Preterm & Early Term Birth Change Package

By July 2016, reduce prevalence of preterm and early term singleton births. States will:
1. Decrease non-medically indicated births between 37 0/7 weeks of gestation through 38 6/7 weeks of gestation by 20%
2. Increase the percent of pregnant women on Medicaid with a previous preterm birth who receive progesterone to 40%
3. Achieve or maintain equity in utilization of progesterone by race/ethnicity

Primary Driver	Secondary Driver	Changes	State Priorities
PD1- Support providers in timely, reliable and effective screening, identification and prevention of pre-term birth	SD1- Timely and reliable identification of women with a singleton prior preterm birth or short cervix	1. Wide access to sonographers skilled in ultrasound measurement of the cervix 2. Doctors are trained and certified in reading and interpreting ultrasound measurement of the cervix 3. Use a care algorithm to identify women eligible for progesterone (OPQC example) 4. Use a practice protocol to selectively or universally screen cervical length 5. Use a practice protocol for screening women for OB history of preterm birth 6. Use prenatal checklists to facilitate screening and risk stratification 7. Screen women for history of preterm birth during scheduling of initial visit 8. Align and communicate with EDs, WIC, and other points of access to screen and refer women with history of preterm birth 9. Educate American Registry for Diagnostic Medical Sonography (ARDMS) on relation of preterm birth to infant mortality 10. Promote credentialing for cervical length screening via CLEaR or FMF	KS, MA

Primary Driver	Secondary Driver	Changes	State Priorities
		11. Use claims data and data linkages to identify women and notify physicians of history of preterm birth 12. Expand funding and access to appropriate sonograms 13. Presumptive eligibility for Medicaid coverage of prenatal care 14. Do not require pre-authorization for cervical length screening or progesterone 15. Standardize initial L&D/OB Triage, e.g., AWHONN Maternal-Fetal Triage Index that targets early identification of women presenting with signs of preterm labor/risk for preterm birth 16. Think outside the medical paradigm to find eligible women late to prenatal care 17. Develop locally appropriate screening strategies (Universal not always cost effective)	**OK** (want to connect w/Dr. Iams), **KS** (Already removed this for progesterone w/Medicaid, working on private payors)
	SD2- Reduce late entry into prenatal care	1. Facilitate rapid new OB appointments 2. Accelerated 1st prenatal visit for women with history of preterm birth 3. Presumptive eligibility for Medicaid coverage of prenatal care 4. Screen women for history of preterm birth during scheduling of initial visit 5. Support women in keeping appointments (childcare, food, transportation)	
	SD3- Reliable method to determine gestational age based on ACOG committee opinion on is standard of care for every patient	1. http://www.acog.org/Resources-And-Publications/Committee-Opinions/Committee-on-Obstetric-Practice/Method-for-Estimating-Due-Date 2. Promote/support implementation of widespread dissemination strategies	

Primary Driver	Secondary Driver	Changes	State Priorities
	SD4- Standardized provision of education and training for health professionals on screening for preterm birth and use of progesterone	1. Partner with local AGOG/ACNM/AWHONN/AAFP chapters and state hospital association for professional development opportunities	MO
		2. Utilize work of the FMEC IMPLICIT Network (http://www.fmec.net/implicitnetwork.htm)	
		3. Educate providers on Medicaid policy for administration and coverage of progesterone (OH coverage tool)	OK, HI, KS
		4. Utilize existing materials for provider education:	
		a. Ohio Perinatal Quality Collaborative's Doing More to Reduce Preterm Birth	
		b. Ohio Perinatal Quality Collaborative's Cervical Length Measurement	MA
		c. Ohio Perinatal Quality Collaborative's video Using Transvaginal Ultrasound to Help Prevent Pre-term Birth	MA
		5. Disseminate progesterone best practices through pockets cards	OK (general training)
		6. Partner with state perinatal quality collaboratives	
		7. Provider knowledge survey	KS (on 17-p), MA
		8. Educate providers with a 17-P fact sheet on indications	KS
		9. MFM webinar: CME on 17-P and ACOG guidelines	WV
	SD5- Use data to support need for improvement and motivate physicians, pharmacists and sonographers	1. Share provider level data on progesterone utilization to motivate improvement	
		2. Adopt uniform billing/administrative codes for progesterone across public and private payers.	
		3. Adopt uniform administrative coding for screening of prior preterm birth (history-taking) and screening for short/shortening cervix	
PD2- Eliminate barriers to access, administration	SD1- Make progesterone affordable	1. Start process of obtaining insurance coverage and approval for progesterone therapy at first visit (10-14 weeks)	
		2. Host educational talks on Medicaid/ Makena to lower costs of 17-P	WV, MN

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and adherence to progesterone	SD2- Streamline ordering process	1. Develop universal 17-P Authorization Form (e.g., South Carolina) 2. Utilize 17P Louisiana Resource Center	OK HI (general)
	SD3- Partner with pharmacy, providers, home visiting organizations, payors and community based organizations to improve access	1. Expand access to progesterone by partnering with pharmacies and home visiting organizations, such as the Walgreens and Alere 2. Develop and use standard protocol for preparation of compounded 17P in concert with local compounding pharmacy 3. Use flexible strategy for treating women with progesterone 4. Partner with Medicaid to screen pregnant women for history of preterm birth 5. Expand access to group prenatal care	WV TN (TENNderCARE)
	Use patient engagement techniques (e.g., motivational interviewing, teach back) and patient centered medication management and care coordination to improve access, initiation and adherence	1. Use case managers and home visitors to improve patient adherence 2. Involve key support individuals 3. Integrate health literacy into all patient and family interactions 4. Follow up with women to check on continued use of progesterone as prescribed 5. Use a log, flag or tracking system to help ensure that women receive progesterone when and as needed 6. Designate a progesterone Coordinator/navigator 7. Utilize existing materials for training on teachback and motivational interviewing (example 1, example 2, example 3) 8. Use motivational interviewing with families to surface resistance and engage in joint problem solving 9. Expand access to group prenatal care	 UT (connecting with moms in the NICU regarding risk and prevention of preterm birth using a preterm birth prevention booklet) MA

Primary Driver	Secondary Driver	Changes	State Priorities
	SD4- Home visitation and Nurse-Family Partnership programs, WIC and Title X programs educate and use patient engagement techniques (e.g., motivational interviewing, teach back) and care coordination to improve knowledge and adherence	1. Incorporate education or screening to WIC regular work – intake, appointment interviews, data that they track, etc. 2. Coverage for home health services for 17P 3. Utilize existing materials for training on teachback and motivational interviewing (example 1, example 2, example 3 4. Use motivational interviewing with families to surface resistance and engage in joint problem solving	KS
	SD5- Develop a process to learn from patient and provider feedback related to experience	1. Develop processes to consistently obtain information from patients regarding needs and experience i.e. focus groups, interviews 2. Develop resources to support patients as a member of improvement teams 3. Start a patient advisory committee	HI, OK (provider focus groups), ND (provider surveys) MA

Primary Driver	Secondary Driver	Changes	State Priorities
PD3- Increased patient, family and community understanding of and demand for progesterone and carrying to full term	SD1- Home visitation and Nurse-Family Partnership programs, WIC and Title X programs educate and use patient engagement techniques (e.g., motivational interviewing, teach back) and care coordination to improve knowledge and adherence	1. Incorporate education or screening to WIC regular work – intake, appointment interviews, data that they track, etc. 2. Coverage for home health services for 17P 3. Utilize existing materials for training on teachback and motivational interviewing (example 1, example 2, example 3 4. Use motivational interviewing with families to surface resistance and engage in joint problem solving	KS
	SD2- Develop a process to learn from patient and provider feedback related to experience	1. Develop processes to consistently obtain information from patients regarding needs and experience i.e. focus groups, interviews 2. Develop resources to support patients as a member of improvement teams	

	SD3- Healthcare professionals use education and engagement techniques (e.g., motivational interviewing, teach back) on the risks of EED and benefits of progesterone	1. Utilize existing materials for training on teachback and motivational interviewing (example 1, example 2, example 3 Progesterone 2. Conduct postpartum counseling on progesterone for those eligible in next pregnancy 3. Educate providers on approaches to help women make informed decisions about progesterone, such as motivational interviewing, teachback and shared decision making 4. Use existing educational resources such as: a. Ohio Perinatal Quality Collaborative's Preventing Preterm Birth: A Guide for Pregnant Women b. Ohio Perinatal Quality Collaborative's Every Week Matters Fact Sheet/infographic c. Ohio Perinatal Quality Collaborative's Give Your Baby a Healthy Start: How Progesterone Can Help You Prevent an Early Delivery d. Ohio Perinatal Quality Collaborative's Common Questions and Answers About Progesterone e. Ohio Perinatal Quality Collaborative's Videos Every Week Matters: Progesterone Stories: Patrece's Story, Jieney's Story, Angela's Story EED 5. Educate providers on proven approaches to helping women make informed decisions about EED and spontaneous labor, such as motivational interviewing, teachback and shared decision making 6. Develop a patient education sheet (brochure) to explain induction policy 7. Incorporate EED educational content and materials into local childbirth education programs and group prenatal care models 8. Use ACOG/SMFM definitions for "early term," "full term," "late term," and "post term" to reduce misconception that	HI (education at discharge), OK, MN (education at discharge)

Primary Driver	Secondary Driver	Changes	State Priorities
		there are no differences in outcome when scheduling deliveries after 37 weeks of gestation 9. Have structured informed consent discussion that outlines risk of non-medically indicated elective deliveries prior to 39 weeks gestation (document in medical record) a. Utilize a standardized form that documents the informed consent discussion 10. Distribute patient education materials prior to admission, e.g., at physician offices, prenatal classes, and tours a. March of Dimes bilingual booklet "Why the Last Weeks of Pregnancy Count" b. March of Dimes Late Preterm Brain Development Card (available in multiple languages) c. Agency for Healthcare Research and Quality Thinking About Inducing Your Labor: A Guide for Pregnant Women d. AWHONN's 40 Reasons to Go the Full 40	

	SD4- Utilize community based organizations, social media and educational materials to reach target audience and raise awareness about progesterone and risks of EED	1. Incorporate EED and progesterone educational content and materials into local childbirth education programs and group prenatal care models 2. Partner with promotoras, doulas, retail pharmacies, public health departments, health plans, community-based or nonprofit organizations, and others to develop and disseminate educational materials 3. Promote text4baby, a mobile information service designed to promote maternal and child health through text messaging 4. Take advantage of existing blogs, websites and text messaging, such as Healthy Mom and Baby, March of Dimes Share Your Story and CineMama, and Text4Baby to provide information about progesterone to target audience 5. Use media to highlight hospitals with low EED rates 6. Partner with business to increase family friendly business practice that can influence birth outcomes 7. Use existing educational resources such as: a. March of Dimes bilingual booklet Why the Last Weeks of Pregnancy Count b. March of Dimes Late Preterm Brain Development Card (available in multiple languages) c. Agency for Healthcare Research and Quality Thinking About Inducing Your Labor: A Guide for Pregnant Women d. AWHONN's 40 Reasons to Go the Full 40 e. Ohio Perinatal Quality Collaborative's Preventing Preterm Birth: A Guide for Pregnant Women f. Ohio Perinatal Quality Collaborative's Every Week Matters Fact Sheet/infographic g. Ohio Perinatal Quality Collaborative's Give Your Baby a Healthy Start: How Progesterone Can Help You Prevent an Early Delivery h. Ohio Perinatal Quality Collaborative's Common Questions and Answers About Progesterone	WY (use media to highlight WY IM rates) HI, IA (distribute MOD 17-P brochure to women w/babies in the NICU due to a preterm birth)

Primary Driver	Secondary Driver	Changes	State Priorities
		i. Ohio Perinatal Quality Collaborative's Videos Every Week Matters: Progesterone Stories: Patrece's Story, Jieney's Story, Angela's Story	
PD4- Public and private payment policies aligned with aims	SD1- Functional agreement between providers, hospitals and payors to maximize use		
	SD2- Improve access to and coverage for (1) early screening for risk of preterm birth, (2) progesterone, including home administration of progesterone, (3) pre/inter conception assessment of risks	1. Expand funding and access to appropriate sonograms 2. Fund Medicaid pilot for paying for alternative administration approaches 3. Presumptive eligibility for Medicaid coverage of prenatal care 4. Do not require pre-authorization for cervical length screening or progesterone 5. Coverage for home health services for 17P 6. Coverage for home visiting nurses' time transporting 17P from pharmacy/physician to client's home 7. Introduce legislation to allow for 17P compounding 8. Increase reimbursement for group prenatal care	KS (Already removed this for Medicaid, working on private payors) IA MA

Primary Driver	Secondary Driver	Changes	State Priorities
	SD3- Financial incentives and disincentives to reduce EED and increase utilization of progesterone	<u>Progesterone</u> 1. Offer incentives to encourage certification for cervical length screening 2. Provide incentives or pay for performance measures around progesterone 3. Payment reform through Medicaid and private payors <u>EED</u> 4. Provide payment disincentives for early elective cesarean deliveries (e.g., equalize payment for low-risk vaginal and cesarean births) 5. Lower the payment for non-emergency cesarean sections to a level below that of a vaginal birth 6. Payment updates based on meeting targets for EED 7. Allow incremental payment increase or modest bonuses to facilities that meet quality targets(Anthem Blue Cross Blue Shield included EED as a quality metric since 2012 for its QHIP™ (Quality InSights Hospital Incentive Program)/Washington State) 8. ALL hospitals must submit NQF #0469 *(The Joint Commission Perinatal Care PC-01)* Elective Delivery Measure to CMS <u>QualityNet</u> for the Hospital Inpatient Quality Reporting (IQR) Program 9. No payment policy for non-medically-indicated or elective deliveries prior to 39 weeks of gestation 10. Require monthly reporting of hospital early elective deliveries rates by gestational age 11. Require clinicians to add a modifier to claims indicating medical necessity for pre-39 week deliveries	MO MO MO

Primary Driver	Secondary Driver	Changes	State Priorities
PD5- Build capacity of and support for hospitals and providers to reduce EED	SD1- Healthcare professionals use ACOG criteria for the indication and timing of scheduled births	1. Partner with local AGOG/ACNM/AWONN/AAFP chapters and state hospital association for professional development opportunities 2. Use ACOG guidelines on estimating due date 3. Use ACOG Scheduled Birth Criteria, includes proper pregnancy dating by ultrasound confirmation of gestational age at 20 weeks; scheduled birth for social or soft indications only at 39 weeks gestation or later; and adoption of a Scheduled Birth Form	

	SD2- Implementation of standardized policies and administrative supports to reduce early elective delivery	1. Create or utilize existing standard forms for scheduling that collect gestational age and indication for delivery; both pieces of information determine whether the requested interventions are defined as medically indicated (examples: Ohio, ACOG) 2. If there is a clinical question as to the proposed medical indication for a labor induction or cesarean birth before 39 weeks, a process for reaching consensus is in place including a chain of consultation that may consist of the nursing, obstetric, and/or administrative leadership teams 3. Establish prior authorization or peer review prior to scheduling early elective deliveries 4. Implement a system for the labor and delivery charge nurse to review each scheduled c-section < 39 weeks before it can be posted to the OR schedule 5. Policy standardizes scheduling form, informed consent, flow charts, protocols, etc. 6. Hospitals develop and strictly enforce a hard stop policy for no medically unnecessary inductions prior to a gestational age of 39 weeks 7. Policy and procedures follow ACOG and national quality criteria 8. Establish policies for approving appropriate exceptions to standards that are guided by strong physician leadership 9. Establish policies that provide clear direction to nursing staff and clerks for scheduling process 10. Clarify role of OB department chair in upholding EED policy 11. Require OB quality committee chair or department chair to approve all scheduled case < 39 weeks 12. Require documentation of a medical reason for any patient scheduled to deliver prior to 39 weeks 13. Limit how far in advance inductions can be scheduled 14. Partner with State Hospital Associations to encourage hospitals to implement policies on EED	MO WV (Continue monitoring rates over time)

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		15. Utilize existing toolkits such as Elimination of non-medically indicated deliveries before 39 weeks gestation age quality improvement toolkit, AWHONN's Go the Full 40, New York State's Obstetrical Improvement Project Toolkit, NQF Playbook for the Successful Elimination of Early Elective Delivery, Policy Toolkit to Support Reduction of EED	
	SD3- Use data to support need for improvement and identify and motivate physicians, nurses, admin and hospitals	1. Educate providers on implications of EED for CMS, The Joint Commission, and other organizations such as Leapfrog 2. Engage with OB Medical Staff Committee to review data and solicit support for elimination of EED and accountability for adherence to EED policy 3. Have OB department establish EED as a provider-level measure for the mandated every-6-month quality reporting now required by the Joint Commission (OPPE: Ongoing Physician Performance Evaluation) 4. Display "days since last EED" on unit to motivate data collection 5. Display data in ways other than just numbers (e.g., "last month 8 infants were electively delivered too early, resulting in a need for O2, feeding problems", show a list of 37-38 week infants admitted to the NICU; use infographics with babies instead of dots on a graph) 6. Recognize hospitals that have reduced early elective deliveries through programs such as the March of Dimes Banner Recognition program 7. Send regular reports to hospitals with their progress on certain measures (also compared to other hospitals)	MA SC

Primary Driver	Secondary Driver	Changes	State Priorities
	SD4- Standardized provision of education and training for health professionals on current ACOG guidelines for EED	1. Partner with local AGOG/ACNM/AWONN/AAFP/MOD chapters and state hospital association for professional development opportunities 2. Widely distribute and post the list of TJC, ACOG EED indications 3. Hold grand rounds with a combination of respected leaders and local champions. Show data on 37-38 infants admitted to NICU 4. Education addresses perception of little or no harm to the baby or increased risk to the mother 5. Publish articles in the OB department newsletter to reinforce guidelines 6. Educate providers on implications of EED for CMS, The Joint Commission, and other organizations such as Leapfrog 7. Utilize work of the HENs in efforts to reduce obstetric harm 8. Utilize videos on reducing EED such as Iowa's Reducing Early Elective Deliveries in Iowa and Reducing Early Elective Deliveries webcast	

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