In February 2014, OHA announced a comprehensive and targeted plan to reduce Ohio’s infant mortality rate five percent annually over the next three years. The 2014-2016 strategic areas of focus for infant mortality are listed below (see www.ohiohospitals.org/infantmortality for the Ohio Hospital Association-OHA White Paper on Infant Mortality). The safe sleep initiative launched on April 1, 2014 and has been widely embraced by hospitals and the community. Ninety-five of Ohio’s 107 maternity hospitals and all six of Ohio’s pediatric hospitals have committed to the project in the first three months (see details at www.ohiohospitals.org/safesleep). The next step in OHA’s strategic plan is to continue reducing Ohio’s decreasing rate of early elective delivery.

OHA Infant Mortality Areas of Focus (2014 – 2016)

- Promote and practice safe sleep
- Reduce elective deliveries before 39 weeks
- Increase breastfeeding
- Promote safe spacing of pregnancies
- Provide progesterone for high risk mothers
- Increase access to prenatal care
- Eliminate health disparity

Reduce Ohio Early Elective Deliveries (EED) before 39 Weeks

Early Elective Delivery (EED) is defined as a scheduled delivery (vaginal or cesarean) at 37-39 completed weeks of gestation (37 weeks + 0 days to 38 weeks + 6 days).¹

This may seem tedious, but in fact, each day of gestation does matter in fetal maturation. Health care experts have determined that EED is associated with an increase in infant mortality, neonatal morbidity, and C-section rates. OHA’s quality team is committed to working with hospitals on this issue.
Early Elective Delivery Impact

Elective deliveries between 37-39 weeks (37 weeks + 0 days to 38 weeks + 6 days) can cause:2, 3

- Increase neonatal intensive care unit (NICU) admissions;
- Increase transient tachypnea of newborn (TTN);
- Increase respiratory distress syndrome (RDS);
- Increase ventilator support;
- Increase suspect or proven sepsis;
- Hypoglycemia;
- Newborn feeding problems and other transition issues; and
- Infant mortality.

All of these complications dramatically increase costs; and babies delivered early are twice as likely to die of SIDS, have an 80 percent chance of Attention Deficit Disorder (ADD) and suffer the likelihood of ongoing medical conditions throughout their childhood.3 Mothers are also impacted by early elective delivery with an increased risk of Postpartum Depression and a doubling of the rate of cesarean section.4

For almost three decades, the American College of Obstetricians and Gynecologists (ACOG) and the American Academy of Pediatrics (AAP) have advocated 39 completed weeks gestation (39 weeks + 0 days and not 38 weeks + 6 days) prior to scheduling a delivery for both vaginal or C-section. Many organizations currently promote eliminating EED, including:5

- Health Resources and Services Administration (HRSA)
- Secretary’s Advisory Committee on Infant Mortality (SACIM)
- Ohio Department of Health (ODH)
- March of Dimes
- Association of State and Territorial Health Officials (ASTHO)
- Centers for Disease Control and Prevention (CDC)
- Collaborative Improvement and Innovation Network (COIIN)
- Centers for Medicare and Medicaid Services (CMS).

In Ohio, eliminating elective deliveries before 39 Weeks is a major priority for the Ohio Hospital Association’s Hospital Engagement Network (HEN), Ohio Department of Health (ODH), the Ohio Perinatal Quality Collaborative (OPQC), the Ohio Chapter of American College of Obstetricians and Gynecologists (ACOG), the March of Dimes, and the Association of Women’s Health, Obstetric and Neonatal Nurses (AWHONN).
Reducing EED

The Ohio Perinatal Quality Collaborative (OPQC) has been working to reduce EED since 2007. Starting with Ohio’s largest maternity and pediatric hospitals, this public and private collaboration has made dramatic improvements in this measure and has since expanded this effort to all maternity hospitals in 2014 (see figure). It is clear that while significant progress has been made, opportunity for continued improvement exists. OHA plans to work with hospital leadership to promote awareness, standardize and simplify process, promote transparency and hardwire EED reduction into hospital Quality Improvement and Peer Review infrastructure to continue OPQC’s good work.

As part of the national Partnership for Patients initiative, the Ohio Hospital Association’s Hospital Engagement Network (HEN) conducted a campaign in 2013 to reduce EED in 52 Ohio maternity hospitals. During this campaign those participating hospitals demonstrated a 35% reduction in EED.
Proposed Action Steps—Maternity Hospital

Promote Awareness

Educate the provider, patient and community on the detrimental effect of EED on both infant and mother, and provide a simple culturally-sensitive summary of evidence from the literature to include literature from OPQC,6 ODH,7 ACOG,2 CMS,8 March of Dimes,9 text4baby.org,10 AWHONN,11 National Child & Maternal Health Education Program,12 the California Maternal Quality Care Collaborative,13 and the VHA Alliance.14

Goal: **Board and leadership commit to the goal, and educates providers, patients and the community**

- Name a lead for the project who has the authority to implement and provide oversight.
- Provide a summary of evidence from the literature.
- Provide statements from The Joint Commission, ACOG, and March of Dimes to highlight the issue.
- Enlist childbirth educators to inform women and families (disseminate during hospital tours).
- Enlist office staff of outpatient providers to provide a copy of “Why the Last Weeks of Pregnancy Count,” available from the March of Dimes.5
- Provide a copy of the toolkit to outpatient providers’ offices to reinforce information among clinicians and office staff.
- Coordinate with other local, state and national leaders working on similar projects.
- Develop a community education plan.

Standardize and Simplify Process

Develop a new or updated scheduling process, which is not only flexible, but also requires a medical rationale for the elective delivery. This process should be supported by leadership, discussed and publicized well in advance of implementation. Physicians, schedulers, health care providers, and nursing staff should be educated, and the process streamlined and simplified for all stakeholders involved.3 Coders and birth certificate clerks should be trained to identify and meticulously document the exact infant age; for example, 39 weeks is 39 weeks + 0 days, and not 38 weeks + 6 days.15 Informed consent should ensure that women are aware of the risks of early delivery to their infants. The scheduling process may be used to document the discussion. Hospitals should consider implementing a “Hard Stop” at 39 weeks, by preempting scheduled induced labor or cesarean births before 39 weeks + 0 days that do not meet medical necessity.

Goal: **Standardize and simplify the process**

- Adopt new and/or updated scheduling processes. Prior to implementation, it should be publicized, schedulers and nursing staff trained, and the process streamlined.
- Document informed consent discussions with patients in the medical record to ensure that women are aware of the risks of early elective delivery to their infants.
- Train coders and birth certificate clerks in documenting accurate neonatal age.
- Consider a “Hard Stop” at 39 weeks for induced deliveries.
Proposed Action Steps—Specific Maternity Hospital Goals (cont’d)

Promote Transparency

Hospitals should track, trend and provide data on hospital and individual physician outcomes in a transparent fashion to the leadership, medical staff and other engaged providers and stakeholders. Quality data should identify and trend the portion of elective deliveries prior to 39 weeks gestation. Once trended, methods or strategies to prevent elective preterm deliveries should be developed. Internal data validation will require a thorough understanding of provider documentation, coding practices, and collaboration with the coders. Measures for performance-based privileging of physicians should include improvement activities. Best practices should be shared within the hospital, health system, region and state.

Goal: Promote transparency
- Meet with risk management, quality and/or safety officers.
- Highlight the importance of data collection and analysis.
- Provide data on hospital outcomes and individual physician outcomes.

Ongoing Professional Practice Evaluation (OPPE)

Ongoing Professional Practice Evaluation (OPPE) policies and procedures (including hard-stop), should be developed and approved by medical staff, to enable and empower nurses and clerical staff to enforce policy. The process for OPPE should be clearly defined and put in place to facilitate the evaluation of each practitioner’s professional practice; including advance practice nurses (APNs), midwives, and physician assistants (PAs).

Hospitals should collect <39 week early elective data for every practitioner utilizing clear definitions such as those from the National Quality Forum (NQF)-NQF# 0469, the Joint Commission-PC-01 Elective Deliveries, Leapfrog, or Partnership for Patients Maternity Care/Obstetrical Adverse Event. The medical staff should be empowered to police its membership through formal and informal physician and provider leadership.

Goal: Ongoing Professional Practice Evaluation (OPPE)
- Medical staff-approved OPPE policies and procedures should be developed and to be included in provider credentialing.
- Peer to peer discussion should be encouraged.

OHA has provided tools, resources and links to best practice on its web site: www.ohiohospitals.org/39weeks. The OHA webpage will be a resource for participating hospital members for implementation of the maternity hospital goals, and OHA will track progress through the OPQC data base.
Summary

There are many causes of infant mortality. Most infant deaths occur when babies are born too small and too early (before term), born with a serious birth defect, victims of Sudden Infant Death Syndrome (SIDS), Sudden Unexpected Infant Death Syndrome (SUIDS), affected by maternal complications of pregnancy, or victims of injuries (e.g., suffocation). OHA has developed a plan to support its member hospitals in addressing Ohio’s unacceptably high rate of infant death. For more information regarding OHA’s Infant Mortality and the EED initiative, visit: www.ohiohospitals.org/39weeks.

References


(Continued)
References (cont’d)


