Creating a Hospital Based Maternal/Infant Mortality Task Force

Mistie Winkfield Hughes, CNM, IBCLC, MSN
Cleveland: Things to be Proud of…

2016 NBA World Champs

ALMOST 2016 MLB World Champs
Cleveland: Things to be Proud of…

A Christmas Story House
Our Infant Mortality Crisis

Healthy People 2020 Infant Mortality Rate Goal: 6.0 per 1,000 live births

Infant Mortality Rates in 2013:
- Ohio: 7.4 per 1,000 live births
- Cuyahoga County: 8.9 per 1,000 live births
- Cleveland: 13 per 1,000 live births

Black Infant Mortality Rates:
- Ohio (2014): 14.3 per 1,000 live births
- Cuyahoga County (2011-2013): 13.7 per 1,000 live births
- Cleveland (2012): 15.73 per 1,000 live births
University Hospitals Cleveland Medical Center
Deaths under 1 year of age across Cleveland Wards, 2008-2012

University Hospitals
Cleveland Medical Center
MacDonald & Rainbow Maternal/Infant Mortality Task Force

Timeline

• 12/2014—small, informal group meetings

• 7/2015—separate OB and Peds task forces formed

• 9/2015—MacDonald & Rainbow Maternal/Infant Mortality Task Force formed
Inventory of Involvements

Surveyed task force members

Identified 30 committees/initiatives
Infant Mortality

GLOBAL AIM

Increase the number of infants in our community surviving their first year of life

SMART AIM

Decrease the infant mortality rate to <13/1000 births in the patient population served by MacDonald Women’s and Rainbow Babies and Children’s Hospital by 2020

Revision Date: 12-20-15

KEY DRIVERS

- System/resources to support execution of identified deliverables
- High Reliability leadership methods to support clinicians
- Prevention of premature birth
- Optimal health before/during and after pregnancy
- Prevention of Birth Defects
- Injury Prevention
- Access to Care
- Elimination of Health Inequity/Poverty
- Coordinated continuum of care across institutions in the community
- Coordinated Community Response

INTERVENTIONS

- Progesterone for all eligible patients
- Long Acting Reversible Contraception Program (LARC)
- Family planning /Reproductive life plan
- Expansion and promotion of Centering Pregnancy and Centering Parenting
- Case management via Rainbow Care Connection
- Community support of current programs/therapies
- Focused efforts to manage obesity, diabetes and hypertension
- Access to mental health services (screening, treatment and follow up)
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- Transportation to and from clinic appointments
- Availability of child supervision during visits
- Optimal clinic locations with on site ancillary resources
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Increase the number of infants in our community surviving their first year of life.

- Decrease the infant mortality rate to <13/1000 births in the patient population served by MacDonald Women’s and Rainbow Babies and Children’s Hospital by 2020.

**KEY DRIVERS**
- Prevention of Birth Defects
- Injury Prevention
- Access to Care
- Elimination of Health Inequity/Poverty
- Coordinated continuum of care across institutions in the community
- Coordinated Community Response
- Resources to support of identified deliverables
- Reliability leadership to support clinicians
- Reduction of premature birth
- Health before/during and after pregnancy

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**INFANT MORTALITY**

**Optimal health before/during and after pregnancy**

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**Safe sleep education and reinforcement throughout continuum of prenatal/newborn/infant care**

- Access to safe sleep equipment in the home
- Community support of safe sleep practices
- Community wide Injury Prevention Campaign

**Coordinated Continuum of Care**

- Across institutions in the community

**Coordinated Community Response**

- System/resources to support execution of identified deliverables
- High Reliability leadership methods to support clinicians
- Prevention of premature birth
- Optimal health before/during and after pregnancy
- Prevention of Birth Defects
- Injury Prevention

**Revision Date:** 12-20-15
Focus Areas

Safe Sleep
Centering Pregnancy
Immediate Postpartum LARCs
Progesterone
Reducing Infant Mortality with a Focus on Safe Sleep

Erin Frank MD FAAP
Pediatric Hospitalist, Rainbow Babies and Children’s Hospital

Katherine Griswold MD FAAP
Newborn Hospitalist, MacDonald Women’s Hospital
Sleep Related Deaths

- Sleep related deaths continue to be 15% of infant mortality state wide
- Improved death scene reviews better identify cause of death
  - SIDS numbers decreasing
  - Better identification of suffocation and asphyxiation
- Despite Back to Sleep Campaign and improved parental education, the numbers have remained largely steady
- This made it an obvious target for identification as an initial focus area within out infant mortality group
Safe Sleep Needs Assessment

- **Inpatient Needs:**
  - Hospital system wide safe sleep policy and practice guidelines
  - Hospital system branded educational resources to provide to families
  - Available referral resources for families identified without a safe sleep environment in the home (will require coordination with community resources)
  - MD/RN/PCA ongoing education regarding safe sleep practice system wide
  - Control of the sleep environment including
    - Sleep sacks for all infants <1 yr of age
    - Removal of blankets for standard crib set ups
    - Alternative sleeping options for stable children not tolerating our current crib setups (these may include regulation compliant bassinets of portable cribs)
  - Gold Cribs for Kids Designation for our hospital system including affiliation with local Cribs for Kids partner
Safe Sleep Needs Assessment

• **Outpatient Needs:**
• Universal education for all OB and Peds providers with UH affiliation
• Educational resources for patients to be distributed at 2nd trimester OB visits during
• Available referral resources for families identified without a safe sleep environment in the home
• Home RN visits focused on educations for new parents targeted at safe sleep
• Improved access to prenatal education classes (including transportation and child care options for women in attendance)
• Referral resources for community support and plans for developing a community doula model where infant safety can be discussed and reinforced in the home setting.
First Steps: Modeling safe sleep in the Hospital Setting

- 2016 AAP Safe Sleep Recommendations:
  - Health care professionals, staff in newborn nurseries and NICUs, and child care providers should endorse and model the SIDS risk-reduction recommendations from birth

- Studies in the premature population have demonstrated that families follow the behaviors modeled for them in the hospital setting upon discharge from the NICU

- Initial evaluation of our inpatient sleep environments demonstrated high risk sleep environments and inconsistent messages to families regarding home going recommendations
Infant Safe Sleep Key Driver Diagram

Project Name: Improving Safe Sleep Conditions for Infants <12 months in the Inpatient Setting

**Global Aim**

Improve the safety of the sleep environment for infants <1 year of age

**Smart Aim**

By 12/31/16 there will be 90% compliance with AAP safe sleep guidelines for infants <12 months admitted to the standard medical floors at RBC and newborn nursery at MacDonald Women’s Hospital.

*Alone*

*placed on their Back*

*in a bare Crib

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**Key Drivers**

- **Nursing Education**
  - Nursing online LMS modules reviewing safe sleep guidelines/ CE module
  - Nursing script to discuss hospital guidelines with families
  - Nursing documentation of sleep environment
- **Provider Education**
  - Resident Education modules
  - Discussion of sleep concern at bedside rounds
  - Subspecialist education on safe sleep guidelines
- **Education Materials**
  - Admission Handout Packets with RBC/Mac branded educational materials
  - Take home magnets
  - FLC engagement
- **Management of the Environment**
  - Sleep Sacks (<1 yr of age)
  - Change in reflux precautions
  - Removal of blankets by environmental services from standard crib setup
  - Alternative sleeping options for stable children not tolerating the crib environment
- **Administrative Support**
  - Hospital system wide Safe Sleep Policy and Clinical Practice Guidelines
  - Gold Cribs for Kids Designation

---

*Alone* placed on their Back *in a bare Crib
Ohio AAP EASE Project Phase 1 (2014)

- Education and Sleep Environment learning collaborative
  - Hospital based program with 6 Children’s Hospitals Participating
  - Goals:
    - Focus on modeling a safe sleep environment during acute hospitalization
    - Providing education regarding safe sleep prior to discharge
  - Monthly data tracking by random audits of the hospital sleep environment
  - Clinical Changes
    - Routine education provided to all RN and PCA staff
    - Yearly education on safe sleep as part of the resident curriculum
    - Standardized education for families on admission
    - Standard use of sleep sacks in the hospital setting (removal of hazards)
    - Removal of head of bed elevation
EASE Study Results (Phase 1)

**Safe Sleep Position**
Rainbow Babies and Children’s Hospital
March 2014 - June 2015

**Received Information on Safe Sleep Practices**
Rainbow Babies and Children’s Hospital
March 2014 - June 2015
Ohio AAP EASE Project (Phase 2)

- Phase 2 expanded to include birthing hospitals in addition to children’s hospitals
  - 11 hospitals total (8 birthing, 3 children’s)
  - Ran 6/15 – 5/16
- Continued focus on family education and safe sleep environment through additional PDSA cycles and room audits
- Each hospital was able to adopt a safe sleep policy
  - Currently active in MacHouse and Rainbow Babies and Children’s
  - Can be shared across the hospital system
EASE Study Results (Phase 2)

UH MacDonald
Performed at the top of all birthing hospitals in the collaborative

UH Rainbow maintained steady gains seen during Phase 1 of the project
Family Education: Newborn Nursery and Beyond

- Emphasis on parental education
  - Discussed on daily rounds with the pediatric team
  - Routine education by nursing staff
  - Re-education provided if an unsafe sleep environment is identified during the stay (multidisciplinary MD and RN)
- Injury Prevention staff round M-F to discuss safe sleep and provide additional information in the newborn nursery
- Safe sleep cards/posters
- Use of sleep sacks to model safe sleep environment
Safe sleep policy

- Ensure all providers are modeling the same behavior system wide
- Focus on stable infants <1 year nearing the time of discharge
- Developed by an interdisciplinary team from both the children’s and birthing hospital
  - RN
  - MD
  - Social Work
- Approved by hospital administration after vigorous review
- Provides support to staff when they are educating families about the need to follow safe sleep procedures
- Having a formal policy emphasizes the importance of this issue to families touched by our health care system
Safe Sleep Statewide

- Ohio Senate Bill 276 Passed in 2015
- Requires birthing hospitals to have an identified safe sleep policy in accordance with the AAP recommendations
- Requires hospitals to provide resources to families who do not have an identified safe sleep environment for their newborn prior to hospital discharge
  - Referrals to local health agencies
  - Cribs for Kids providers can provide a free or low cost pack-n-play
Community Engagement

- Increasingly use the term sleep related death rather than SIDS
  - SIDS is felt to be unpreventable by patients
  - Causes such as suffocation and asphyxiation from high risk sleeping environments is tangible and families can take control of these changes
  - Encourage breast feeding and room sharing, not bed sharing both of which has been shown to decrease SIDS numbers
- Prenatal Education
  - Discussion promoting use of a safe sleep environment should begin prenatally
  - Determine where they plan to have the infant sleep
  - Ideally this discussion would happen before soft bedding/bumpers would be purchased
- Postnatal Education
  - Routine discussion of home sleep environment at every WCC visit during the first year of life
  - Identify and target barriers specific to each patient’s situation
  - Referrals to local agencies for high risk families
Questions?
Room Sharing

- New stronger recommendations for room sharing (not bed sharing) for the 1st year of life
  - 50% reduction in SIDS deaths
  - Strongest recommendation for the first 6 months of life when 90% of SIDS death occur
- Recommend a separate sleep surface in the same room
- Also promotes breast feeding which is SIDS protective as well
Sleep Surface

In recognition of the fact that many parents are over tired, the AAP has addressed the issue that parents may fall asleep while feeding and comforting their infant.

In this situation, it is preferable to be in an adult bed, away from the wall and without any bedding or pillows than in a recliner, couch or other sleep surface.

It is recommended that when a parent awakens in this situation, they should immediately place the infant back in their own sleep environment.
CenteringPregnancy® @ University Hospitals

Gretchen Mettler, CNM, PhD, FACNM
Centering Program Director
Tenisha Gaines, BA
Centering Coordinator
Centering Pregnancy

- Group prenatal care, done on the same schedule as regular obstetric appointments for 8 sessions, embodying principles of facilitation, group support, and empowerment
- Started 2010
- Over 1500 women have attended Centering to date
- Comparable to national statistics for LBW and prematurity
Centering Pregnancy

- From 2010 – 2014 we recruited women to attend Centering.
- In 2015 we went to an “Opt Out” model.
- Clients are given their 2nd ob appointment in Centering.
- The LPN or Tenisha follows up on the CNM explanation of Centering.
Centering Staff
Needs identified

• **Staff Buy-in:** Everyone from the front desk to the cleaning crew and in between (all CNMs, RNs, LPNs, scheduling, etc.) need to buy-in to Centering for prenatal care.

• Everyone needs to recognize that Centering is **The Gold Standard for Prenatal Care**

• All patients should be in Centering groups.
SAFE SLEEP
Needs identified

• Making sure that EVERYONE is on board with getting the patients into a Centering group. Currently about 1/3 of the midwives’ patients are enrolled in Centering, we should be much closer to 85%
Needs identified

- **Client buy-in**: When staff is fully on-board, they can help clients realize that Centering is not just more time, or inconvenient, or anything other than the best thing for them and their baby.
Needs identified

• More money for
• Books (Centering materials)
• Snacks
• Parking (a constant problem)
• Incentives
  – Clients
  – Staff
Needs identified

**Staffing** – co-coordinators and CNMs.

- In 2015-2016 we had a down tick in numbers of CNMs doing Centering and no extra co-coordinators
- We will be back to full CNM capacity in early 2017
- RNs have been trained, but have never participated
Needs identified

- Since switching to “Opt Out” scheduling instead of recruitment, our attendance at the first session has dropped, as has our overall attendance and adherence.
Conclusions

• Working on client buy-in is a constant issue.
• Staffing is a constant issue
• Good results keep us committed to what we do
One Mode of Preterm Birth Prevention: Insertion of Immediate Postpartum LARCs

Amy Schmidt, MPH, CHES
Maria Shaker, MD
Maternal & Infant Mortality Taskforce
MacDonald Women’s Hospital
University Hospitals Cleveland Medical Center
Immediate Postpartum LARC - Background

Unintended/Short Interval Pregnancy

- Nearly 50% = ~ 3 million in USA per year
- ½ women experience unintended pregnancy by age 45
- 1 in 3 women will have an abortion
- ¾ teen pregnancies are unintended
- Disproportionately affects lower SES women
Immediate Postpartum LARC - Background

Risks of unintended/short interval pregnancy

- Adverse maternal and child health outcomes
  - Delayed prenatal care
  - **Premature birth**
  - Lower educational attainment
  - Obesity, diabetes
  - Negative mental health impacts
Immediate Postpartum LARC - Background

Current state of contraception in the United States
  o Most commonly used methods: pill, sterilization, male condom
  o Failure rates high with typical use!
  o Show rates for postpartum visit dismal at Mac House

Safe and effective contraception to combat unintended pregnancy rate/preterm birth
  o ACOG → charge to increase access to LARCs
  o Contraceptive CHOICE Project
  o Promote LARCs amongst teens and nulliparous women
Immediate Postpartum LARC - Background

U.S. women’s use of long-acting reversible contraceptive (LARC) methods, like the IUD, has increased over the past decade.

Female contraceptive users aged 15–44

<table>
<thead>
<tr>
<th>Year</th>
<th>Implant</th>
<th>IUD</th>
</tr>
</thead>
<tbody>
<tr>
<td>2002</td>
<td>2.4%</td>
<td>0.4</td>
</tr>
<tr>
<td>2007</td>
<td>3.7%*</td>
<td>3.5</td>
</tr>
<tr>
<td>2009</td>
<td>0.1</td>
<td>8.5%</td>
</tr>
<tr>
<td>2012</td>
<td>0.8</td>
<td>11.6%</td>
</tr>
</tbody>
</table>

www.guttmacher.org

*Numbers do not add to total due to rounding.
Immediate Postpartum LARC – The Solution
Immediate Postpartum LARC – Benefits

- Reliably exclude pregnancy
- Women motivated to prevent pregnancy
- Clinician and patient are in same place @ same time
- Easy access to uterine cavity
- Insurance coverage
- U.S. Medical Eligibility Criteria
- Cost effective
- Higher continuation rate vs interval placement**
Immediate Postpartum LARC – Disadvantages

- Higher expulsion rate vs interval insertion
  - *Remember:* higher continuation rates vs interval placement!

- Possible reimbursement issues
Immediate Postpartum LARC – Key Drivers to Initiating Program

GLOBAL AIM

Reduce short interval pregnancy by increasing accessibility to Long Acting Reversible Contraceptive (LARC) methods

SMART AIM

Increase post-placental insertion of levonorgestrel (Lilletta) IUD in desiring, eligible patients from 0%-50% by July 1, 2016
Immediate Postpartum LARC - Eligibility

IUD: Within 10 minutes of placenta: vaginal or cesarean delivery
Nexplanon: anytime prior to discharge

Exclusion criteria:
- Membranes ruptured > 24 hrs
- Intrapartum fever/choriomamnionitis
- Known uterine malformation
- Severe anemia (for Paragard insertion only)
- Personal history of breast cancer (levonorgestrel IUD)

No need to remove if:
- Endometritis
- Delayed hemorrhage
Immediate Postpartum LARC – How To

A) IUD strings placed in palm of hand
B) Manual insertion at top of fundus

Lots of resources… find them on ACOG’s Website
Immediate Postpartum LARC – How To

IUD
- Precaution patient on risk of and signs/symptoms of expulsion
  - Backup form of birth control until can confirm location
- May need to return for string trim prior to postpartum visit
- Lost strings?! Don’t go to the OR!

Nexplanon
- No different than interval insertion
Immediate Postpartum LARC
Ah… What about the reimbursement, you ask…

Currently offering PP LARCs to Medicaid patients only

Ohio Medicaid – reimbursing at least for professional fee
  o Delivery diagnosis code + surgical procedure code for IUD insertion
    ▪ ICD 10 diagnosis code such as Z30.430
    ▪ CPT code 58300
  o U/S guidance IUD
    ▪ CPT code 76999, U02-26
Immediate Postpartum LARC – Future Directives

Expand insertion to Paragard, Nexplanon

Track outcomes:
- Number of LARCs placed in women requesting insertion
- Reason for not inserting an IUD if it was requested
- Insurance reimbursement rates for insertion
- Expulsion rate (IUDs), factors affecting this
- Continuation rates
- Short interval pregnancy, preterm birth rates
- Breastfeeding rates
Immediate Postpartum LARCs

Thank you!

Questions?

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IM Progesterone for preterm birth prevention

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A STATEWIDE QUALITY IMPROVEMENT PROJECT TO REDUCE OHIO PRETERM BIRTHS BEFORE 37, 35, AND 32 WEEKS’ GESTATION BY IDENTIFYING AND TREATING PREGNANT WOMEN ELIGIBLE FOR PROGESTERONE SUPPLEMENTATION

Revision Date: 09-17-12

1° DRIVERS
- Identification of Women at Risk for Preterm Birth by Hx
- Identification of Women at Risk for Preterm Birth by Cervical Length Screening
- Prescription of Progesterone to Eligible Women at Risk for Preterm Birth
- Removal of Administrative Barriers to Administration of Progesterone

2° DRIVERS
- Earlier and More Consistent Recognition of Risk
- Adopt a selective or universal cervical ultrasound screening algorithm
- Sonographers credentialed to perform TVU for cervical length measurement
- Initiate progesterone within 7 days of identification of Short Cervix < 20 mm
- Initiate progesterone supplementation before 17 weeks in women with a Prior SPTB between 16 and 36 weeks
- Prompt initiation and completion of all administrative steps in provision of progesterone Rx

INTERVENTIONS
- Screening & accelerated 1st OB visit for women w/Hx PTB into care < 14 weeks; improve recognition of the Ob Hx at risk
- Promote early dating ultrasounds
- Teams of Resource Nurses, Pharmacists & Doctors to Answer Questions re: Progesterone
- Visits by QI Teams to Hospitals & Clinics in each Metro Area of Ohio: Adopt a Plan
- Promote ACOG 2012 PTB Guidelines
- Promote CLEAR & FNF Cervical Length Credentialing
- Presumptive eligibility for 1st prenatal visit
- Involve Ohio Medicaid, Managed Care & FFS, and Pvt Insurance Cos

SMART AIM
- By July 1, 2015, DECREASE THE RATE OF PRETERM BIRTHS BEFORE 37, 35, & 32 WEEKS IN OHIO BY 20%

GLOBAL AIM
- TO REDUCE INFANT MORTALITY IN OHIO BY REDUCING PRETERM BIRTH

Reduction of Fertility Practices that are Known to Increase Higher Order Multiple Gestations
Next steps

Continue to work on interventions
Address other drivers
Gather baseline data on interventions, determine measurable outcomes, then collect data to evaluate effectiveness of interventions
Explore funding opportunities
Explore partnership with community and community organizations
Challenges

Coordination of efforts
Time restraints
Obtaining baseline stats
“Insanity: doing the same thing over and over again and expecting different results”

- Albert Einstein
Thank You