

Summary of Presentations

A group of 35 professionals representing 23 organizations convened at the Indianapolis Marriott Downtown on 25 September 2009 to begin a discussion on late preterm birth. Dr. William Engle, Dr. Judith Ganser, and Dr. Caroline Doebbeling presented data findings about late preterm births and smoking during pregnancy during this meeting. After the data was presented, participants identified what stood out most to them.

First, there are many data overlaps, which could be indicative that the issues at hand are “real”. Second, although there is some data, there is a need to gather more, and current, data that focuses on short and long-term consequences of late preterm birth, as well as NICU services and care. Next, in addition to data, there is a need for transparency and consistent use of definitions and terminology. It was also discussed that medical professionals are not following ACOG recommendations, including those regarding elective inductions, and it is unclear whether or not following the recommendations would change the outcomes. Also, with the rise of late preterm births in Indiana, it is still important to take appropriate steps to minimize still births and infant deaths. Questions were raised about the possible correlation between the rise in late preterm births and the lack of regionalized care in Indiana, and the increased number of hospitals offering NICU care. Finally, participants found the high rate of c-sections among women less than 22 years of age particularly troubling. After discussing the key points from the presentations, participants started to brainstorm about what they believe the needs are and identified possible solutions to decrease the incidence of late preterm birth and to improve the outcomes of those who are born late preterm. The following is a summary of the discussion.

Recommendations

When looking at possible interventions, participants identified potential stakeholders. Some stakeholders include consumers (especially young women), providers, health systems, parents, schools, communities, professional organizations, payers, pediatricians, family practitioners, nursing staff, and office staff. The recommendations made were then broken down into four categories: data, provider, consumer, and policy.

1. Data

- a. Analyze interventions: What has been done in Indiana? What worked? What didn't work? What are the obstacles? What have others done?
- b. Consider other sources of statewide and local data, specifically the Indiana Hospital Association (IHA) dataset.
- c. Look at differences/disparities among different types of hospitals: different practices due to urban versus rural setting, capacity, provider availability, rates of late preterm deliveries, link to IPN statewide provider maps, may need a different message for different communities.
- d. Track progress of Presumptive Eligibility (PE) and Notification of Pregnancy (NOP) Form data regarding risk factors and entry into prenatal care and share NOP data with a broader audience of providers and stakeholders.
- e. Publish hospital and provider c-section and elective delivery data, and consider using professional associations as a venue for distribution.
- f. Assess NICU admission, discharge, and readmission data.

- g. Need local and more timely data that is coordinated and standardized.
- h. HEDIS is a standard methodology for collecting data on interventions. Develop something along these lines.
- i. Improve quality and completeness of ISDH birth certificate data set, educate providers (and others completing the certificate) and add “system fixes”, i.e. error messages, fixed fields, etc. However, birth certificate data is not set up as a research data set.
- j. Learn about the “other” indications for c-section (ISDH data- figure 23).
- k. Determine if premature rupture of membranes is driving late preterm births.
- l. Keep data updated and market results to professional organizations.

2. Provider

- a. By speaking up about how any baby born before 39 weeks is preterm, providers, especially pediatricians, can drive change in earlier deliveries at the hospital level.
- b. Promote childbirth education classes.
- c. Promote centering pregnancy.
- d. Educate provider office and nursing staff.
- e. Provide education and oversight to providers, especially those who are not following ACOG guidelines.
- f. Publicize “best practices” that already exist in the state. i.e. Hendricks Regional (comprehensive system of care), Centering Pregnancy model, hospitals using IHI bundling quality improvement process.
- g. Use IHA teleconference process to increase communication and share knowledge.
- h. Providers need to collaborate and develop consistent messages to give patients.

- i. Publicize standards of inpatient care, discharge criteria and follow-up care for late preterm babies. Consider bundling 48-72 hr. post discharge pediatric visit into routine hospital care.
- j. Increase professional association crossover among Peds, Obs, and FP's on this issue, emphasizing the importance of individualized care.

3. Consumer

- a. Educate mothers about late preterm birth, cesarean sections, and the impact tobacco has on preterm birth. Focus especially on initial c-section, especially among young women.
- b. Encourage participation in child birth education and pregnancy centering groups.

4. Policy

- a. Professional organizations should promote AAP/ACOG guidelines.
- b. Involve payers and consider changes in reimbursement practices that pay more for c-section vs. vaginal birth (disincentive).
- c. JCAHO (new measures regarding inductions and c-sections 4/1/10) and “pay for performance” will drive change.
- d. Standardize assessment of infants admitted to NICU.
- e. Assess and adopt best practice models.
- f. Improve quality control in NICUs, discharge criteria, and follow-up of preterm babies.
- g. Revisit regionalization issue: proliferation of NICUs that are not really NICUs, hospitals “inflating” their self-report levels of care, have them demonstrate their capability, can't deliver a baby that will likely have these types of problems unless you are at this level.