OUR MISSION

MARCH OF DIMES LEADS THE FIGHT FOR THE HEALTH OF ALL MOMS AND BABIES.

TOO MANY TRENDS IN THE WRONG DIRECTION

PRETERM BIRTH RATES have risen for 3 consecutive years

INFANT MORTALITY RATES unacceptably high in many communities

OPIOID EXPOSURE rising among newborns

STARK DISPARITIES in maternal-child outcomes among African American women and babies

2

OUR CURRENT FOCUS

THE MATERNAL HEALTH CRISIS

OVER 700 WOMEN die in the US each year from complications related to childbirth.

2 WOMEN will die from childbirth in the US today. And every day.

50,000 WOMEN in the USsuffer life-threatening complications every year during pregnancy.

WOMEN OF COLOR share over 3X more likely than white women to die from pregnancy-related causes.

3

#BlanketChange

WHAT IS MARCH OF DIMES DOING AROUND HEALTH EQUITY?

CONVENING	IMPLEMENTING	DRIVING CHANGE
Bringing partners together	Developing & delivering programs	Using data to address disparities

4

CT 17P/LOW DOSE ASPIRIN CPQC WORKGROUP

- Chris Nold, MD – Hartford Health Care (HHC)
- Beth Deckers, MD – HHC
- Erica Hammer, MD – HHC
- Veronica Pimentel, MD –St. Francis
- Mary Beth Janicki, MD – St. Francis
- Shefali Pathy, MD – Yale New Haven Health (YNHH)
- Doreen Picagli, DNP, APRN – Yale Women's Health Center
- Jordana Frost, DrPH, MPH – March of Dimes
- Chris Morosky, MD - UCONN Health & Co-Chair of Connecticut Perinatal Quality Collaborative (CPQC)*

* CPQC is staffed and administered by Connecticut Hospital Association (CHA)

MARCH OF DIMES

Connecticut Perinatal Quality Collaborative

An initiative of the Connecticut Hospital Association, focused on:

- Promoting high quality maternal and newborn care
- Cooperation between hospitals and providers
- Supporting evidence-based practices
- Sharing educational and training resources
- Gathering critical data

CT ACTIVITIES THUS FAR

- 2015 – March of Dimes issued Prematurity Prevention Intervention Roadmap, which included 17P and Low Dose Aspirin
- Spring 2017 – Developed workgroup as part of CPQC
- Fall 2017 – Collected provider survey responses
- Jan. 2018 – Hosted provider educational conference through CPQC
- Nov. 2018 – Participated in regional convener meeting (CT, MA, RI, NY) hosted by March of Dimes

MARCH OF DIMES

7

LOW DOSE ASPIRIN FOR PREVENTION OF PREECLAMPSIA AND WOMEN'S CARDIAC HEALTH REGIONAL CONVENER

NOVEMBER 27TH 2018
BURLINGTON, MA

CT, MA, NY, RI

CARDIOVASCULAR DISEASE IN PREGNANCY

Dr. Nandita Scott, MD, FACC

Co-Director - MGH Corrigan Women's Heart Health Program
Cardiovascular Disease and Pregnancy Program

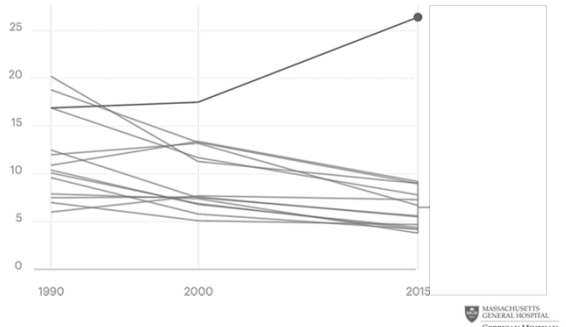
TREND IN MATERNAL MORTALITY

Pregnancy-related death has more than doubled over the past 25 years.

Pregnancy-related mortality ratio is the number of pregnancy-related deaths per 100,000 live births. A pregnancy-related death is the death of a woman during pregnancy or within one year of the end of pregnancy from a pregnancy complication, a chain of events initiated by pregnancy, or the aggravation of an unrelated condition by the physiologic effects of pregnancy. Source: CDC. 1987-2013 (http://www.cdc.gov/reproductivehealth/maternalinfanthealth/pmss.html)
Prepared by March of Dimes Perinatal Data Center, March, 2018.

MARCH OF DIMES

Maternal Mortality in Developed Countries



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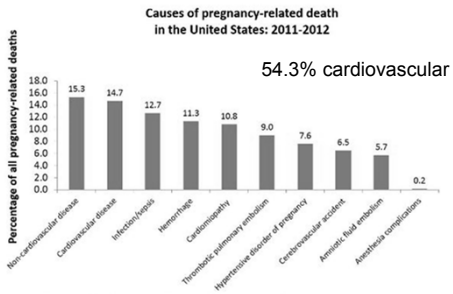
CORRIGAN MINEHAN HEART CENTER

11

Causes of Pregnancy –Related Death CDC data



54.3% cardiovascular cause

Note: The cause of death is unknown for 6.2% of all pregnancy-related deaths.

SACHUSETTS ERAL HOSPITAL
RIGAN MINEHAN HEART CENTER

12

Background

- As maternal age advances, preexisting heart conditions more likely
- Rise in multifetal pregnancies
- Increase in obesity and diabetes in population increase risk of CV complications during pregnancy
- Patients with congenital heart disease are surviving to reproductive age
- Childhood cancer survivors with cardiotoxic effects from therapy

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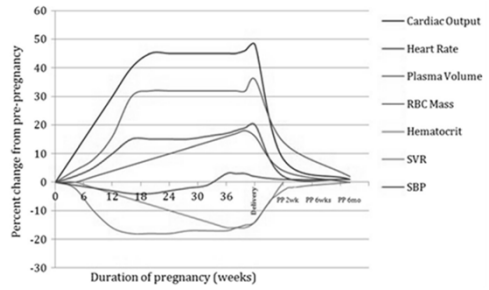
CORRIGAN MINEHAN HEART CENTER

Normal Hemodynamics of Pregnancy



Yucel E, DeFaria Yeh D. Curr Treat options CardioMed 2017

14

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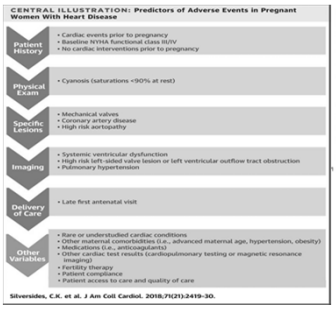
How to Risk Stratify



PREDICTOR	POINTS
Prior cardiac events or arrhythmias	3
Baseline NYHA III-IV or cyanosis	3
Mechanical valve	3
Ventricular dysfunction	2
High risk left-sided valve disease/ left ventricular outflow tract obstruction	2
Pulmonary hypertension	2
Coronary artery disease	2
High risk aortopathy	2
No prior cardiac intervention	1
Late pregnancy assessment	1

Risk of Primary Cardiac Event:

0-1 – 5%

2 – 10%

3 – 15%

4 – 22%

> 4 – 41%

Silversides et al. JACC 2018 71 (21): 2419-2430

15

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Modified WHO Classification of Pregnancy Risk					
	mWHO 1	**mWHO II**	**mWHO II-III**	**mWHO III**	**mWHO IV**
Diagnosis	Mild PS small PDA MVP repaired ASD/VSD/PDA Ectopy	ASD/VSD Repaired ToF Turner with normal aorta Most arrhythmias	Mild LV EF impairment HCM Native or tissue valve disease not WHO 1 or IV Marfan without dilatation Aorta < 45 in BAV AVSD Repaired coarctation	Moderate LV systolic dysfunction Prior PPCM with normal LV EF Mechanical valve Fontan circulation Moderate MS Severe AS Moderate Aortic dilatation in Marfan or BAV VT Systemic RV Unrepaired cyanotic	PAH LV EF < 30% Prior PPCM with impairment Severe MS Severe symptomatic AS Systemic RV with moderate or more impairment Severe aortic dilatation Vascular EDS Severe coarctation Fontan with any complication
Mortality Risk	None	Small increase	Intermediate	Significant increased	Extremely high
Morbidity Risk	No/mild	Moderate	Moderate to severe	Severe	Severe
Maternal cardiac event rate	2.5 – 5%	5.7-10.5%	10-19%	19-27%	40-100%
Care During Pregnancy	Local	Local	Referral hospital	Expert center	Expert center
Followup	Once or twice	Once per trimester	Bimonthly	Monthly or bimonthly	Monthly

16

Mode of Delivery

- Vaginal delivery remains optimal method of delivery
- Cesarian section increases risk of maternal infection, has greater hemodynamic shifts and blood loss, risk of surgical injury and greater risk for thrombotic events
- Option for assisted 2nd stage
- No consensus absolute contra indications to vaginal delivery, in a few unique situations, can be considered first
  - preterm labor in the presence of full oral anticoagulation
  - Marfans with aorta over 45 mm
  - Acute or chronic aortic dissection
  - Intractable heart failure

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17

Multidisciplinary Care

- Managing pregnant women with heart disease implicates several stakeholders, all with different perspectives but COMMON goals
- Team should include Cardiologist with expertise, OB anesthesia, Maternal-Fetal Medicine and Nursing
- Meet regularly to discuss, anticipate and plan for any potential difficulties

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18

Hypertensive Disorders of Pregnancy

- Preeclampsia (5% incidence) can lead to significant pregnancy complications:

IUGR	Preterm birth	Hemorrhage
Placental Abruption	Ruptured Liver	Eclampsia
		Renal failure

- Preeclampsia responsible for 50,000 to 60,000 deaths worldwide and there are many near misses that result in significant health risk and care cost
- Preeclampsia is a risk factor for future cardiovascular and neurological disease
- Etiology remains unclear

20

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How can we prevent preeclampsia?

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CORRIGAN MINEHAN HEART CENTER

B= high certainty that net benefit is moderate, or moderate certainty that net benefit is moderate to substantial

July 2018

The American College of Obstetricians and Gynecologists
WOMEN'S HEALTH CARE PHYSICIANS

Society for Maternal-Fetal Medicine
High-risk pregnancy experts

ACOG COMMITTEE OPINION

Number 743

Committee on Obstetric Practice
Society for Maternal–Fetal Medicine

This Committee Opinion was developed by the Committee on Obstetric Practice in collaboration with committee member T. Flint Porter, MD, and the Society for Maternal-Fetal Medicine in collaboration with members Cynthia Gyamfi-Bannerman, MD, MS, and Tracy Manuck, MD.

Low-Dose Aspirin Use During Pregnancy

"Low dose aspirin prophylaxis is **recommended** in women at **high risk** of preeclampsia and should be initiated...optimally before 16 weeks and continued daily until delivery"

"Low dose aspirin prophylaxis should be **considered** for women with **more than one...moderate** risk factor for preeclampsia"

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CORRIGAN MINEHAN HEART CENTER

Who should receive low dose aspirin?

Risk Level	Risk Factors	Recommendation
High	History of Preeclampsia	Low dose aspirin if any one of these risk factors
	Multifetal gestation	
	Chronic hypertension	
	Diabetes	
	Renal disease	
	Autoimmune disease	
Moderate	Nulliparity	Low dose aspirin if "several" of these risk factors
	Obesity	
	Family history (mother, sister)	
	Socio economic factors	
	Age ≥ 35 Personal history(low birthweight or SGA, prior adverse pregnancy outcome, interpregnancy interval > 10 years	
Low	Previous uncomplicated full term delivery	Do not recommend low dose aspirin

THE BOSTON MEDICAL CENTER PRENATAL ASPIRIN PROJECT

Dr. Jodi Abbott, MD, MSc, MHCM
Asst. Dean for Patient Safety and Quality Improvement
Boston Medical Center (BMC)

Epidemiology

National

- Preeclampsia in 2-5% of all pregnancies in the U.S.
- Leading cause of maternal morbidity and up to 19% maternal mortality
- Rates of hypertension in pregnancy are increasing

BMC

- Approximately 30% of pregnancies complicated by preeclampsia/ Gestational HTN and/or IUGR
- Approximately 40% of preterm births are due to preeclampsia/ Gestational HTN and/or IUGR

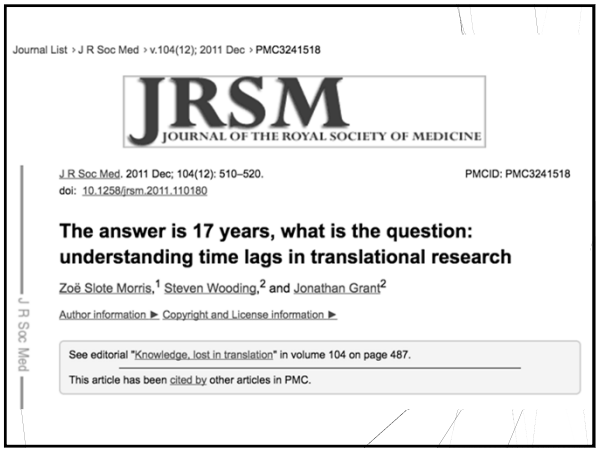
Epidemiology

National

- Preeclampsia in 2-5% of all pregnancies in the U.S.
- Leading cause of maternal morbidity and up to 19% maternal mortality
- Rates of hypertension in pregnancy are increasing

BMC

- Approximately 30% of pregnancies complicated by preeclampsia/ Gestational HTN and/or IUGR 33%
- Approximately 40% of preterm births are due to preeclampsia/ Gestational HTN IUGR 40%


Journal List › J R Soc Med › v.104(12); 2011 Dec › PMC3241518

JRSM
JOURNAL OF THE ROYAL SOCIETY OF MEDICINE

J R Soc Med. 2011 Dec; 104(12): 510–520. PMCID: PMC3241518
doi: 10.1258/jrsm.2011.110180

The answer is 17 years, what is the question: understanding time lags in translational research

Zoë Slote Morris,[1] Steven Wooding,[2] and Jonathan Grant[2]

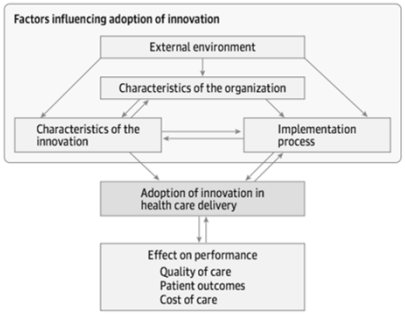
Author information ► Copyright and License information ►

See editorial "Knowledge, lost in translation" in volume 104 on page 487.

This article has been cited by other articles in PMC.

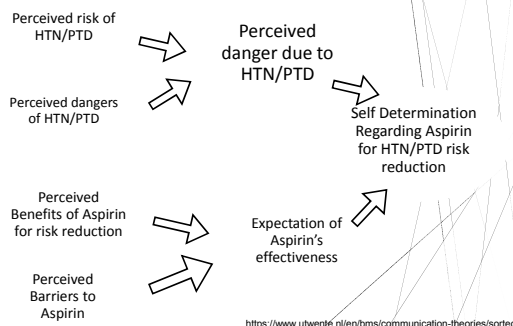
J R Soc Med

Framework for Analyzing the Adoption of Innovations

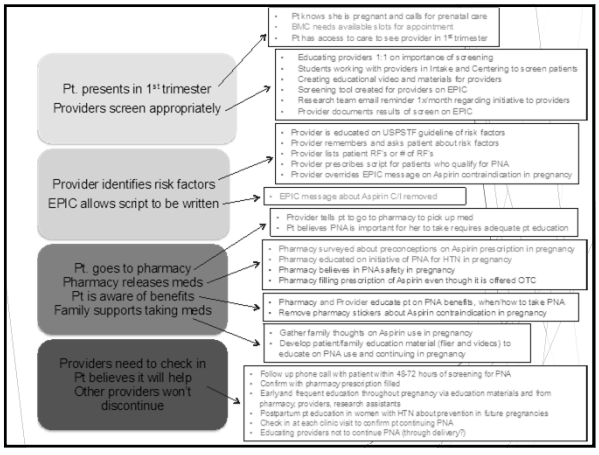


Fisher, Elliott S., Stephen M. Shortell, and Lucy A. Savitz. "Implementation science: A potential catalyst for delivery system reform." JAMA 315.4 (2016): 339-340.

Health Belief Model Applied to Aspirin



https://www.utwente.nl/en/bms/communication-theories/sorted-by-cluster/Health%20Communication/Health_Belief_Model/



Cochrane Effective Practice and Organisation of Care

Trusted evidence.
Informed decisions.
Better health.

Classification of Professional interventions

- DISTRIBUTION OF EDUCATIONAL MATERIALS
- EDUCATIONAL MEETINGS
- LOCAL CONSENSUS PROSESSES
- LOCAL OPINION LEADERS
- PATIENT MEDIATED INTERVENTIONS; NEW INFORMATION FROM PATIENT COLLECTED INFORMATION
- AUDIT AND FEEDBACK
- REMINDERS (PROMPTS)
- MARKETING
- MASS MEDIA

EPOC TAXONOMY: Cochrane Effective Practice and Organization of Care

Cochrane Effective Practice and Organisation of Care

Trusted evidence.
Informed decisions.
Better health.

Classification of Professional interventions

- DISTR
- EDU
- LOC
- LOC
- PAT… ECTED
  INFO
- AUD
- REM
- MAR
- MASS

Most Effective:

HARD STOPS IN THE EHR
AUDIT AND FEEDBACK

EPOC TAXONOMY: Cochrane Effective Practice and Organization of Care

Preeclampsia, gHTN, and/or IUGR in current pregnancy

- 83 cases of the following:
  - 24 cases of preeclampsia
  - 37 cases of gHTN
  - 24 cases of IUGR

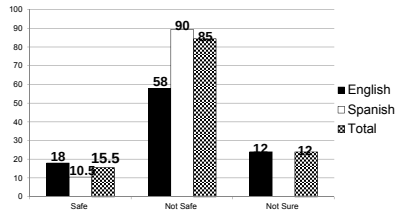
60% patients had complications that were potentially preventable if on prenatal aspirin

- 79 of these patients qualified for PNA

71% of qualified pts with IUGR and/or preeclampsia or gHTN were *not* on Prenatal Aspirin

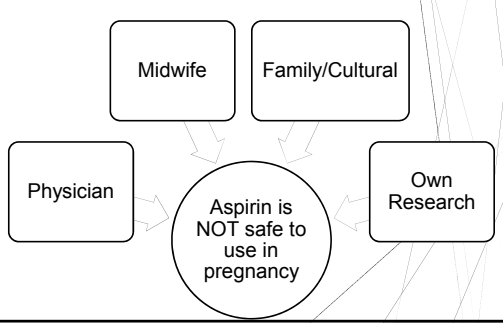
Patient Survey Data

% of surveyed about aspirin safety in pregnancy?

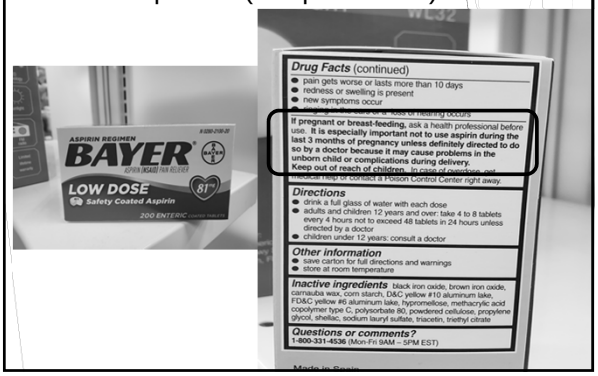


Language	Safe	Not Safe	Not Sure
English	9	29	12
Spanish	2	17	0
Grand Total	11	46	12

Causes of "aspirin in pregnancy-is-unsafe" preconceived notions



What the patient (and pharmacist) sees



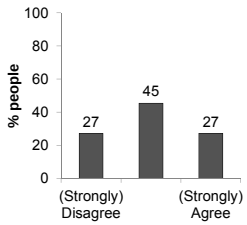
Pharmacist Survey Data

Two Pharmacist Surveys

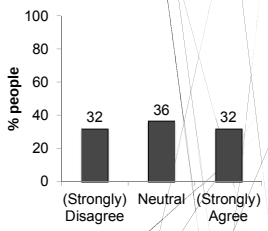
- Survey of Pharmacists at BMC
- (n=22)
- Staff working at the outpatient pharmacies in the hospital
- The survey, conducted via email using SurveyMonkey, was sent to 26 staff and 22 responded, which included a mix of both pharmacists and pharmacy technicians.

- MA Pharmacists Needs Assessment Survey
- Sent out to over 4,000 pharmacists in New England, and 50 responded
- The majority of respondents reported working in a hospital inpatient or outpatient pharmacy (48.9%), 22.4% in a community pharmacy, 14.2% in ambulatory care, and 12.2% in Other.
- Most pharmacists had been in practice for 21+ years (48.9%), between 11 and 20 years (22.4%), and between 0 and 5 years (20.4%).

Low Dose Aspirin is safe in pregnancy…



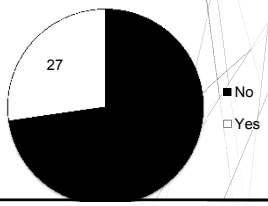
Low Dose Aspirin can prevent hypertensive disease in pregnancy…



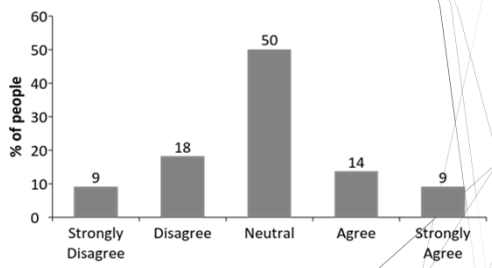
Hesitations in filling prescription?

- < 30% report feeling (very) comfortable filling a prescription of aspirin for a patient who is pregnant
- Self-reported hesitations
  - Bleeding, harm to fetus, risk vs. benefit, lack of knowledge

% aware of USPSTF guidelines for Aspirin in pregnancy to prevent hypertensive disorders of pregnancy?



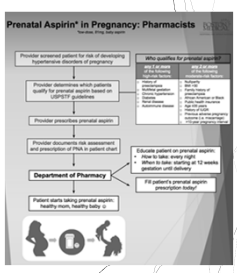
If a pregnant patient came to my pharmacy with a prescription for aspirin (81mg), I would feel comfortable dispensing her prescription



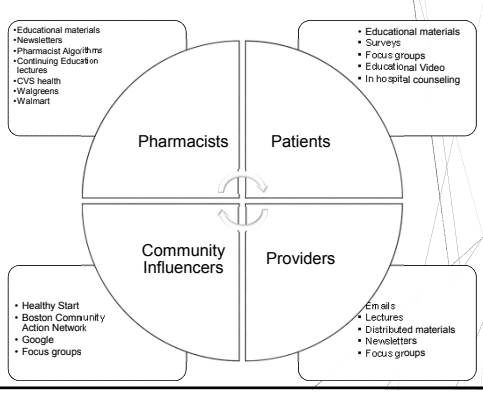
Pharmacist Intervention

Most effective way to reach pharmacists is to:

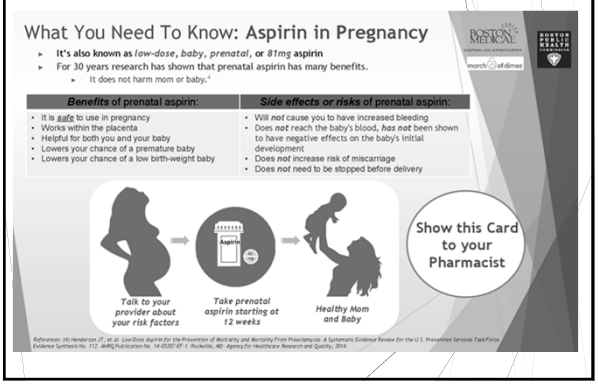
- Recruit pharmacy liaisons
- Attend, present, and table at pharmacy conferences
- Pass on all of our educational materials

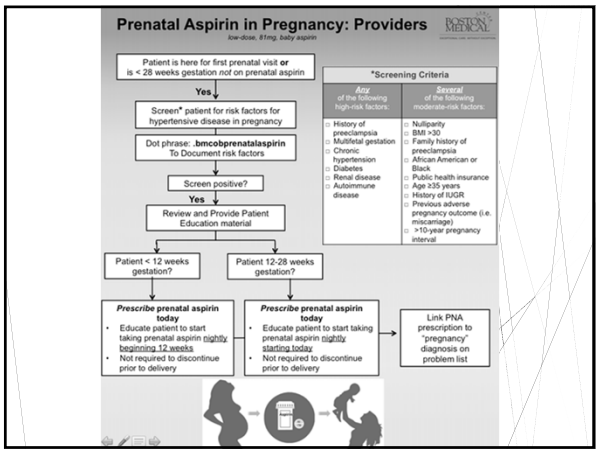


Stakeholder Directed Implementations

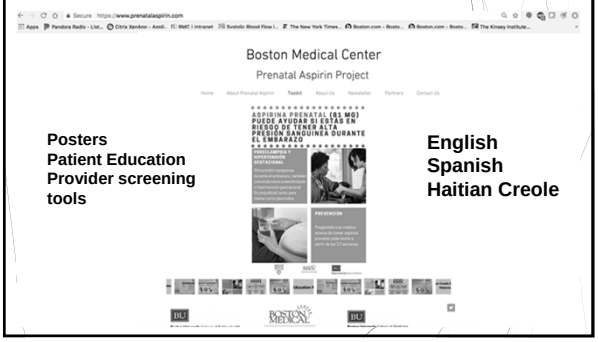


Sample of Education Materials





BMC Toolkit is available at: prenatalaspirin.com



Posters
Patient Education
Provider screening tools

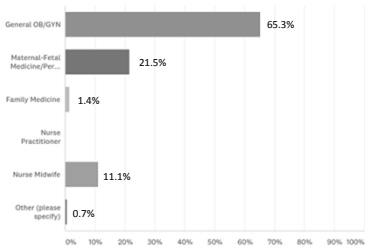
English
Spanish
Haitian Creole

LOW DOSE ASPIRIN PROVIDER SURVEY – A PROJECT OF THE CONNECTICUT PQC

Dr. Christopher Morosky, MD
UCONN Health

CPQC Provider Survey 2017-2018

- Survey Monkey and in-person paper surveys
- CPQC list-serv and local resources
- Provider practices and beliefs related to Low Dose Aspirin (LDA) and 17-OH progesterone (17P)
- Rolled out October 2017 – January 2018
- n = 163 total survey respondents

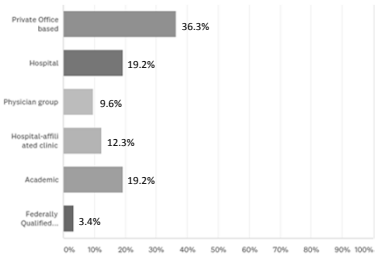


Primary Profession

Majority OBGYN and MFM

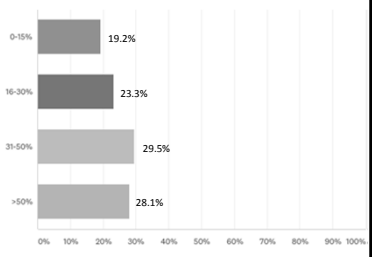
Practice Type

Majority Private Office with Hospital and Academic tied for second

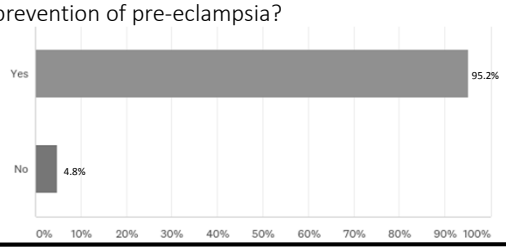


Percent Medicaid

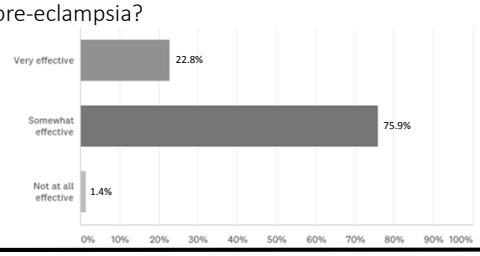
Pretty well split, but overall majority Medicaid



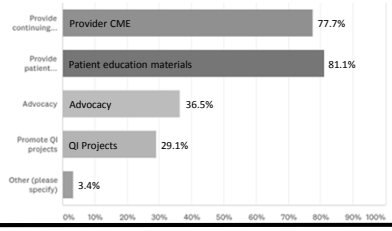
Do you currently recommend LDA for the prevention of pre-eclampsia?



Do you believe that LDA is effective to prevent pre-eclampsia?



What can the CPQC and MOD do to support increased use of indicated LDA?



Healthy Moms and Babies Connecticut

Healthy Moms and Babies Connecticut

Open Comments

- "Advocate pharmacy staff that this is safe and recommended in pregnancy."
- "Many patients are hesitant about safety. Advocacy in pharmacies would be helpful."
- "Signs at the pharmacy."
- "Public service announcements."

Strategy for Postpartum Hypertension

- During the postpartum period, there are marked cardiovascular and hemodynamic shifts
- There are few standardized approaches for identification and management of women most at risk for postpartum hypertensive complications leading to variability in practice
- Opportunities for inequities in care
  - practitioners vulnerable to management errors
  - women at risk of harm

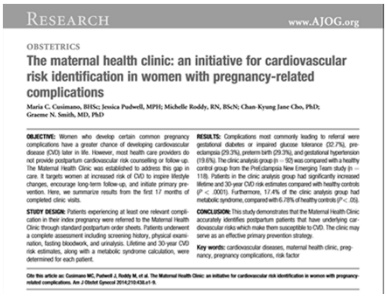
58

Strategy for Postpartum Hypertension

- ACOG provides detailed protocols for management of severe and acute hypertension during pregnancy
- There are no specific guidelines for the initiation of antihypertensive medications in the postpartum period for women with blood pressure elevations that are not severe.
- MGH Plan: Electronically-Integrated Management Strategy in women with hypertension or preeclampsia post partum

59

What we can do about history of preeclampsia?



RESEARCH www.AJOG.org

OBSTETRICS

The maternal health clinic: an initiative for cardiovascular risk identification in women with pregnancy-related complications

Maria C. Cusimano, BHSc; Jessica Pudwell, MPH; Michelle Roddy, RN, BScN; Chan-Kyung Jane Cho, PhD; Graeme N. Smith, MD, PhD

OBJECTIVE: Women who develop certain common pregnancy complications have a greater chance of developing cardiovascular disease (CVD) later in life. However, most health care providers do not provide postpartum cardiovascular risk counselling or follow-up. The Maternal Health Clinic was established to address this gap in care. It targets women at increased risk of CVD to inspire lifestyle changes, encourage long-term follow-up, and initiate primary prevention. Here, we summarize results from the first 17 months of completed clinic visits.

STUDY DESIGN: Patients experiencing at least one relevant complication in their index pregnancy were referred to the Maternal Health Clinic through standard postpartum order sheets. Patients underwent a complete assessment including screening history, physical examination, fasting bloodwork, and urinalysis. Lifetime and 30-year CVD risk estimates, along with a metabolic syndrome calculation, were determined for each patient.

RESULTS: Complications most commonly leading to referral were gestational diabetes or impaired glucose tolerance (32.7%), preeclampsia (29.3%), preterm birth (29.3%), and gestational hypertension (19.6%). The clinic analysis group (n = 92) was compared with a healthy control group from the PreEclampsia New Emerging Team study (n = 118). Patients in the clinic analysis group had significantly increased lifetime and 30-year CVD risk estimates compared with healthy controls ($P < .0001$). Furthermore, 17.4% of the clinic analysis group had metabolic syndrome, compared with 6.78% of healthy controls ($P < .05$).

CONCLUSION: This study demonstrates that the Maternal Health Clinic accurately identifies postpartum patients that have underlying cardiovascular risks which make them susceptible to CVD. The clinic may serve as an effective primary prevention strategy.

Key words: cardiovascular diseases, maternal health clinic, pregnancy, pregnancy complications, risk factor

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60

Brigham and Women's Hospital Cardiometabolic Clinic in Maternal Fetal Medicine 2011-present

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Assistant Professor Harvard Medical School
Division of General Medicine and Primary Care,
Department of Medicine, Brigham and Women's Hospital

BWH Cardiometabolic Clinic in MFM Thursday mornings 732-4840

Clinical Care for Postpartum women with complex hypertensive pregnancies

- started October 2011
- >600 patients seen and followed

Louise Wilkins-Haug MD, PhD- Maternal Fetal Medicine

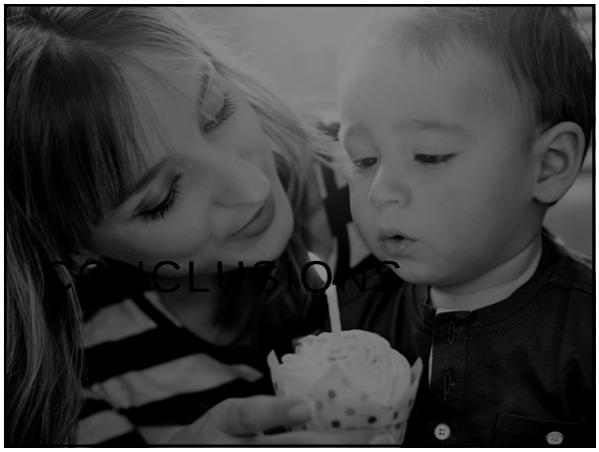
Ann Celi MD, MPH – Primary Care Medicine

BWH Cardiometabolic Clinic Design

- Early postpartum hypertension medical management
- Patient and provider education around cardiovascular risk
- Clinical bridge with primary obstetric and medicine providers
- Sustainable clinical model reimbursed by private and public insurances

Innovations

- **Blood pressure monitors**
- **Medical Home and Primary Care**
- **Breastfeeding education/support**: includes compatibility of medications
- **Contraception counseling** informed by complex pregnancy/delivery and hypertension history
- **Resources** including housing, WIC, food stamps, summer camp, Globe Santa
- **Nutrition** to optimize heart healthy lifestyle
- **Paternal leave** to help care for maternal and infant medical issues
- **Maternal leave** and transition back to work.
- **Community engagement**- family, friends, church to provide additional help after complex pregnancy



CT OPPORTUNITIES

- Greater coordination of care throughout the life course, and particularly before, during, and after/between pregnancies
  - Women's health care providers (gynecology, obstetrics, midwifery)
  - Primary care providers (internal medicine and pediatrics)
  - Family medicine providers
  - EMR changes? Patient advocates/navigators? Special Postpartum Clinics? Digital BP cuffs?
  - Paid family medical leave?

CT OPPORTUNITIES

- Patient education
  - Acceptability and tailored messaging
  - Patient education handout (MOD→ HH)
  - Patient education video clips (DPH)
  - CHNCT perinatal intensive care management program?
- Clinical provider education and quality measures
  - Traveling grand rounds (CPQC workgroup)
    - Effectiveness, safety, indications, Medicaid OTC coverage
  - Video? Podcast episode? (DPH)
  - Uniform screening
  - OB P4P?

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67

CT OPPORTUNITIES (CONT'D)

- Pharmacy professional education
  - Professional association conferences & meetings?
  - Partnership with major pharmaceutical companies (CVS, Walgreens, Walmart, RiteAid, etc.)?
- Pharmaceutical labeling
  - "Prenatal aspirin" (PNA)?
- Public health approaches to chronic disease prevention, pre-/interconception health, and pregnancy intentionality

Every Woman Connecticut

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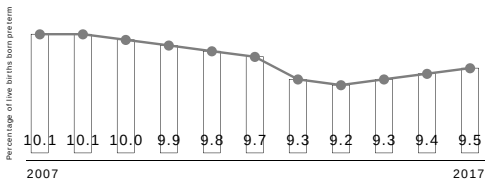
68

Video: Visit www.prenatalaspirin.com

2018 PREMATURE BIRTH REPORT CARD

PRETERM BIRTH TREND IN CONNECTICUT, 2007-2017



Preterm is less than 37 weeks gestation based on obstetric estimate.
Source: National Center for Health Statistics, 2007-2017 natality data

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2018 PREMATURE BIRTH REPORT CARD

Premature birth and its complications are the largest contributors to infant death in the U.S., and a major cause of long-term health problems in children who survive. March of Dimes aims to reduce preterm birth rates and increase equity, and monitors progress through Premature Birth Report Cards. Report Card grades are assigned by comparing the 2017 preterm birth rate in a state or locality to March of Dimes' goal of 8.1 percent by 2020. Report Cards provide county and race/ethnicity data to highlight the importance of addressing equity in areas and populations with elevated risk of prematurity. March of Dimes is working to expand solutions to help all mothers and babies have healthy, full-term births.

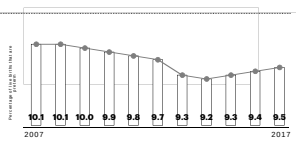
CONNECTICUT

GRADE

C

PRETERM BIRTH RATE

9.5%



Preterm is less than 37 weeks gestation based on obstetric estimate.
Source: National Center for Health Statistics, 2007-2017 natality data

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2018 PREMATURE BIRTH REPORT CARD

COUNTIES IN CONNECTICUT

Counties with the greatest number of births are graded based on their 2016 preterm birth rates.

COUNTY	GRADE	PRETERM BIRTH RATE	CHANGE FROM LAST YEAR
Fairfield	B	9.2%	Improved
Hartford	D	10.5%	Worsened
Litchfield	A	7.8%	Improved
Middlesex	A	7.5%	Improved
New Haven	C	9.6%	Worsened
New London	B	8.3%	Improved

Preterm is less than 37 weeks gestation based on obstetric estimate.
Source: National Center for Health Statistics, 2016 natality data

MARCHOFDIMES.ORG/REPORTCARD

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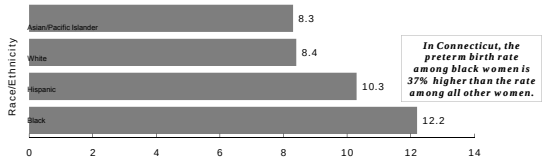
2018 PREMATURE BIRTH REPORT CARD

RACE & ETHNICITY IN CONNECTICUT

Percentage of live births in 2014-2016 (average) born preterm



In Connecticut, the preterm birth rate among black women is 37% higher than the rate among all other women.

Preterm is less than 37 weeks gestation based on obstetric estimate.
Race categories include only women of non-Hispanic ethnicity.
Source: National Center for Health Statistics, 2014-2016 natality data

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