Improving Birth Outcomes in the U.S.: State Efforts to Reduce Prematurity

Tuesday, July 12, 2012
2:00-3:00PM, ET

For Audio
Dial-in: 1-800-768-2983
Access Code: 2663049
Brief Notes about Technology

Audio

• All telephone lines will be in “listen only” mode.

• To submit questions throughout the call, type your question in the chat box at the lower left-hand side of your screen.
  – Send questions to the Chairperson (AMCHP)
  – Be sure to include to which presenter/s you are addressing your question.
Technology Notes Cont.

Recording

• Today’s webinar will be recorded.

• The recording will be available on the AMCHP website: [www.amchp.org](http://www.amchp.org)
Learning Objectives

Upon completion of this webinar, participants will be able to:

• Understand national efforts to improve birth outcomes by reducing infant mortality and prematurity in the U.S.

• Identify strategies and resources states can apply to reduce prematurity and improve birth outcomes.

Related MCH Leadership Competencies:

• #1: MCH Knowledge Base
• #11: Working with Communities and Systems
Featuring:

- **Ellen Pliska, MHS**  
  Director, Family and Child Health, Maternal and Child Health Policy, Association of State and Territorial Health Officials (ASTHO)

- **Stephanie Birch, RNC, MPH, MS, FNP**  
  MCH Title V and CSHCN Director, Alaska Department of Health and Social Services

- **Breena Holmes, MD**  
  Director, Maternal and Child Health, Vermont Department of Health

- **Barbara O’Brien, RN, MS**  
  Program Director, Office of Perinatal Quality Improvement, The University of Oklahoma Health Sciences Center

**Moderator:** Lauren Raskin Ramos, MPH, Director of Programs, AMCHP
ASTHO Healthy Babies Initiative and Infant Mortality

Ellen Pliska, MHS, CPH
July 12, 2012
ASTHO President’s Challenge

Improve birth outcomes by reducing infant mortality and prematurity in the United States

Objectives:

- Focus on improving birth outcomes as SHOs and state leadership teams work with state partners on health and community system changes
- Create a unified message that builds on the best practices from around the nation
- Develop clear measurements to evaluate targeted outreach, progress, and return on investment

Pledge: Reduce preterm births by 8% by 2014
44 States Have Taken the Pledge

Pledge to Reduce Prematurity by 8% by 2014

As of 7/9/2012
ASTHO-March of Dimes Partnership

- State Health Agency/MOD Press Event
- MOD State Chapter/SHA Partnership
- Co-Branding of Healthy Babies are Worth the Wait Campaign
- MOD Materials and tool kits
- Visible/Active State Leadership
- Virginia Apgar Award (8%)
- Franklin Delano Roosevelt Award (9.6%)
HRSA Region IV & VI Summit on Infant Mortality

- January 12-13, 2012
- 7 member State Teams
  - State Health Officials, MCH Directors and other MCH experts, State Medicaid Officials, March of Dimes, Hospitals, Legislative and Governor’s Office senior staff
- Federal partners – HRSA, CMS, CDC
- Regional Goals and State Strategies
- Region IV, V, VI Collaborative Summit
www.astho.org/healthybabies/
www.astho.org/healthybabies/
National Interest

- NPP – Maternity Action Team
- Leapfrog Group Hospital Survey
- March of Dimes – Healthy Babies are Worth the Wait
- CMMI/CMS Strong Start Initiative, P4P
- NGA – Improving Birth Outcomes project
- Secretary’s Advisory Committee on Infant Mortality
- Consumer Group Involvement
ASTHO Resources

- ASTHO President’s Challenge on Healthy Babies –
  http://www.astho.org/healthybabies/

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Family and Child Health Director
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Improving Birth Outcomes in Alaska
Approaches, Activities and Challenges

STEPHANIE BIRCH, RN, MPH, MSN, FNP
SECTION CHIEF
TITLE V AND CYSHCN DIRECTOR

WITH CONTRIBUTIONS FROM
KATHY PERHAM-HESTER, M.S., M.P.H.
MARGARET BLABEY YOUNG, M.P.H.
DEBRA GOLDEN, RN, MSN
JULY 12, 2012
Alaska postneonatal and neonatal mortality rates, 1980-2010 (Rates per 1,000 live births)
Neonatal and Post-neonatal Mortality Rates
AK Bureau of Vital Statistics and National Center for Health Statistics at the Centers for Disease Control and Prevention.

Neonatal and post-neonatal mortality rates, Alaska and United States, 1992-2008

Rate per 1,000 live births


Alaska neonatal  Alaska postneonatal  US neonatal  US postneonatal
Figure 3. Neonatal and postneonatal mortality rates for Alaska Native and non-Native infants, 1992-2008.
History in Alaska

- Early 1980’s Alaska was at the bottom of all states in Infant mortality with particularly high rates of neonatal and post neonatal mortality.
- Level III had just opened and was staffed with one neonatologist and rotating fellows. Two other facilities attempting to develop Level II NICU’s
- No infrastructure for early identification or transport
- No maternal fetal medicine
- No roads to most of Alaska-air travel was developing
- High rates of drug and alcohol abuse and isolation complicated by challenges with access to health care
THE ALASKA NATIVE HEALTH CARE SYSTEM

Typical Referral Patterns

REFERRALS FROM:
- HOSPITALS
- MD HEALTH CENTERS
- PANIP HEALTH CENTERS
- CHA CLINICS
Approaches: System Changes

- Guidelines for Perinatal Care - AAP/ACOG served as the framework to guide the regionalization of care
- Healthy Babies Project - funded by Title V MCH federal dollars - regional outreach and training
- Equipment - stabilization boards, warming beds and resuscitation
- Development of a neonatal air and ground transport system
- Late 80’s – addition of maternal transport training and implementation
- Implementation of maternal homes for tribal health beneficiaries - meant leaving village at 36 weeks to live in a hub community until delivery
Systems Changes: Perinatal Care

- Hospitals- acceptance statewide of one neonatal/perinatal regional center
- Development and enhancements in support of two Level II NICU’s.
- Joint recruitment of perinatologists, neonatologists and neonatal nurse practitioners
- Hospital support for training stipends
- Title V funded continuing education for physicians and nurses
- Intentional Quality Improvement work-joining the Vermont Oxford Network
Strategies for Perinatal Success: “39 Weeks Campaign”

- Collaborative effort between AMCHP, ASTHO and the March of Dimes to reduce non medically indicated inductions or cesarean sections prior to 39 weeks of completed pregnancy and reduce pre term births
- Statewide effort - most of the larger hospitals are involved. Coalition led by the MOD and the All Alaska Pediatric Partnership
- “Hard Stops” initiated at two of the larger birthing facilities with a planned initiation at the states regional perinatal/neonatal facility in November 2012.
Figure 6. Cause-specific mortality rates, Alaska 1992-2005, 3-year moving averages

- SIDS/SUID/asphyxia
- Preterm birth
- Congenital anomalies
- Infections
- Perinatal events or conditions
- Injury
- Unknown
- Other
Contributing Factors to Post Neonatal Mortality: Sudden Unexplained Infant Deaths and Asphyxia

- SUID or asphyxia in a sleep environment was the most common determination made by the MIMR/CDR committee.
- Known risk factors: suffocation related to unsafe sleep environments (sleeping prone; non standard sleep surfaces, bed sharing with an impaired person and exposure to prenatal tobacco or environmental tobacco smoke.
Strategies to reduce Post Neonatal Morality

- Creation of an Infant Safe Sleep Task Force
- Division Position Statement on Infant Safe Sleep—reflects the revised AAP position statement
- Social Marketing evaluation on safe sleep information
- Tool Kit development and education for nursing
- Engagement of hospital nursing staff and health care providers on messaging consistent information about safe sleep practices
- Home Visiting programs – MIECHV and Healthy Start
Future challenges: Improving Birth Outcomes

- Reducing the effects of alcohol and drug abuse – limited treatment facilities for pregnant and parenting mothers
- Tobacco cessation programs for pregnant and postpartum women
- Child maltreatment prevention – new attention in our state
- Reducing the rates of preventable congenital anomalies – increase in folic acid intake; abstinence from alcohol and drug use
- Better management of intrapartum and neonatal infections
Thank you
For more information: Stephanie.birch@alaska.gov
Vermont’s Story for Preventing Prematurity

Breena W. Holmes, MD
Maternal and Child Health
Vermont Department of Health
Objectives

• Review Vermont data
• Review state programs for prematurity prevention
• Highlight a few key initiatives and effective partners
• Identify barriers and ongoing challenges
Vermont Data

- **8.7%** Preterm Births (<37 weeks) 2011
- **8.4%** Preterm Births 2010
- approximately 6000 deliveries per year
- **1.6%** of total births = young teen (age less than 18) births
- **4.9%** of births were “new families at risk” (first births to single mothers aged less than 20 with less than high school education)
State of Vermont Programs

- Children’s Integrated Services (CIS)
- Integrated Family Services (IFS)
- Vermont Chronic Care Initiative
  - Care Coordination for Medicaid beneficiaries
- Maternal and Child Health
  - WIC
  - Maternal, Infant, Early Childhood Home Visiting (MIECHV)
  - Maternal and Child Health Coordinators
Children’s Integrated Services

• Health promotion, prevention and Early Intervention for pregnant women and children to age 6

• Medical and Dental Care Access

• Centralized Intake Coordination
  – Early Intervention,
  – Nursing Family Support,
  – Specialized Child Care and
  – Early Childhood and Family Mental Health
Integrated Family Services

• Prenatal to 22yrs
• Similar model to CIS but broader age range
• Coordinated funding
• Shared Outcomes
  – % of deliveries that received a prenatal care visit in the first trimester
  – % of deliveries that had a postpartum visit on or between 21 and 56 days after delivery
Vermont Chronic Care Initiative

- Registered nurses and social workers
- Intensive case management to highest cost, highest risk, medically and socioeconomically complex beneficiaries
- 2012: added 2 additional staff for high risk pregnant women
Maternal and Child Health

• WIC
  – Smoking cessation

• 12 MCH coordinators
  – Public health nurses doing population health
  – Policy development in their communities
  – Strong relationships with health care providers
  – Work closely with WIC
Maternal and Child Health

• Affordable Care Act
  – Maternal, Infant, Early Childhood Home Visiting (MIECHV)
  – Vermont Model
    • Nurse Family Partnership
    • Launched July 2012
Vermont Child Health Improvement Program (VCHIP)

• Population-based research and quality improvement (QI) program based in the University of Vermont’s College of Medicine in partnership with Department of Health
• Improving Care for Opioid-Exposed Newborns (ICON)
• Obstetrical Outreach
  – OBNet data collection and analysis
  – Prenatal care standards
  – Impact of obesity
• Regional Perinatal QI projects
  – Late Preterm Initiative
Late Preterm Initiative

- Community hospital based project to:
  - Eliminate elective inductions of labor and elective cesarean sections prior to 39 weeks gestation
  - Early identification of maternal risk for late preterm delivery
  - Ensuring appropriate, timely, effective and efficient surveillance and intervention
  - Structure for comprehensive parent education
  - Standards for discharge planning
  - Comprehensive follow-up services
Late Preterm Initiative

• Objectives met
  – Increased surveillance of the late preterm infant
  – Standardized late preterm infant order/care sets
  – Standardized criterion for elective deliveries AT 39 weeks gestation (this includes inductions of labor and c-sections)
Other Factors

• Health Insurance coverage
• Health Access including reproductive health
• Preconception
  – Statewide comprehensive sexuality education
  – Health access for young women
Ongoing Challenges

• Smoking in Pregnancy
• Healthy Weight in Pregnancy
• Substance Use in Pregnancy
  – Opioid dependence
  – Alcohol
Oklahoma Every Week Counts Collaborative

Barbara O’Brien, RN, MS
Program Director, Office of Perinatal Quality Improvement
The University of Oklahoma Health Sciences Center
Oklahoma Every Week Counts Collaborative

Purpose

• To eliminate non-medically indicated scheduled cesareans and inductions prior to 39 weeks

• Three Pronged Approach
  • Every Week Counts Collaborative among Oklahoma birthing hospitals
    • Data Collection
    • Scheduling Process Change
    • “Hard Stop” Policy
  • Patient Education through March of Dimes patient education materials
  • Public awareness through airing of “Masterpiece” PSA
Oklahoma Every Week Counts Collaborative

History—2009

- **Oklahoma Perinatal Advisory Task Force** identified early elective deliveries as a potential area for improvement
- Evidence published regarding outcomes for early term births
- **Oklahoma State Department of Health, Oklahoma Health Care Authority, Oklahoma Hospital Association, Oklahoma March of Dimes, OUHSC Office of Perinatal Quality Improvement**
  - Convened perinatal providers and Oklahoma birthing hospital staff
  - OUTCOME: Develop a collaborative to eliminate early, elective deliveries
Oklahoma Every Week Counts Collaborative

History—2010

- **OHA** applied for and received *March of Dimes* grant to support collaborative
- Planning—data tool (revised from Maryland Patient Safety Center)
- CMQCC/March of Dimes Toolkit published
Oklahoma Every Week Counts Collaborative

History—2011

• January—Recruitment brochures sent to Oklahoma birthing hospitals (62 at that time) CEOs and Nursing Directors
• January-April—Commitment forms returned with EWC team identified
• Oklahoma State Department of Health provided additional funding due to large number of participating hospitals
• February-April—Individual calls made to hospital teams, materials/instructions distributed, baseline data collected/submitted
• April 28—Learning Session #1—52 out of 59 hospital teams in OKC
• Distributed MOD patient education materials to participating hospitals
• June and November—”Masterpiece” PSA aired
• July 22—Learning Session #2
• October 4—Learning Session #3
Oklahoma Every Week Counts Collaborative

Where are we now?

• 52 out of 59 OK birthing hospitals participating
• Continue to send monthly data
• Create and send monthly hospital reports, quarterly aggregate and hospital comparative reports
• Learning Session #4—July 13, 2012
First Quarter 2012 Oklahoma Data
(January – March, 2012)
EVERY WEEK COUNTS
Total Deliveries by Gestational Age and Documented Indication

Qtr 1 2011: January 1 – March 31, 2011

- Inductions > 39 weeks
- Inductions <39 weeks WITH a documented indication
- Inductions <39 weeks WITHOUT a documented indication

~ 8/day

Qtr 1 2012: January 1 – March 31, 2012

- Scheduled C-Sections <39 weeks WITHOUT a documented indication
- Scheduled C-Sections <39 weeks WITH a documented indication
- Scheduled C-Sections >39 weeks
- Others

<3/day
Scheduled C-Section Rates by Gestational Age and Indication

As percentage of Total Scheduled C-Sections

*comparison is difference between 1st Qtr. 2011 – 1st Qtr. 2012

- Rate of Scheduled C-Sections >39 weeks
- Rate of Scheduled C-Sections <39 weeks WITH a documented indication
- Rate of Scheduled C-Sections <39 weeks WITHOUT a documented indication
Induction Rates by Gestational Age and Indication
as percentage of Total Inductions

(All)

*comparison is difference between 1st Qtr. 2011 – 1st Qtr. 2012
Scheduled C-Sections AND Inductions <39 Weeks WITHOUT a documented Indication
- as percentage of Total Deliveries

- 7.22%
- 8.12%
- 5.30%
- 5.11%
- 4.79%
- 3.57%
- 3.14%
- 3.24%
- 2.52%
- 2.03%
- 2.78%
- 2.46%
- 1.98%
- 1.63%
- 1.64%
- 3.08%
Oklahoma Birth Certificate Data

Percent of singleton births delivered 39-41 weeks and 36-38 weeks by month of birth: Oklahoma, April 2009 to June 2012*

*Provisional Data
Oklahoma Every Week Counts Collaborative

Key Factors for Success

• Support and funding from Oklahoma State Department of Health
  • OSDH *Preparing for a Lifetime, It’s Everyone’s Responsibility* initiative to reduce infant mortality
Oklahoma Every Week Counts Collaborative

Key Factors for Success

- **PARTNERSHIPS**—OSDH, March of Dimes, OHA, OHCA, OUHSC, birthing hospitals, perinatal providers
- Collaborative approach—working together rather than alone
- Data—supports need, provides information, illustrates improvement and opportunities for improvement, comparative data
- Executive support
- Feature national leader speakers at learning sessions
- Networking opportunities
- March of Dimes toolkit and other resources/publications for participants
- Created community of perinatal providers with will to improve birth outcomes together

AMCHP
Oklahoma Every Week Counts Collaborative

Lessons Learned

• Strong physician champion on hospital team critical—willing and able to support goal of collaborative in actions and words
• Anticipate resistance—develop strategies to meet resistance
• Keep the pressure on
• Provide individualized strategies
• DATA, DATA, DATA—use it to inform
• Success ultimately depends on belief in process
Contact information:

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Questions?

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ASTHO/AMCHP Resources

Available on the AMCHP website:

- Forging a Comprehensive Initiative to Improve Birth Outcomes and Reduce Infant Mortality: Policy and Program Options for State Planning
- AMCHP Innovation Station: Emerging, Promising and Best Practices on Infant Mortality & Improving Birth Outcomes
  - [http://www.amchp.org/programsandtopics/womens-health/infant-mortality/Pages/default.aspx](http://www.amchp.org/programsandtopics/womens-health/infant-mortality/Pages/default.aspx)

Available on the ASTHO website:

- President’s 2012 Challenge: Healthy Babies Initiative
  - [http://www.astho.org/healthybabies/](http://www.astho.org/healthybabies/)
Additional Resources

Resources from MCHB’s 2012 Region IV & Region VI Infant Mortality Summit

• [http://mchb.hrsa.gov/infantmortalitysummit.html](http://mchb.hrsa.gov/infantmortalitysummit.html)

March of Dimes: Healthy Babies are Worth the Wait awareness and educational materials

• [www.marchofdimes.com/39weeks](http://www.marchofdimes.com/39weeks)
Thank you for participating!

A brief evaluation survey will appear after you exit the webinar. Your feedback is much appreciated!