

Risk Appropriate Perinatal Care Change Package

By July 2016:

1. Increase the % of VLBW (< 1500 grams) and very preterm (<32 weeks gestation) infants delivering at risk appropriate facilities (Level III+ Neonatal Intensive Care Units) to 90% (or 20% increase relative to state baseline)
2. Increase the % of pregnant women with high risk placental conditions (placenta accreta or placenta previa with prior uterine surgery, placenta percreta), expectant management of preeclampsia with severe features at less than 34 weeks of gestation and severe maternal cardiac conditions receiving care at appropriate facilities (Level III or IV) by 10%

Primary Driver	Secondary Driver	Change Idea	State Priorities
<p>PD1 -Early risk assessment, referral and seamless access to risk-appropriate care facility</p>	<p>SD1- Healthcare professionals and facilities understand and endorse standards and outcomes of risk appropriate care for mothers and infants and have well-defined threshold for transferring women to higher level facilities</p>	<ol style="list-style-type: none"> 1. Foster positive relationships between all levels of care and care providers by establishing annual opportunities for learning: EB practice updates, review of state or regional data to include the Level I, Level II, Level III multidisciplinary team and transport staff 2. Utilize data on maternal and neonatal outcomes to educate providers, hospital leadership and facilities (including outcomes of higher weight VLBW babies) 3. Conduct individual annual Transport Review Conferences for multidisciplinary team for Level I & II sites, facilitated by Level III faculty, to review care processes and outcome data on all transported patients. Provide opportunity to review individual gaps in care and outcomes data 4. Provide timely education to providers and facilities identified as inappropriately delivering VLBW or very preterm infants or caring for high risk mothers 	<p>IN: Verify quality of data collected by ISDH Vital Statistics from birth hospitals; CA</p> <p>NM; MI</p>

Revised: October 14, 2015

Infant Mortality CoIIN | Risk Appropriate Perinatal Care Learning Network (n=14)

		5. Target in-services and facilitate linkages between appropriate facilities and facilities identified as inappropriately delivering VLBW or very preterm infants or caring for high risk mothers	
--	--	---	--

Primary Driver	Secondary Driver	Change Ideas	State Priorities
	<p>SD2- Provider and nursing annual updates in evidence based (EB) practice, ongoing education opportunities and use of EB screening tools (and treatment) to identify women at risk (available for hospital and community providers)</p>	<ol style="list-style-type: none"> 1. Establish Regional Perinatal Forums involving hospital and community stakeholders. Regional Perinatal Forums bring together hospital and community perinatal professionals, who strive to improve pregnancy outcomes through collaborative efforts to increase access to care, achieve improvements in quality of care and to address other state and region-wide public health issues related to maternal and infant health 2. Foster positive relationships between all levels of care and care providers by establishing annual opportunities for learning: EB practice updates, review of state or regional data to include the Level I, Level II, Level III multidisciplinary team and transport staff. 3. Create a clearinghouse of evidence based resources and tools 4. Utilize AWONN's Maternal-Fetal Triage Index 5. Utilize March of Dimes Preterm Labor Assessment Toolkit 6. Utilize AWONN's Late Preterm Infant Implementation Toolkit 	<p>CA</p>

	<p>SD3- Risk assessment and referral through all state agencies and programs that interact with pregnant women</p>	<ol style="list-style-type: none"> 1. All state agencies and programs that interact with pregnant women and families such as home visiting, WIC, injury prevention, substance abuse, child welfare, breastfeeding promotion, immunization, housing assistance receive training and materials on appropriate levels of care 	
	<p>SD4- Formal agreements, communication and collaboration/consultation between hospitals and community providers and across states</p>	<ol style="list-style-type: none"> 1. 24 hour consultation for providers including use of telemedicine 2. Weekly conferences are conducted between Level I/II providers along with Level III/IV providers/maternal fetal medicine specialists to discuss individual cases 3. Develop formal agreements and MOUs between care providers and facilities, including transfer agreements 4. Clarity in distribution of DRG between higher level and back-transport site 5. Establish Regional Perinatal Forums involving hospital and community stakeholders. Regional Perinatal Forums bring together hospital and community perinatal professionals, who strive to improve pregnancy outcomes through collaborative efforts to increase access to care, achieve improvements in quality of care and to address other state and region-wide public health issues related to maternal and infant health 6. Foster positive relationships between all levels of care and care providers by establishing annual opportunities for learning: EB practice updates, review of state or regional data to include the Level 	<p>CA – Promote CCS required Regional Cooperative Agreements (RCAs)</p>

		<p>I, Level II, Level III multidisciplinary team and transport staff</p> <ol style="list-style-type: none"> 7. Conduct individual annual Transport Review Conferences for multidisciplinary team for Level I & II sites, facilitated by Level III faculty, to review care processes and outcome data on all transported patients. Provide opportunity to review individual gap in care and outcomes data 8. Provide timely education to providers and facilitates identified as inappropriately delivering VLBW or very preterm infants or caring for high risk mothers 9. Offer financial incentives for rural providers to partner with a tertiary center to treat pregnant women in the community. Both providers are reimbursed for co-managing care 10. Higher level facilities provide access to lab tests, screening and review 11. Establish a common electronic health record system in each region 12. Agreements for back transport (to a level I or II community hospital) based on the full array of nursing and support services that the infant and/or mother require 	
	<p>SD5- Availability of beds, staffing and transportation to appropriate facilities before delivery</p>	<ol style="list-style-type: none"> 1. Upgrade services in facilities in high risk communities 2. Improve reimbursement for back transport to level I or II community hospital 	

<p>PD2- Activated* pregnant women and their support system</p>	<p>SD1- Reduce maternal presentation in advanced preterm labor (Women and their support system recognize the signs and symptoms of preterm labor)</p>	<ol style="list-style-type: none"> 1. Utilize breastfeeding and child birth classes, group prenatal care models, and existing perinatal quality collaboratives to educate consumers on signs and symptoms of preterm labor 2. Promote Text4Baby, a mobile information service designed to promote maternal and child health through text messaging. 3. Take advantage of existing campaigns, blogs, websites, and magazines such as Prematurity Prevention, Healthy Mom and Baby website, Healthy Mom and Baby magazine, and Share Your Story to provide information about preterm labor to target audience 4. Utilize existing education materials on preterm labor (e.g., March of Dimes, AWHONN) 5. Partner with Healthy Start 	<p>IL</p>
	<p>SD2- Women and their support system understand their risk for maternal and fetal complications and the need for the most appropriate level of care and are empowered to seek appropriate referrals to support services and chose to deliver in risk appropriate facility</p>	<ol style="list-style-type: none"> 1. Utilize Perinatal Case Managers 2. Utilize breastfeeding and child birth classes, group prenatal care models, and existing perinatal quality collaborative to educate consumers on appropriate levels of care 3. Providers use motivational interviewing with families to surface resistance and engage in joint problem solving 4. Utilize existing materials for training on teachback and motivational interviewing (example 1, example 2, example 3) 5. Providers use teach back with pregnant women on the risks of maternal and fetal complications 6. Use geocoding to determine where women prefer to deliver 7. Promote Text4Baby, a mobile information service designed to promote maternal and child health through text messaging. 	<p>CA (generally engaging families on this topic)</p>

		<p>8. Take advantage of blogs, websites, and magazines such as Healthy Mom and Baby website, Healthy Mom and Baby magazine, Share Your Story to provide information about appropriate levels of care</p>	
	<p>SD3- Develop/adapt culturally congruent education materials, social marketing messages and communication strategies on appropriate levels of neonatal and maternal care</p>	<ol style="list-style-type: none">1. Utilize public awareness campaigns to communicate information on appropriate levels of care to the public2. Develop a brief video on perinatal regionalization (e.g., Tennessee's video on their perinatal regionalization program)3. Utilize social media outlets such as Text4Baby	

<p>PD3- Clear and consistent definition, criteria, and state monitoring of levels of care in line with AAP & ACOG/SMFM recommendation</p>	<p>SD1- Every hospital is classified by level of care accurately, according to AAP/ACOG/SMFM guidelines and on a recurring basis</p>	<ol style="list-style-type: none"> 1. State Department of Health (or other state entity) designates all obstetrical hospitals and NICUs 2. Appropriate professional organization verifies level of care 3. Concentrate care for the highest risk pregnant women at the highest level maternal and neonatal centers to promote improved outcomes associated with increased volume and experience 	
	<p>SD2- Certifying authority assigns (and reassesses) level designation based on accurate assessment of the services provided</p>	<ol style="list-style-type: none"> 1. State Department of Health (or other state entity) designates all obstetrical hospitals and NICUs 4. Medicaid payments are tied to care at appropriate level of care and in hospitals in which level of care is verified 	<p>IL</p>
	<p>SD3- Regularly monitor effectiveness of regionalization system through data (e.g., birth weight specific mortality, maternal morbidity/mortality by maternal levels of care</p>	<ol style="list-style-type: none"> 1. Utilize state perinatal quality collaboratives to monitor effectiveness 2. MCH statisticians maintain an updated list of verified hospital designations each year 3. Analyze circumstances around VLBW and preterm deliveries from facilities with lower levels of care (I and II) and use information to develop strategies to improve rates 4. Analyze circumstances around pregnant women with high risk placental conditions, expectant management of preeclampsia with severe features at less than 34 weeks of gestation or severe maternal cardiac conditions being cared for at facilities with lower levels of care (I and II) and use information to develop strategies to improve rates 	

		<ol style="list-style-type: none"> 5. Fetal and Infant Mortality Review programs and/or Maternal Mortality Review Committees examine all contributors to fetal, infant and maternal mortality including the use of appropriate health care services 6. Use data to identify providers and facilities inappropriately delivering VLBW or very preterm infants or caring for high risk mothers 	
	<p>SD4- OBs, hospital leadership, hospital systems and payors support antenatal transfers</p>	<ol style="list-style-type: none"> 1. Engage leaders/stakeholders /champions (e.g., ACOG, SMFM, AAP, state Medicaid offices and hospital associations) at all levels to ensure/advocate for strengthening perinatal and maternal regionalization 2. Relationships among Level II and Level III/IV hospitals are prescribed by the health plan and providers operate within guidelines set forth by the plans 3. Connect with existing perinatal quality collaboratives 4. Cost of transportation and NICU stay covered by a financial safety net 	
<p>PD4- Policy and Financial Approaches facilitate perinatal regionalization (Cont.)</p>	<p>SD1- Perinatal regionalization system supported by policies governing hospitals</p>	<ol style="list-style-type: none"> 1. Regulation requires all level I and II hospitals to have a formal agreement and MOU with their regional level III or IV center 2. Levels of neonatal and maternal care included in hospital licensure regulations and require external verification on a recurring basis 3. Regulation of increasing level (from level II to III) through State certificate of need (CON) legislation 	

	<p>SD2- Reimbursement and payment models include financial incentives and disincentives to support perinatal regionalization</p>	<ol style="list-style-type: none"> 1. Relationships among Level II and Level III/IV hospitals are prescribed by the health plan and providers operate within guidelines set forth by the plans 2. Compensate hospitals and providers for appropriate referral and transport of at risk mothers and infants 3. Increase hospital reimbursement for antenatal care and transport 4. Offer financial incentives for rural providers to partner with a tertiary center to treat pregnant women in the community. Both providers are reimbursed for co-managing care 5. Medicaid payments are tied to care at appropriate level of care and in hospitals in which level of care is verified 6. Cost of transportation and NICU stay covered by a financial safety net 7. De-bundle antenatal transport from delivery 8. Compensation disincentives for delivery at inappropriate level of care 9. Improve reimbursement for back transport to level I or II community hospital 10. Clarity in distribution of DRG between higher level and back-transport site 11. Offer lower malpractice insurance premium for providers who have a certain level of management and delivery in appropriate levels of care 	
--	--	--	--

The accompanying information, materials, and recommendations are the result of the collaborative efforts of a number of organizations and individuals on this project and do not necessarily reflect the views of any national partner.

This project is supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) under grant #UF3MC26524 providing support for the Collaborative Improvement and Innovation Network (CoIIN) to Reduce Infant Mortality for \$2,870,658 (for this year 09/30/2015-09/29/2016)." This information or content and conclusions are those of the author and should not be construed as the official position or policy of, nor should any endorsements be inferred by HRSA, HHS or the U.S. Government.

