |
| Testing frequency for those 30 years and older (Pap alone or Pap and HPV co-testing) | Pap alone: every 3 years (acceptable); Co-testing: every 5 years (recommended)               | Pap alone: every 3 years<br>Co-testing: every 5 years |
| Age to stop screening  | At 65 years after 3 consecutive negative Pap results or 2 negative HPV tests in past 3 years | At 65 years, after adequate screening                 |
| After hysterectomy <sup>3</sup>  | Discontinue if no dysplasia or cancer  | Discontinue if no dysplasia or cancer                 |
| Screening after HPV <sup>4</sup> vaccine   | Same as unvaccinated women   | Same as unvaccinated women                            |

<sup>1</sup>ACS-ASCCP-ASCP = American Cancer Society, American Society for Colposcopy and Cervical Pathology, and American Society for Clinical Pathology. <sup>2</sup>USPSTF = United States Preventive Services Task Force. <sup>3</sup>Hysterectomy includes removal of the uterine cervix. If cervix not removed, age-based screening continues. <sup>4</sup>HPV = human papillomavirus.



# The Health of Migrant Women in Rural Communities

*Renée Bouvion  
Jesus Reyna*

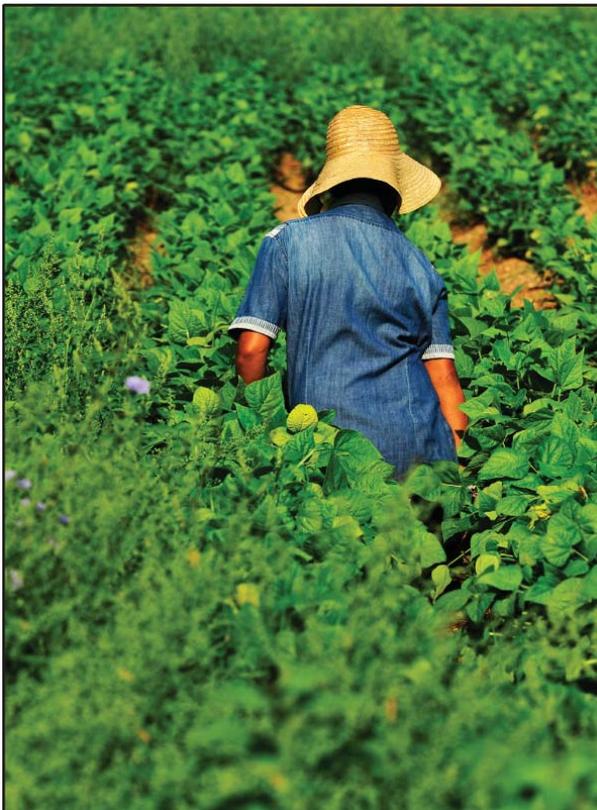
**M**igrant and seasonal farmworkers play a vital role in our region's agricultural industry and economy. Nationwide, women make up nearly a quarter of migrant and seasonal farmworkers.(1) Migrant women in rural communities face many challenges in maintaining their health and accessing health services. This article explores factors that affect migrant women's access to health services and programs that have been established to address the needs of this population.

## Who Are Migrant and Seasonal Workers?

The Public Health Service Act, which established services for migrant and seasonal agricultural workers in 1962, defines a migrant worker as someone whose principle employment is in agriculture, has been so employed in the last 24 months, and establishes for the purposes of employment a temporary abode. A seasonal farmworker is someone whose principle employment is in agriculture, has been so employed in the last 24 months, but does not move from place to place.

Estimating the number of migrant and seasonal farmworkers in the United States is difficult. It is thought that between three and five million migrant and seasonal farmworkers follow crops in the United States each year.(1) Data from a series of farmworker enumeration studies are available for a number of states. For the year 2000, Idaho had 54,659 migrant and seasonal farmworkers, Oregon had 103,453, and Washington had 289,235. Comparable data are not available for Alaska.(2) These data include both women and men: data specific to migrant women for the states of Region X (Alaska, Idaho, Oregon, and Washington) are not available.

According to the National Agricultural Workers Survey, migrant farmworkers across the United States are mostly foreign born, with 75% from Mexico. Most speak Spanish exclusively, with 18% speaking some English. The median level of completed education is sixth grade. It is estimated



that 30% of all farmworkers have total family incomes below the federal poverty level.(2)

### Health Issues of Migrant Women

Migrant women experience many obstacles to maintaining their health, including substandard housing and unsafe and unsanitary working conditions. The migrant farmworker population experiences higher rates of disease, including diabetes, cardiovascular disease, tuberculosis, and asthma.(3) Migrant women face addi-

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Migrant women experience many obstacles to maintaining their health, including substandard housing and unsafe and unsanitary working conditions.

tional health issues related to the lack of prenatal care, domestic violence, and sexual harassment and assault. (1) It is also thought that migrant women are at higher risk of contracting HIV and STDs due lack of education about contraception and preventive measures and use of sex workers by boyfriends and husbands.(4)

Factors that limit migrant women’s access to health services include lack of transportation, language barriers, time away from work due to health clinic service hours, and lack of insurance or other means to pay for services. (4, 5) Another factor that may lead to a hesitation among migrant women in accessing health services is a lack of trust, especially for women who are undocumented.

### Programs and Services for Migrant Women

Many organizations in rural communities have established programs and services to better serve migrant women. One of the primary sources of health care and information for migrant women is the Health Resources and Services Administration’s Migrant Health Center program. This program provides funding and support to health centers to provide preventive and primary care services to migrant and seasonal farmworkers and their families, with special attention to their specific needs. Health Resources and Services Administration’s community health centers also serve migrant and seasonal farmworkers. It is estimated that these health centers serve more than one quarter of migrant and seasonal farmworkers nationwide.(6)

### Promotoras

The Centers for Disease Control and Prevention’s policy brief, [Addressing Chronic Disease through Community Health Workers: A Policy and Systems-Level Approach](#), gives examples from across the country of how promotoras are being used to prevent chronic disease. It also includes resources for training and policy implementation.

Through [Promotores de Salud Initiative](#), the Office of Minority Health in the Department of Health and Human Services promotes the role of promotoras in health education, prevention, and increasing access to health insurance programs.

Oregon’s [Nuestra Comunidad Sana](#) uses promotoras in many of their projects.

[Moses Lake Community Health Center](#) has what is considered a model promotora program at their Quincy Clinic.

### Promotoras

Often health centers and other organizations that serve migrant women in our region use community health worker programs or promotoras as a way to extend their reach and provide health information to vulnerable population. Promotoras are lay community members trained to provide education and outreach about health issues and resources, as well as peer support. They are able to build relationships and establish trust because they understand the culture and speak the language of the communities they serve. The role of promotoras can vary but often includes linking individuals to the health care system, providing culturally appropriate health education, and informal counseling. Promotoras can be a key to linking underserved migrant women with the information and health care they need. (See box for additional information.)

In Region X, the recently established Women’s Health Leadership Institute in the Office on Women’s Health provides training to community health workers so that they can become effective leaders in addressing



the needs of their communities. In addition, the Office of Minority Health, through a partnership with local churches, provides health fairs and screenings to Latino communities throughout Washington. ☺

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#### RESOURCES

Centers for Disease Control and Prevention, Office of Minority Health and Health Equity  
Migrant Farmworker Stream Forums

[www.cdc.gov/minorityhealth/EOs/Farmworker.html](http://www.cdc.gov/minorityhealth/EOs/Farmworker.html)

Migrant Clinicians Network

[www.migrantclinician.org/](http://www.migrantclinician.org/)

National Center for Farmworker Health, Inc.

[www.ncfh.org/](http://www.ncfh.org/)

Rural Assistance Center

Migrant Health Resources

[www.raonline.org/topics/public\\_health/migrant.php](http://www.raonline.org/topics/public_health/migrant.php)

Women's Health Leadership Institute

[www.whli.org/](http://www.whli.org/)

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## Educación en la Estética/Education in the Beauty Salon: Increasing Latinas' Awareness of Emergency Contraception

*Adelaida Magallanes*

**A**s a medical student, I participated this past June in the University of Washington School of Medicine's Rural/Underserved Opportunities Program (R/UOP) (see box describing the program) at the Yakima Valley Farm Workers Clinic. The clinic, with locations throughout Washington and Oregon, provides health care for migrant and seasonal farm workers.

Latinos are the fastest growing minority group in the United States. It is estimated that by 2025, 25% of all teens will be Latino.(1) According to the United States Department of Health and Human Services, of the 6,923 births to women, aged 19 years and under, in Washington in 2009, approximately, 2,450 of those births were to

Rural/Underserved Opportunities Program (R/UOP) is a four-week elective rotation in community medicine completed the summer prior to second year of medical school. During their four-week rotation, students live in rural or urban underserved communities throughout Washington, Wyoming, Alaska, Montana, and Idaho (WWAMI). They work side-by-side with local physicians and learn about the challenges and rewards of practicing primary care medicine in these communities and how community health care systems function in those communities. Administered by the University of Washington Department of Family Medicine, R/UOP is a collaborative effort of the School of Medicine, WWAMI campuses, and Area Health Education Centers. Students receive stipends, travel money, and assistance with housing expenses. Most of student housing is donated by the communities. For more information, contact the R/UOP Administrative Offices.

Latinas. For the same year, in Oregon, 1,395 of the 2,353 births to women, aged 19 years and under, were to Latinas. In Idaho, 594 of the 2,053 births to women in this age range were to Latinas. In Alaska, Latinas accounted for 77 out of 1,114 births.

With the exception of Alaska, Latinas who first give birth under the age of 20 years are, on average, 20% more likely than non-Hispanic whites to give birth a second time.(2) In Washington, Yakima County ranks the third highest in overall teen births for all counties.(3)

I was reminded of these statistics while monitoring fetal heart rates of young, expecting Latinas receiving prenatal care at the clinic. After interviewing several of these young women about their thoughts on pregnancy and sex education, I decided to focus my R/UOP project on emergency contraception education.

The project consisted of a short, culturally relevant iPad presentation in Spanish given in the waiting area of a beauty salon that serves Yakima's Latino community. A total of six young Latinas, aged 13 to 26 years, who were waiting for salon services participated. Much of our discussion focused on emergency contraception's mechanism of action and side effects, and how to obtain emergency contraception. The goal was to provide adequate information about emergency contraception with the intention of empowering these young women to make the reproductive choices they feel are best for them and their families.

Connecting with these women in places where they feel comfortable and approaching the issue of emergency contraception from my own experiences as the daughter of Mexican immigrants proved to be very beneficial.



*Ade with her grandmother, Piedad Rodriguez*

Places such as Planned Parenthood can be intimidating at first, as mentioned by one woman who participated in the project.

Educación en la Estética may grow into a larger project where University of Washington medical students provide linguistically and culturally competent health education a couple times a month in settings like beauty salons in small towns east of the Cascade Mountains. ☺

*Adelaida Magallanes is a second year medical student at the University of Washington School of Medicine. Before becoming a medical student, Ade studied biology and Latin American studies at the University of San Francisco, California. Her academic interests include women's health and educational pipeline programs. Ade also enjoys writing, tweeting, and riding her bike.*

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## RESOURCES

The National Campaign to Prevent Teen and Unplanned Pregnancy

[www.thenationalcampaign.org/resources/pdf/FastFacts\\_TPChildbearing\\_Latinos.pdf](http://www.thenationalcampaign.org/resources/pdf/FastFacts_TPChildbearing_Latinos.pdf)

US Department of Health and Human Services: Office of Adolescent Health

[www.hhs.gov/ash/oah/adolescent-health-topics/reproductive-health/states/index.html](http://www.hhs.gov/ash/oah/adolescent-health-topics/reproductive-health/states/index.html)

County Health Rankings and Roadmaps

[www.countyhealthrankings.org/](http://www.countyhealthrankings.org/)

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## Internship Opportunity. . .

# Graduate Student Epidemiology Program

**T**he Graduate Student Epidemiology Program, sponsored by the Maternal and Child Health Bureau (MCHB), promotes student internships at state and local health agencies. Interns obtain experience with addressing specific, defined data or analytic issues while states and agencies get help with developing their Children with Special Health Care Needs information systems. Students receive a stipend of \$4,000 for a 12-week summer project from the bureau.

Internships offered this past summer included an analysis of congenital anomalies and infant and child mortality through Alaska State's Maternal and Child Health Epidemiology Unit, and Pregnancy Risk Assessment Monitoring System (PRAMS) analysis through the Oregon Public Health Division, Office of Family Health.

The deadline for agency proposals is November 16, 2012 for a summer 2013 project. Student applications open January 2, 2013.

[More information for agencies](#)

# Collaborations for Healthy Homes

Margo Young

The Federal Healthy Homes Workgroup defines a healthy home as one that is dry, clean, pest-free, safe, contaminant-free, well-ventilated, and thermally controlled. Health issues arise from peeling lead-based paint or dust, pesticide use, uncontrolled asthma triggers (ie, dust mites, fragrances, and dander), and mold due to excess moisture from leaks or substandard ventilation.

Women and children who live in rural, low-income, or ethnic minority communities are often disproportionately affected by environmental contaminants that can have a lasting impact on health. Stress, lack of political power, and reduced access to health care make vulnerable populations even more susceptible to these exposures.

It is critical that health professionals working with families in their homes recognize environmental hazards and understand the connection between exposures and health outcomes.

The table at right lists resources for training in order to help families mitigate problems and prevent additional exposures.

A growing body of research points to environmental factors as significant determinants of our health.

(1, 2) Given the budget climate and the overlapping nature of these environmental health issues, there is a critical need for increased collaborations between sectors, including public health, health care, environmental health, education, and social services. Through these collaborations we can prevent harmful environmental exposures in the home and keep Northwest children, families, workforce, and communities healthy. ☺

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Home in rural Alaska

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2. Federal Healthy Homes Workgroup. Advancing Healthy Homes. Available at [www.leadssafe.org/elements/uploads/files/fileManager/HHWGoverviewNAPA.pdf](http://www.leadssafe.org/elements/uploads/files/fileManager/HHWGoverviewNAPA.pdf) Accessed September 2012.

| Table. Environmental Health Training Resources |   |
|--|---|
| Stakeholder                                    | Professional Education  |
| Health care providers and clinic-based staff   | <ul style="list-style-type: none"> <li>• Learn the basics of environmental health and receive continuing education credits through <a href="#">Pediatric Environmental Health Online Training</a></li> <li>• Learn how to use the <a href="#">Pediatric Environmental Health Toolkit</a></li> <li>• Integrate the <a href="#">Pediatric Environmental Health History Form</a> into practices and protocols</li> </ul> |
| Public health nurses and social workers        | Take a <a href="#">Healthy Homes Training for Community Health Workers</a>  |
| Tribal and public housing staff                | Receive technical assistance and training to create healthy housing programs in your area through the <a href="#">National Center for Healthy Housing</a> and <a href="#">Tribal Healthy Homes Northwest</a>  |
| Environmental health staff                     | Take a Healthy Homes Training through the <a href="#">National Healthy Homes Training Center and Network</a>  |

# Improving Health Outcomes in Rural Areas through Technology

*Maria Campanaro*

**T**elehealth is the use of electronic information and telecommunications technologies to support long distance clinical health care, patient and professional health-related education, public health, and health administration.(1) One of the most famous and perhaps first examples of the use of telehealth in the Northwest Region was the application of a new telegraph system in 1925 to organize the emergency transfer of diphtheria serum from Anchorage to Nome by train and dogsled (over 1,000 miles total).

Telehealth remains especially useful in the sparsely populated, geographically isolated rural and frontier areas of this region. Geographic isolation poses significant challenges to ensuring that women and children in these areas have access to routine preventive care as well as acute medical and specialty care.

Rural health and telehealth intersect in fascinating programs all across the country. This article highlights three programs directly impacting women's health.

**Text4Baby** provides free text messages on prenatal care, baby health, and parenting. When a woman signs up, she receives three text messages per week throughout her pregnancy and until her baby is one year old. Messages are in both English and Spanish. Launched in 2010, the program is the result of a broad public-private partnership. The National Healthy Mothers, Healthy Babies Coalition develops the text-length messages and coordinates content review in collaboration leading federal agencies, health care providers, major medical associations, and national nonprofit organizations. A number of evaluations of the program are underway, including one at Madigan Army Medical Center in Tacoma, Washington.

## Telephysical Therapy in Alaska and Washington States

Alaska and Washington are the only states in the United States that have adopted licensure standards for physical therapists to provide services via telehealth.(2) With these standards in place, the rural Bristol Bay Area Health Corporation in Alaska has seen the practice of telephysical therapy grow. One physical therapist located in Dillingham, Alaska, is able to visit with patients in an area about the size of Ohio. Using current technologies, this physical therapist was able to evaluate a young female patient's low back pain and demonstrate her rehabilitation exercises and techniques.(3)

## Robotic Connections in Idaho, Oregon, and Washington States

Grande Ronde Hospital, located in La Grande, Oregon, has a telemedicine program that offers medical consults, specialty care, and education to rural areas of the region. In January 2009, the Oregon Medical Board made permanent a ruling to allow physicians to practice medicine across Oregon State lines. Central to the hospital's telemedicine program is an RP-7 robot called EDGAR. As an example, the robot is used in a maternity ward so that a new mother recovering from a delivery is able to see and talk to her premature baby at a children's hospital in Boise, Idaho, or Portland, Oregon, via the robot's monitor. Oregon is one of twelve states to require insurers to cover telemedicine—the only state to do so in Region X.(4)

## Telemedicine Abortions

Planned Parenthood of the Heartland offers medication abortions at their clinics via a secure, two-way video and audio conferencing system to women living in rural settings or areas that lack physicians. The conference system allows the physician to "meet" with a patient at a Planned Parenthood clinic, and a remote control system allows the physician to unlock a drawer so that the patient can access the medication. The physician observes the

patient swallow the medication and provides follow-up instructions. This telemedicine format is not only highly effective but also acceptable to patients.(5) Currently, Planned Parenthood of the Great Northwest is investigating the feasibility of a similar program in Alaska. ☺

*Maria Campanaro is an MPH student in the University of Washington Maternal and Child Public Health Leadership Training Program. She is interested in rural health and children's health.*

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5. Grossman D, Grindlay K, Buchacker T, et al. Effectiveness and acceptability of medical abortion provided through telemedicine. *Obstet Gynecol.* 2011;2(1):296-303. doi: 10.1097/AOG.0b013e318224d110

## Telehealth Programs at the University of Washington

The University of Washington offers many types of telehealth services, including 1) the Department of Medicine's Grand Rounds provided weekly via video teleconference to numerous sites in western Washington, 2) telepsychiatry consultation services provided by the Department of Psychiatry to Forks Hospital, and 3) multidisciplinary fetal diagnosis and therapy weekly case conferences via video teleconference between University of Washington Perinatal Medicine and Children's Hospital and Regional Medical Center, with plans to expand to rural and remote sites in Washington and the WWAMI region.

Two other University of Washington telehealth projects include [PROJECT ROAM](#) (Rural Opiate Addiction Management Project for Rural Washington Physicians) and [Project ECHO](#) (Extension for Community Healthcare Outcomes). The goal of Project ROAM is to decrease the rate of overdoses from prescription opiates in rural areas by training rural physicians in opioids and helping them apply for the waiver to legally prescribe buprenorphine. The project also helps community practices address non-clinical issues that may impede care for addiction. Project ECHO allows primary care providers to present via video conferencing their difficult chronic pain cases to a multidisciplinary panel of pain specialists. After Project ROAM trains clinicians, Project ECHO's multidisciplinary experts mentor them as they begin to treat addiction in their practices.

Contact Cara Towle at 206-744-6920 or at [ctowle@u.washington.edu](mailto:ctowle@u.washington.edu) for further information, to access current programming, to offer programming to remotes sites, or to develop new programs.

# Healthy Babies Are Worth the Wait

Gina Legaz

**N**ine months—to most people it defines the duration of a pregnancy. In the world of obstetrics, a full term pregnancy is considered 39 to 41 completed weeks (see glossary at end of article). Or, simply put, ten full months of pregnancy. Today, more than ever, this distinction has become an important one.

## More Babies Are Born Early

In recent years, there has been a dramatic increase in elective (non-medically indicated) inductions and cesarean deliveries prior to 39 weeks. Reasons for this increase are many. Advances in medicine, specifically neonatology, have created the expectation that babies born a little bit early will be fine. Women are giving birth later in life and may choose to schedule deliveries to accommodate their careers and busy lives. Carrying a baby is hard on a woman's body, especially at the end of a pregnancy.

A women may want the physician who has provided prenatal care throughout her pregnancy to deliver her baby. As a result, some physicians will schedule a delivery (early or not, and medically necessary or not) to accommodate a patient's request and their own schedules. Women living in rural areas may decide to schedule a delivery to avoid going into labor hours away from a birthing hospital. While there are medical indications for some early deliveries (the list continues to evolve), non-medically indicated early term deliveries are cause for concern.

New evidence has dramatically changed our understanding of the safety of these early term (37 to 38 completed weeks gestation) deliveries. A 2009 study in the *New England Journal of Medicine*, sponsored by the National Institutes of Health, discovered that rates of medical problems increased 50% for infants born at 38 weeks compared with infants born at 39 weeks. At 37 weeks, the risk increased by two-fold. We now know that the additional weeks of gestation provide benefits to a baby that can be measured as long as five to ten years after birth.

Concerned about a “slippery slope” of babies being delivered earlier and without sound medical reasons, the March of Dimes and its partners developed the “Healthy Babies Are Worth the Wait” campaign. The campaign concentrates on quality improvement efforts to reduce elective deliveries before 39 weeks, consumer and physician education, community programs, and national and state collaborations.



## Unique Rural Challenges

Rural areas pose different challenges to reducing early elective deliveries than urban areas. Often there are very few obstetricians in rural communities. This not only limits a woman's choice when selecting a physician but also makes it difficult to deliver every baby. What happens when the only obstetrician in town refuses to limit early elective deliveries and continues to schedule deliveries before 39 weeks? This is one of the reasons there are multiple approaches to reduce elective deliveries, including consumer education, physician education, and hospital quality improvement initiatives that facilitate physician oversight and the creation of hospital-wide policies.

Likewise, hospitals and their clinicians who care for pregnant women in rural areas have difficult decisions to make in regards to early deliveries because where a woman lives plays an important role in a her ability to get back to the hospital if her condition changes. What seems like an early elective delivery may become a medically necessary one in just a day or even a few hours. The difficulty of traveling back and forth from home to the hospital complicates the decision to wait or to deliver early for non-medically indicated reasons.

## Achievable Success

We have made tremendous strides in reducing the rate of early elective deliveries. There are still many reasons for an early delivery, including conditions that threaten the well-being of the mother and the baby. Ultimately, the decision to deliver a baby before 39 weeks needs to be made in collaboration between skilled obstetric and newborn providers together with the knowledge and consent of the mother. ☺

*Gina Legaz, MPH, State Director of Program Services and Government Affairs, Washington Chapter March of Dimes, is a native Washingtonian and a graduate of Gonzaga University in Spokane. In graduate school, Gina worked with the Confederated Tribes of Siletz Indians and Student Health Services. She spent nearly five years at the Washington Health Foundation before moving to the March of Dimes to focus on stronger, healthier babies.*

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Term birth is defined as 37 to 41 completed weeks of gestation. In the past, the 37 to 41 weeks were often lumped together and compared to earlier and later gestational ages to assess risks of morbidity and mortality.

A review of the history of the definition of term birth led Fleishman, Oinuma and Clark to conclude that it was determined somewhat arbitrarily.<sup>(1)</sup> In their 2010 commentary, they pointed to a growing body of evidence that suggests significant differences in birth outcomes within the five week period and suggested a new subcategory, "early term," to indicate 37 to 38 completed weeks gestation.

### Definitions:

**Preterm:** less than 37 weeks gestation

**Late preterm:** between 34 0/7 weeks and 36 6/7 weeks gestation

**Term:** between 37 0/7 and 41 6/7 weeks gestation

➤ **Early term:** between 37 0/7 and 38 6/7 weeks gestation

**Full term:** between 39 and 41 6/7 weeks gestation

**Post term:** 42 weeks gestation and beyond

**Elective induction of labor:** induction of labor without an accepted medical or obstetric indication before the spontaneous onset of labor or rupture of membranes

**Elective cesarean:** scheduled primary or repeat cesarean without an accepted medical or obstetric indication before the spontaneous onset of labor or rupture of membranes

**Scheduled:** a planned induction or cesarean scheduled for either elective or non-elective medically indicated reasons

### REFERENCE

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State Reports . . .

## Alaska Honored by the March of Dimes

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### Alaska Department of Health and Social Services

*Yvonne Wu Goldsmith*

Alaska has seen an increase in early term births (37 to 38 completed weeks gestation) from a low of 15.4% of all singleton births in 1980 to a high of 27.0% in 2005. In 2010, the proportion of early term singleton births in Alaska was 24.7%. An unknown portion of these were elective deliveries, ie, an induced or cesarean delivery done without a documented medical or obstetric indication.

We analyzed birth certificate data for 65,998 singleton births during 2005–2010 to estimate the proportion of non-medically indicated early term deliveries in Alaska.<sup>1</sup> A non-medically indicated (elective) early term birth was defined as either an induced vaginal birth or a cesarean birth where no medical conditions affecting the pregnancy and no complications of labor or delivery were documented on the birth certificate.

During this time period, 25.9% of births were early term and 3.7% were elective early term. The proportion of elective early term births ranged from 0.7% to 16.9% in the six in-state birthing hospitals where 65% of Alaska’s resident births occur.

We matched births to Medicaid records. Forty-four percent of 2010 elective early term births and full term births (those with no medical or obstetric conditions noted on the birth certificate) matched to Medicaid records. The average claim amounts were \$22,711 for elective early term births compared to \$7,122 for full term births (39 to 41 completed weeks gestation).

Among the births that matched to Medicaid, a larger proportion of elective early term births were repeat cesarean births, compared to the full term births (39.8% vs. 6.5%, respectively). This may be explained by the fact that failed early term elective inductions result in cesarean births and many elective repeat cesarean births

are scheduled prior to 39 weeks.

These findings demonstrate an opportunity to improve hospital standards regarding elective early term deliveries. One option is for hospitals to prohibit elective early term elective deliveries.

Preterm birth (less than 37 weeks gestation) rates in Alaska during 2000-2010 averaged 15% below the national rate. In 2010, the rate dropped by 11.8% from the previous year. For this achievement, Alaska was one of two states honored by the March of Dimes for achieving their challenge of reducing preterm births by at least 8%. ☺

*Yvonne Goldsmith, MS, tracks health indicators and engages in research on maternal, child, and family health for the Alaska Department of Health and Social Services, Division of Public Health. She also serves on the editorial board of the Northwest Bulletin: Family and Child Health.*

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<sup>1</sup>A limitation of our analysis is that we used the absence of birth certificate documentation of “medical indication” as a proxy for an “elective” delivery. Thus, we might have overestimated the number of elective births as some complications are not listed on the birth certificate form.

# Reducing Preterm Births: A Focus on Frontier Counties

Idaho Department  
of Health and Welfare

*Jacquie Daniel-Watson*

The Idaho Division of Public Health has joined the partnership between the March of Dimes and the Association for State and Territorial Health Officers to reduce preterm births (less than 37 weeks gestation) and ensure more healthy births in Idaho. As part of this partnership, Idaho has accepted the challenge to reduce the state's preterm birth rate by 8% by 2014.

Although Idaho fairs better than the nation on rates of preterm birth, there is still work to be done. In 2009, the state's preterm birth rate was 10.1% of live births compared with the national rate of 12.2%. An 8% reduction by 2014 would result in approximately 200 fewer preterm births statewide.(1)

The division has begun work with the local March of Dimes chapter on the "Healthy Babies are Worth the Wait" campaign to encourage pregnant women and health care providers to wait until labor occurs naturally or until 39 weeks gestation before inducing delivery. In Idaho, during the past 20 years (from 1990 to 2010):

- ◆ the induction of labor rate more than doubled from 11.1% to 27.7%
- ◆ the percent of babies born prior to 39 weeks gestation increased by 39%, from 25.6% to 35.6%
- ◆ the cesarean rate increased by 31%, from 18.9% to 24.7% of deliveries (2)

An analysis of Idaho birth data indicate approximately 8% of all births delivered prior to 39 weeks gestation were induced without medical or obstetric indication. Further analysis using the infant's location of birth indicates that in frontier counties, 14.6% of births were induced without medical or obstetric indication prior to 39 weeks gestation. This rate is nearly double that of urban counties (7.7%). When compared with rural

counties, frontier counties still had a rate 1.7 times higher for elective induction prior to 39 weeks gestation (8.4% versus 14.6%, respectively).(2) Some research indicates that women living in rural and frontier areas may choose elective deliveries to plan for long travel distances or mitigate the risk of winter travel.(3) As the Idaho Division of Public Health and March of Dimes work together on this effort, special attention will be focused on families and providers in frontier areas. ☺

*Jacquie Daniel-Watson manages the Maternal and Child Health Program at the Idaho Department of Health and Welfare and is the Title V Children with Special Health Care Needs director for Idaho State. Prior to this, she managed the Idaho Pregnancy Risk Assessment Tracking System, a significant source of maternal and perinatal data for the state.*

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## REFERENCES

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2. Idaho Vital Statistics 2010, Idaho Department of Health and Welfare, Division of Health, Bureau of Vital Records and Health Statistics, February 2012.
3. Kornelsen J, Grzybowski S. The reality of resistance: The experiences of rural parturient women. *J Midwifery Wom Heal.* 2010;51(4):260-265.

Note: Hospital discharge data are not available at the state level. Analysis of birth certificate data using an algorithm was used as a proxy measure for elective inductions prior to 39 weeks gestation.

# Healthy Babies are Worth the Wait: The Oregon Community Challenge

Oregon Department  
of Human Services

*Joanne Rogovoy*

In the year 2010, there were 45,540 live births in Oregon. Of these, 4,529 (9.9%) were infants delivered before 39 weeks gestation, including some who were delivered for no known medical or obstetric reason. The “Healthy Babies are Worth the Wait: Oregon Community Challenge” is an effort to eliminate elective deliveries before 39 weeks gestation. It is a partnership between the Oregon Chapter of the March of Dimes, the Oregon Health Leadership Council, and the Oregon Health Authority.

## Hard Stop Policy

The Oregon Community Challenge was delivered to all chief executive officers and lead obstetricians at Oregon hospitals who provide delivery services. It asked them to adopt a hard stop on early elective deliveries by September 1, 2011.

A “hard stop” refers to a policy to deny requests made to labor and delivery units to schedule a delivery by labor induction or cesarean without documented medical necessity. By December 2011, 33 out of 53 hospitals that offer birthing services in the state had signed onto the challenge.

The Oregon Perinatal Collaborative Steering Committee, funded by the March of Dimes and Regence Foundation, assists hospitals that have committed to implementing hard stop policies and works to secure hard stop commitments from remaining hospitals in the state. The committee is a partnership between the Oregon Chapter of the March of Dimes, the Oregon Health Leadership Council, the Oregon Association of Hospitals and Health Systems, the Doctors Company, and the Oregon Q Corporation.

## Public Education Campaign

In conjunction with the challenge to providers and hospitals to adopt a hard stop policy, “Healthy Babies are Worth the Wait: Oregon Community Challenge” includes two public education campaigns:

- ◆ an announcement in the media of the challenge to hospitals with a list of hospitals that have agreed to the hard stop policy.
- ◆ a media campaign directed at women of childbearing age and their partners about the importance of the last weeks of pregnancy for the development and well-being of the fetus. The media messages were designed to educate families and show support for the hospitals’ and providers’ decisions to stop early elective deliveries in Oregon.

The Oregon Health Authority has accepted the Association of State and Territorial Officials and the March of Dimes challenge to reduce preterm births by at least 8% by 2014. With the “Healthy Babies are Worth the Wait: Oregon Community Challenge” in place nearly a year before the March of Dimes challenge, we believe we are on the way to significantly reducing late preterm births by eliminating elective deliveries. ☺

*Joanne Rogovoy is the state director of Program Services and Government Affairs, March of Dimes Foundation Greater Oregon Chapter. She has been with the March of Dimes Oregon Chapter for 30 years.*

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## RESOURCES

[www.prematurityprevention.org](http://www.prematurityprevention.org)  
[www.marchofdimes.com](http://www.marchofdimes.com)

# Perinatal Collaborative Leads Efforts to Reduce Preterm Births

Washington State  
Department of Health

*Bat-Sheva Stein*

**E**arly term elective deliveries increase the likelihood of cesarean section, breathing problems for the infant or the need for a ventilator, feeding difficulties, need for neonatal intensive care, likelihood of infection, and risk of newborn death.(1) In contrast, benefits of full term deliveries are bigger bodies and adequate body fat for temperature regulation and strength; bigger and more developed brains, ears, lungs, eyes and livers; greater ability to suck and swallow, which improves feeding; and better developed reflexes.

Since 1979, the American College of Gynecology has cautioned against elective inductions before 39 weeks gestation. Despite this, deliveries before 39 weeks rose nationally between 1990 and 2009, from 9.5% to 23.2%. (2) Factors that influenced this rise include a woman's desire to be delivered by her own provider, maternal intolerance to late pregnancy, prior experience with complex pregnancies and deliveries, physician convenience, and living at great distance from the birthing hospital.

## Washington State Perinatal Collaborative

The Washington State Perinatal Collaborative, a voluntary group of individuals and organization, including birthing hospitals, Washington State Hospital Association, March of Dimes, Washington State Department of Health, Washington State Healthcare Authority, and Medicaid, promotes statewide perinatal quality improvement by forming leadership groups and coordinating quality improvement projects.

In 2010, 24% (20,736) of births in Washington were early term. That year, the collaborative launched an initiative to reduce elective deliveries prior to 38 completed weeks gestation. Hospitals participating in the initiative were educated on best practices to reduce elective early term deliveries and how to collect and submit their chart-abstracted data to the Washington State Hospital Association's database. Through 2011, elective deliveries at 37 to 38 completed weeks gestation declined from 14.8% to 5.4 % in 46 hospitals represent-

ing 88% of births in the state. In 2012, a number of rural hospitals joined the initiative. Hospital specific elective delivery rates are available at [www.wahospitalquality.org/](http://www.wahospitalquality.org/) Other hospital reports are available at <http://hrsa.dshs.wa.gov/evidencebasedmedicine/obdsr2.shtml>.

## Challenges for Rural Hospitals

Rural hospitals and smaller delivery hospitals experience challenges in reducing their elective early term deliveries, including lack of physician champions to adopt the recommended policies, lack of a system to over-ride policies when they threaten the well-being of the mother or baby, and lack of required staff time for data abstraction and submission.

Washington is working to launch the March of Dimes "Healthy Babies are Worth the Wait" campaign and hopes to continue to track progress and reduce elective deliveries through the end of 2013. At that point, the collaborative will launch statewide labor management standards in an effort to reduce unnecessary cesarean deliveries. ☺

*Bat-Sheva Stein RN, MSN, is a public health nurse consultant with the Washington State Department of Health.*

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1. Oshiro BT, Henry E, Wilson J, Branch DW, Varner MW. Decreasing Elective deliveries before 39 weeks of gestation in an integrated healthcare system. *Obstet Gynecol.* 2009;113:804-11.
2. National Center for Health Statistics. Vital Statistics Reports, Volume 60, Number 1, Births: Final Data for 2009. Published on November 3, 2011, accessed on August 5, 2012.



# Maternal and Child Public Health Leadership Training Program

## Welcome to the Maternal and Child Public Health (MCH) Leadership Training Program 2012 Cohort

**Tess Abrahamson-Richards** has worked as a research assistant with the Monitoring the Abuse of Drugs Project at the Northwest Tribal Epidemiology Center, Northwest Portland Area Indian Health Board, and as home visitor for the Warm Springs Early Head Start Program. While in the MCH Program, she would like to participate in research evaluating the adaptation of evidenced-based practices to family-centered community health programs located at American Indian reservations. Her career goals center on tribal maternal and child health leadership and advocacy.

**Arti Desai** earned a medical degree from Wayne State University School of Medicine, Detroit, Mich., and completed her internship and residency in pediatrics at Lucile Packard Children's Hospital at Stanford University, Palo Alto, Calif. While in the MCH Program, she would like to strengthen her skills in research methodology in health disparities, health policy, and cost-effective analysis. She intends to focus on parenting interventions in early childhood that target vulnerable communities.

**Rubee Dev** earned a BS in nursing from the BP Koirala Institute of Health Sciences in Nepal. As a nursing instructor at Kathmandu University School of Medical Sciences, she visited rural areas and understands the neglect of women's health in Nepal. Her goal is to use research skills learned in the MCH Program to understand what prevents poor, rural women in Nepal from demanding, accessing, and using health services.

**Avanthi Jayasuriya** has worked as a Reach Out and Read Manager at SeaMar Community Health Centers with AmeriCorps/HealthCorps. She has also worked as a clinical research coordinator at the University of Michigan Health System's General Oncology and Cancer Prevention Lab. One of her goals is to develop cost-effective, evidence-based programs to improve the development of infants and children pre- and post-partum within underserved minority and immigrant populations.

**Aleen Raybin** has experience with preventing teen pregnancy and relationship abuse. She worked as a

sexual assault and violence prevention educator for the University of California, Santa Cruz. She also taught a life skills workshops and directed a youth mentoring program at the Walnut Avenue Women's Center. Her ultimate goal is to develop preventive intervention programs for adolescents, especially those focused on preventing dating violence.

**Kari Sims** is a concurrent degree student with the University of Washington School of Dentistry, where she is completing a residency in pediatric dentistry. She grew up in a small town in central Wyoming that was surrounded by the Wind River Indian Reservation and saw the challenges residents faced when it came to accessing health and dental care. She ultimately wants to advocate for oral health programs and policies in rural parts of the United States.

**Jane Stieber** is a concurrent degree student in the University of Washington School of Dentistry where she is completing a residency in pediatric dentistry. As a dental student, Jane participated in a National Institutes of Health research program that provided dental care at a summer camp for children with special health care needs. She plans to work with socio-economically disadvantaged families and communities to decrease risks for poor oral health. She plans on eventually working for a public health or community-based agency and later would like to focus on advocacy and education.

For more information and to apply to the Maternal and Child Public Health Leadership Training Program, go to <http://depts.washington.edu/mchprog/>

## Local and State Agency Support. . .

### Maternal and Child Health Practicum

The Maternal and Child Public Health Leadership Training Program offers several stipends to students who complete community-based practicums with government programs that support maternal and child health. Local and state agencies who host a practicum receive assistance with a project of value to the agency. Students participating in a practicum further develop skills or competencies in program planning and evaluation, data analysis, and policy development.

Past practicum projects have included early identification of children with special health care needs at the Washington State Department of Health, reducing exposure of children to lead from non-environmental sources at the US Environmental Protection Agency,

Region X, and evaluation of the effectiveness of an intervention using the Children with Special Health Care Needs National Performance Measures at Public Health - Seattle and King County.

For more information about hosting a maternal and child health practicum student, contact Carmen Velasquez at [carmv@u.washington.edu](mailto:carmv@u.washington.edu).

Maternal and Child Public Health Leadership Training Program



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## On-Line Resources. . .

### Two New Toolkits: Effective Presentations and Adult Learning

How do you best reach adult learners when you are teaching a class, delivering a workshop, or offering a training? How do you give a presentation that resonates with your audience? The Northwest Center for Public Health Practice has developed two new toolkits to help answer those questions. The toolkits are available for download at no cost.

Both toolkits were developed in partnership with The Network for Public Health Law and funded by the Robert Wood Johnson Foundation, to support the development of trainings in public health law. Although examples in the toolkits relate to public health law, they are designed to be useful for all types of public health trainings and presentations.

[Effective Presentations: A Toolkit for Engaging an Audience](#) covers topics such as how to choose your material, tell a story, speak effectively, and make effective presentation slides. An accompanying PowerPoint slide set offers helpful diagrams and displays that can be easily customized for your presentation.

[Effective Adult Learning: A Toolkit for Teaching Adults](#) covers topics such as defining your audience, choosing the right instructional methods, and facilitating effectively. Included is in-depth instruction on how to write learning objectives and avoid common mistakes.



Northwest Center for Public Health Practice  
School of Public Health, University of Washington

## Resources . . .

Alaska Office of Rural Health  
State of Alaska Health and Social Services  
[www.hss.state.ak.us/dph/healthplanning/rural-health/default.htm](http://www.hss.state.ak.us/dph/healthplanning/rural-health/default.htm)

Idaho Rural Health Association  
[www.idahorha.org/](http://www.idahorha.org/)

National Center for Frontier Communities  
[www.frontierus.org/index-current.htm](http://www.frontierus.org/index-current.htm)

National Organization of State Offices of Rural Health  
[www.nosorh.org/](http://www.nosorh.org/)

National Rural Health Association  
[www.ruralhealthweb.org/](http://www.ruralhealthweb.org/)

National Rural Health Resource Center  
[www.ruralcenter.org/](http://www.ruralcenter.org/)

National Rural Recruitment and Retention Network  
[www.3rnet.org/default.aspx](http://www.3rnet.org/default.aspx)

Office of Rural Health Policy  
Health Resources and Services Administration  
US Department of Health and Human Services  
[www.hrsa.gov/ruralhealth/](http://www.hrsa.gov/ruralhealth/)

Rural Assistance Center  
[www.raconline.org/](http://www.raconline.org/)

Rural Health Research Findings  
Agency for Healthcare Research and Quality  
US Department of Health and Human Services  
[www.ahrq.gov/browse/ruralra.htm](http://www.ahrq.gov/browse/ruralra.htm)

Rural Health Section  
Washington State Department of Health  
[www.doh.wa.gov/hsqa/ocrh/](http://www.doh.wa.gov/hsqa/ocrh/)

Office of Rural Health and Primary Care  
Idaho Department of Health and Welfare  
<http://healthandwelfare.idaho.gov/default.aspx-?TabId=104>

Oregon Office of Rural Health  
Oregon Health and Science University  
[www.ohsu.edu/xd/outreach/oregon-rural-health/index.cfm](http://www.ohsu.edu/xd/outreach/oregon-rural-health/index.cfm)

Rural and Urban Women. Women's Health USA 2011  
[www.mchb.hrsa.gov/whusa11/popchar/pages/103ruw.html](http://www.mchb.hrsa.gov/whusa11/popchar/pages/103ruw.html)

Rural Women's Health Project  
[www.rwhp.org/](http://www.rwhp.org/)

What is Rural?  
United States Department of Agriculture  
National Agriculture Library  
[www.nal.usda.gov/ric/ricpubs/what\\_is\\_rural.shtml](http://www.nal.usda.gov/ric/ricpubs/what_is_rural.shtml)

Women's Health. Rural Assistance Center  
[http://www.raconline.org/topics/public\\_health/womenshealth.php](http://www.raconline.org/topics/public_health/womenshealth.php)

Women's Health Issues. National Rural Health Association  
[www.ruralhealthweb.org/go/rural-health-topics/women-s-health/women-s-health-issues](http://www.ruralhealthweb.org/go/rural-health-topics/women-s-health/women-s-health-issues)

WWAMI Rural Health Research Center  
<http://depts.washington.edu/uwrhrc/index.php>



MCH Navigator is a portal to training opportunities for maternal and child health professionals and students. On the website, you will find archived webcasts and webinars, instructional modules and self-guided short courses, video and audio recordings of lectures and presentations from university courses and conferences.

*Chart your professional growth pathway*  
MCH Navigator helps you determine where you are now, where you want to be, and the best route to get there. You can identify the skills and competencies needed to meet your goals and find the learning resources appropriate for those goals. Learning categories include: MCH 101, MCH conceptual models, management, communication, epidemiology, leadership, MCH planning cycle, and targeted MCH populations and topics.

MCH Navigator  
<http://navigator.mchtraining.net/>