

Priority: Prevention of Infant and Maternal Mortality

Goal: Improve health outcomes by lowering mortality and morbidity rates for infants and birthing persons.

What is Prevention of Infant Mortality and Why is it Important?

Infant mortality is an important marker of the overall health of a society and gives us key information about the health of pregnant people and infants. Infant mortality is defined as the death of an infant before the age of one. The infant mortality rate is the number of infant deaths for every 1,000 live births. In 2019, the infant mortality rate in the United States (US) was 5.6 deaths per 1,000 live births.³⁹⁶

Nationally, the top 5 causes of infant mortality in 2022 were birth defects; pre-term birth and low birth weight; sudden infant death syndrome (SIDS); unintentional injuries, and maternal complications of pregnancy. In 2022, New York State (NYS) ranked 7th overall in infant mortality compared to the other US states. The number of NYS infant deaths declined by 14.8% from 5.0 deaths per 1,000 live births in 2012 to 4.26 deaths per 1,000 live births in 2022.³⁶⁰

Despite national and NYS efforts to address and eliminate racial and ethnic disparities in infant mortality, these disparities continue. In NYS, the infant mortality rate for Black, non-Hispanic individuals (8.5/1,000 live births) and Hispanic individuals (4.1) is significantly greater than the infant mortality rate among White, non-Hispanic individuals (3.3/1,000 live births).³⁶⁰ The factors driving disparities in infant health are complex. These factors include the birthing person's employment status, income, housing, transportation, food security, access to healthy foods, stress, social supports, health care coverage, and quality of medical care received. Historic and persistent racism and discrimination also play a role in driving racial disparities in infant health. Even when controlling for insurance status, income, age, and severity of conditions, people of color are less likely to receive routine medical procedures and experience a lower quality of care overall.

What is Prevention of Maternal Mortality and Why is it Important?

Maternal deaths are devastating events with profound and prolonged effects on surviving family members, friends, communities, and health care workers. The US is one of the only countries in the world that has seen a rise in its maternal mortality ratio since 2000. Contributing risk factors to maternal mortality in the US include preexisting chronic health conditions, mental health conditions, gestational diabetes or preeclampsia, and complications, such as having a Cesarean section, problems in labor, and postpartum bleeding.

A 2020 Commonwealth Fund report comparing the US to 10 other wealthy nations revealed that the US's ratio was twice as high as any of the comparison countries, and 10 times as high as the country with the lowest ratio. The US maternal mortality ratio of 17.4 deaths per 100,000 live births would place it at roughly 55th among all countries, according to the WHO's latest report, adjacent to Russia, Saudi Arabia, and Uruguay.³⁹⁷

The maternal mortality ratio in NYS peaked at 24.4 per 100,000 live births in 2008-2010 but decreased to 19.3 per 100,000 live births in 2018-2020. The 2018-2020 maternal mortality ratio for New York City is 18.9 deaths per 100,000 live births, while the Rest of State ratio is 19.6 deaths. The maternal mortality ratio for NYS has remained below the national ratio since 2011.³⁹⁸

Nationwide, Black birthing women die at more than double the rate of White birthing persons (37.1 and 14.7 deaths per 100,000 live births, respectively). Racial disparities in maternal mortality ratios in NYS have persisted over time, despite fluctuations between individual three-year rolling periods. For 2018-2020, the statewide maternal mortality ratio for Black, non-Hispanic birthing people was 55.8 deaths per 100,000 live births, while the maternal mortality ratio for White

birthing people during the same period was 13.2 deaths per 100,000 live births. The Black to White mortality ratio in NYS for 2018-2020 was 4.2 to 1.^{397,398}

By focusing on equity in health care and addressing SDOH for birthing persons, NYS can prevent the widening of disparities and advance maternal and infant health.

SMART(IE) Objective:					
26.0 Decrease the rate of infant mortality per 1,000 live births from 4.3 to 3.5.					
Desired Outcome	Indicator	Data Source	Population	Baseline	Target
Decrease the rate of infant mortality	Infant mortality rate per 1,000 live births	National Vital Statistics System	Infants	4.3 (2022)	3.5 (2030)

SMART(IE) Objective:					
27.0 Decrease the rate of maternal mortality per 100,000 live births from 19.8 to 16.1.					
27.1 Decrease the rate of maternal mortality per 100,000 live births among Black, non-Hispanic birthing persons from 65.2 to 55.0.					
Desired Outcome	Indicator	Data Source	Population	Baseline	Target
Decrease the rate of maternal mortality	Rate of maternal mortality per 100,000 live births	National Vital Statistics System	Birthing persons	19.8 (2017-2021)	16.1 (2030)
			Subpopulation of Focus 1	Baseline	Target
			Black, non-Hispanic birthing persons	65.2 (2017-2021)	55.0 (2030)

SMART(IE) Objective:

28.0 Decrease percentage of birthing persons who experience depressive symptoms during pregnancy from 12.4% to 11.5%.

28.1 Decrease percentage of birthing persons aged 20-24 years who experience depressive symptoms during pregnancy from 26.2% to 19.0%.





Desired Outcome	Indicator	Data Source	Population	Baseline	Target
Decrease percentage of birthing persons who experience depressive symptoms during pregnancy	Percentage of birthing persons who report depression during pregnancy	PRAMS	Birthing persons	12.4% (2022)	11.5% (2030)
			Subpopulation of Focus 2	Baseline	Target
			Birthing persons aged 20-24 years	26.2% (2022)	19.0% (2030)









SMART(IE) Objective:











29.0 Decrease percentage of birthing persons who experience depressive symptoms after birth from 11.9% to 9.9%.




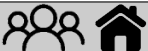
29.1 Decrease percentage of birthing persons aged 20-24 years who experience depressive symptoms after birth from 19.2% to 18.0%.











Desired Outcome	Indicator	Data Source	Population	Baseline	Target
Decrease percentage of birthing persons who experience depressive symptoms after birth	Percentage of birthing persons who report depressive symptoms after giving birth	PRAMS	Birthing persons up to 1 year postpartum	11.9% (2022)	9.9% (2030)
			Subpopulation of Focus 2	Baseline	Target
			Birthing persons aged 20-24 years up to 1 year postpartum	19.2% (2022)	18.0% (2030)




Interventions	Population of Focus	Age Range	Intermediate Measures
 <p>Featured Intervention: Implement the Alliance for Innovation on Maternal Health Bundle for Safe Reduction of Primary Cesarean Birth in birthing hospitals to reduce low-risk cesarean deliveries.³⁹⁸</p> <p>H</p>	Birthing persons, especially those more susceptible or at risk of mental illnesses or disorders associated with pregnancy or postpartum	Ages 15-44	Number of hospitals that adopt use of bundles, number of trainings delivered to hospital staff for implementation of bundles, capacity of hospital staff to implement bundles
 <p>Featured Intervention: Provide free sleep sacks and/or portable cribs to families in need during prenatal period or before discharge from the hospital.³⁹⁹</p> <p>LHD H O</p>	Low-income families with infants	Ages up to 1 year	Number of sleep sacks requested, number of sleep sacks distributed, number of families served
 <p>Featured Intervention: Establish policies and practices to support doula care and services, especially in areas of maternal deserts and historic underinvestments. This could include:</p> <ul style="list-style-type: none"> • Supporting doula training • Supporting doula certification • Enrollment in Medicaid for reimbursement for services • Public-facing promotion about being a doula-friendly hospital^{368,369} <p>H</p>	Birthing persons, infants	Ages 15-44	Number of hospitals that institute doula-friendly policies, number of births involving doula care, utilization of doula Medicaid benefit
 <p>Provide screenings to prenatal and postpartum patients using validated tools, for example:</p> <ul style="list-style-type: none"> • Mental Health: Edinburgh; community-based Perinatal Support Model (CPSM) • Substance Use Disorder: Verbal Screening tools (4P's Plus, ASSIST-lite, DAST-10, BSTAD, etc.) • Social Care Needs: 1115 New York Health Equity Reform (NYHER) Waiver • Pregnancy Risk Assessment: Perinatal Risk Assessment (PRA); Antepartum Risk Score (APRS); Rotterdam Reproductive Risk Reduction (R4U); Maternal Venous Thromboembolism (VTE) Risk Assessment³⁶¹⁻³⁶⁷ <p>LHD H O</p>	Birthing persons, especially those more susceptible or at risk of mental illnesses or disorders associated with pregnancy or postpartum	Ages 15-44	Number of people screened, number of successful referrals made

Interventions	Population of Focus	Age Range	Intermediate Measures
 <p>Implement postpartum depression screening for women participating in the Women, Infants, Children (WIC) program and collaborate with Local Health Departments (LHDs) and community-based organizations (CBOs) to provide referrals to comprehensive pregnancy, birthing, and postpartum services.⁴⁰⁰</p>  	Birthing persons participating in WIC	Ages 14-55	Number of WIC clients screened for mental health needs, number of successful referrals made
 <p>Ensure full and up-to-date implementation of the American College of Obstetricians and Gynecologists' (ACOG) Safe Motherhood Initiative Hemorrhage Bundle, including:</p> <ul style="list-style-type: none"> • Following a standard protocol for massive transfusions • Implementing a universal system for quantification of blood loss • Working with anesthesia teams to follow their facility's emergency management plan for response to hemorrhage during delivery and postpartum • Utilizing checklists and algorithms to assist with decision-making • Conducting training/drills on bundle implementation⁴⁰¹ 	Birthing persons	Ages 14-55	Number of hospitals that adopt use of bundle, number of trainings delivered to hospital staff for implementation of bundles, capacity of hospital staff to implement bundles
 <p>Promote use of Alliance for Innovation on Maternal Health (AIM)/ACOG patient safety bundles: "Perinatal Mental Health Conditions" and "Care for Pregnant and Postpartum People with Substance Use Disorders" in hospital settings to provide care responsive to high-acuity psychiatric symptoms among birthing people.^{402,403}</p> 	Birthing persons with mental health and substance use challenges	Ages 14-55	Number of hospitals that adopt use of bundle, number of trainings delivered to hospital staff for implementation of bundles, capacity of hospital staff to implement bundles
 <p>Connect birthing people, particularly those at high risk for postpartum mental health</p>	Birthing persons	Ages 14-55	Number of people served by home visiting programs, number of home visits per patient, number of screenings

Interventions	Population of Focus	Age Range	Intermediate Measures
<p>and substance use challenges, to evidence-based or evidence-informed home visitation programs (e.g., Healthy Families, Nurse Family Partnership, and the Perinatal and Infant Community Health Collaborative).^{55,373-376}</p> <p></p>			<p>performed for medical or social care needs, number of successful referrals made for medical or social care needs</p>
<p> Implement "Hypertension in Pregnancy Change Package" proposed by Million Hearts and Centers for Disease Control and Prevention (CDC).⁴⁰⁴</p> <p></p>	<p>Birthing persons</p>	<p>Ages 14-55</p>	<p>Number of patients screened for high blood pressure, number of follow-up screenings, number of patients who receive blood pressure control interventions</p>
<p> Implement community-based Doula programs.^{384, 405, 406, 407}</p> <p></p>	<p>Birthing persons</p>	<p>Ages 14-55</p>	<p>Number of programs established, number of birthing persons who receive doula care during (1) prenatal period, (2) birth, (3) postpartum, and number of doulas registered with Medicaid</p>
<p> Implement the utilization of birth certificate information by LHDs to identify and contact new mothers for virtual health check-in post-delivery to increase potential for direct referral to external home visiting programs through Healthy Families New York (HFNY), Perinatal and Infant Community Health Collaboratives (PICHC), or CBOs providing in person home visiting services.⁴⁰⁸</p> <p></p>	<p>Birthing persons, infants</p>	<p>Ages 14-55, under 1 year</p>	<p>Number of records used to contact postpartum birthing persons for checkups, number of referrals made to home visiting programs</p>
<p> Implement a lactation care coordination system that begins during the prenatal period and continues through weaning stages. The system can include formal referral systems, follow-up accountability, and hand-off protocols during transitions of lactation care from one provider or setting to another.²⁶⁶</p> <p></p>	<p>Postpartum birthing persons, infants</p>	<p>Ages 14-55, under 1 year</p>	<p>Number of patients served, number of successful referrals made</p>
<p></p>	<p>Birthing persons</p>	<p>Ages 14-55</p>	<p>Number of people screened, number of successful referrals</p>

Interventions	Population of Focus	Age Range	Intermediate Measures
<p>Implement universal screening for maternal food insecurity and offer resources, such as existing grants and apps to find available food and resources, to women struggling to feed themselves and their families.^{409,410}</p> <p></p>			<p>made to (1) food security resources and (2) Food as Medicine resources</p>
<p> Connect hospitals with LHDs, community-based partners, and philanthropic organizations to support the establishment of midwifery practices, especially in areas of maternal deserts and historic underinvestments.³⁷⁸⁻³⁸⁰</p> <p></p>	<p>Health care organizations, Midwives</p>	<p>N/A</p>	<p>Number of midwifery practices established</p>
<p> Integrate hospital-based midwifery model of care that supports:</p> <ul style="list-style-type: none"> • The employment of midwives in leadership roles • The institution of formal policies and practices supportive of midwives as independent clinical professionals • The emphasis on the value and benefit of such programs³⁷⁸⁻³⁸⁰ <p></p>	<p>Hospitals, Midwives</p>	<p>N/A</p>	<p>Number of hospitals and practices that integrate midwife care, number of births involving midwife care</p>
<p> Provide targeted health literacy education for pregnant patients regarding the importance of immunization for both birthing person and newborn including guided strategies for immunization that outlines locations patients can go to get both services.⁴¹¹</p> <p></p>	<p>Birthing persons, infants</p>	<p>Ages 14-55, under 1 year of age</p>	<p>Number of trainings delivered, number of people who received training, number of timely immunizations for infants</p>
<p> Promote the use of harm reduction toolkits such as Pregnancy and Substance Use: A Harm Reduction Toolkit, among people who use substances and their families.⁴¹²</p> <p></p>	<p>Birthing persons with substance use challenges</p>	<p>Ages 14-55</p>	<p>Number of hospitals and practices that adopt use of toolkits, number of trainings delivered to hospital staff in implementing toolkits, number of patients served using toolkits</p>
<p></p>	<p>Infants</p>	<p>Ages under 1 year</p>	<p>Number of childcare centers that adopt healthy nutrition</p>

Interventions	Population of Focus	Age Range	Intermediate Measures
Support the adoption of healthy nutrition policies and standards at early childcare centers. ⁴¹³ 			policies, number of children served by childcare centers that adopt healthy nutrition policies
 Implement ZERO TO THREE's Healthy Steps Program in pediatric primary care offices. ⁴¹⁴ 	Birthing persons, infants	Ages 14-55, under 1 year	Number of practices that implement Healthy Steps, number of enrolled participants
 Collect and stratify clinical data by race, ethnicity, and language (REAL) data to analyze and identify drivers of inequity and targets for quality improvement. ^{415, 416} 	Hospitals and health care organizations	N/A	Number of records analyzed, intermediate findings of likely drivers contributing to inequities
 Encourage obstetrics and gynecology (OB-GYN) and midwifery practices to adopt the Collaborative Care model and/or enroll in New York State's Collaborative Care Medicaid Program to support maternal mental health needs. ³⁸³⁻³⁸⁵ 	OB-GYN and midwifery practices	N/A	Number of practices enrolled in NYS Collaborative Care Medicaid Program, number of applications for enrollment, number of people served by practices enrolled in program
 Develop peer support services for the prevention of perinatal depression and connect birthing persons to peer support services as part of prenatal care. ³⁸⁶⁻³⁸⁸ 	Birthing persons	Ages 14-55	Number of successful referrals made, number of patients connected to peers, number of peer support specialists available, number of new certifications for peer support specialists
 Promote use of Project TEACH (Training and Education for the Advancement of Children's Health) pediatric and perinatal psychiatry access program to improve provider knowledge and capacity to address maternal mental health needs across diverse settings. ⁴¹⁷ This may include: <ul style="list-style-type: none"> • Primary care practices • Pediatric practices • OB-GYN practices • Nurses • Community health workers (CHWs) 	Birthing persons	Ages 14-55	Number of inquiries made, number of practices/providers who contact Project TEACH, perceived capacity of providers to address perinatal mental health needs

Interventions	Population of Focus	Age Range	Intermediate Measures
			
 <p>Provide support with health insurance navigation assistance to improve health insurance literacy (e.g., NYS Growing Up Healthy Hotline; NYS Perinatal Quality Collaborative).³⁹⁴</p> 	<p>Birthing Persons</p>	<p>Ages 14-55</p>	<p>Number of people served, number of insured birthing persons who were previously uninsured</p>

Lead Partner Agencies and Organizations

[US Centers for Disease Control and Prevention \(CDC\)](#)

[NYS Department of Health](#)

NYS Medicaid

WIC Program

New York State Perinatal Quality Collaborative

Perinatal Infant Community Health Collaboratives

Breastfeeding, Chestfeeding, and Lactation Friendly New York

[NYS Office of Mental Health](#)

[NYS Office of Children and Family Services](#)

Local child and family services agencies

Health care providers, health plans, insurance brokers

American College of Obstetricians and Gynecologists (ACOG), Alliance for Innovation in Maternal Health (AIM)

Project TEACH

Postpartum Support International, Postpartum Resource Center of New York

Regional Food Banks, Medicaid Social Care Network

Nurse Family Partnership, Healthy Families NY

Local midwifery and doula practices

Local childcare organizations

Implementation Resources

[Project TEACH](#)

[NYSDOH - Doula Services Information for Medicaid Members](#)

[New York Center for the Advancement of Behavioral Health Integration - Collaborative Care Medicaid Program \(CCMP\)](#)

[New York 1115 Medicaid Waiver Information Page](#)

[New York State Perinatal Quality Collaborative \(NYSPQC\)](#)

[NYSDA - Creating Healthy Schools and Communities \(CHSC\), 2021-2026](#)

[HRSA - Title V Maternal and Child Health Services Block Grant Program](#)

[Groundswell Fund - Birth Justice Fund](#)

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