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GEORGIA PERINATAL HEATH MEETING 2012

Georgia Health Policy Center

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SUMMARY

Prepared for the Georgia Department of Public Health

Georgia Health Policy Center

CONFERENCE SUMMARY
GEORGIA PERINATAL HEALTH MEETING
EMORY CONFERENCE CENTER

Facilitated by the Georgia Health Policy Center

MEETING CONTEXT

On October 1, 2012, the Maternal and Child Health Section of the Georgia Department of Public Health hosted a two day meeting/event aimed at bringing together a diverse group of stakeholders from across the state to discuss perinatal health in Georgia and approaches to improving outcomes. More than 60 attendees participated in the meeting which was sponsored by the Healthcare Georgia Foundation. Participants[1] included representatives from state and local public health, hospital partners/regional perinatal centers, practice associations and societies, academia, civic and philanthropic community focused organizations.

Commissioner Brenda Fitzgerald welcomed the group, provided an overview of perinatal morbidity and mortality in the state and outlined ongoing efforts to address the issue. She invited their full participation in helping to identify far-reaching solutions to system-wide challenges and pledged the Department's support, particularly because reducing infant mortality rates (IMRs) is a primary and prioritized focus of the Department for the next few years.

Dr. Seema Csukas, Director of the Department's Maternal and Child Health Section set the stage for the meeting by laying out its purpose, anticipated outcomes and the importance of partnerships.

A presentation detailing perinatal health care in the state with a specific emphasis on the delivery of very low birth weight (VLBW) Infants was made by Mark Trail of Health Management Associates.

Following this presentation, meeting participants expressed pleasure in learning of reductions in the number of elective deliveries occurring throughout the state for the month of August. Participants also became aware of the significant extent to which mothers of low birth weight babies (LBW) are covered by Medicaid. Some saw this as an opportunity for health outcomes in LBW babies born to these mothers to rival or exceed those born to privately insured women, if the state's perinatal health care system worked well and in tandem with Medicaid.

[1] A complete listing of meeting participants is attached as an appendix to this summary

Notwithstanding that opportunity, participants were also concerned about the relatively large numbers of women and families who were unaware of the presence of perinatal centers, their services and/or the transportation systems that served them. Additionally, concerns were also voiced about the high rate of maternal mortality associated with the perinatal period – Georgia has one of the highest rates relative to other states.

Over the two days, a host of other interactive presentations were made to the group in an effort to help inform awareness about system assets and challenges. Presentations were also made to facilitate discussions about quality collaboratives and opportunities for data driven improvement. These discussions culminated in the development of recommendations for next steps and strategic action.

Presentations included:

- ***Georgia's Infant Mortality Initiative –*** Mitch Rodriguez, MD, Medical Center of Central Georgia
- ***Access to Data Elements: Where did you get those numbers? –*** Theresa Chapple-McGruder, PhD, Georgia Department of Public Health
- ***Process of Creating a Perinatal Quality Collaborative –*** Peter Grubb, MD, Tennessee Quality Collaborative and Jennifer Bailit, MD, Ohio Quality Collaborative
- ***Quality Improvement from Multiple Perspectives –*** Panel Discussion featuring Diane Weems, MD, Coastal Health District, David Levine, MD, Medical Center at Columbus Regional Hospital and Kesha Clinkscale, MPA, March of Dimes
- ***Moving Perinatal Quality Improvement into Action –*** Lucky Jain, MD, Emory University School of Medicine

SYSTEM ASSETS AND CHALLENGES

Meeting attendees collectively identified the following key assets and challenges of the current perinatal health care system:

Tangible Assets

- Established network of Regional Perinatal Centers (RPCs)
    - Already a good framework for coalition success
    - Funding already available
    - Region appropriately divided
- Committed workforce
- Strong partners and advocates
    - American Academy of Pediatrics, GA chapter (AAP)
    - American College of Obstetrics and Gynecology (ACOG)

- Role being played by Department of Public Health
    - Status as a new department in giving credibility and supportive infrastructure
    - Strong leadership
    - Commitment
    - Facilitating collaboration
    - Link to the WIC program
- Data availability
    - Process already in place to capture data
    - Other examples of successful QI collaborations to follow
    - Broad base of MCH clinical research in GA
- Outreach education efforts
- Technology available to facilitate care
- Medicaid eligibility
    - Pregnant women and infants up to 235% of the Federal Poverty Level covered
    - Increased potential for insurance access as more commercial carriers participate
- Providers who are willing to accept Medicaid

Intangible Assets

- Strong program knowledge, intellectual capacity & commitment
- Shared passion, enthusiasm and momentum with respect to decreasing infant mortality rates in the state
- Strong partnerships and relationships with willingness to collaborate
- Recognized need for change by state leadership

Specific Challenges

- No standardization in the RPC designations
    - Self-designation of Level III's with inconsistent levels of maternal care and neonatal care
    - Insufficient understanding of the role of regionalization
    - Poor clarity on RPC authority
- Fragmented system
    - Not enough of a whole systems approach
    - Little integration across programs and agencies related to public health and health care delivery systems ; "false walls"
    - Non-citizen care not referenced

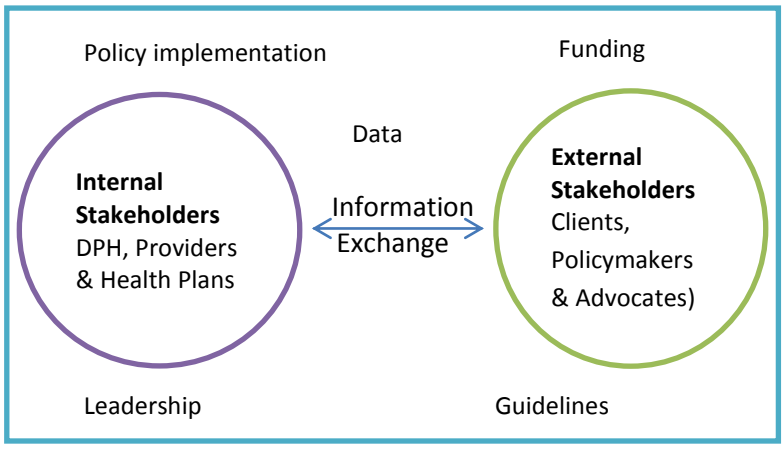
    - Department of Community Health (DCH) and private health plans/payers not fully engaged
    - Need better feedback loops
    - Difficult to navigate between hospitals (policy, financing etc.)
    - Provider reimbursement rates relatively low
- Sub optimal access to care
    - Lack of obstetric providers and healthcare systems in rural areas
    - Increased turnover of qualified providers and non-physician leaders.
    - Too many transportation disincentives
- Limitations with available data and information
    - Missing data and lack of data sharing
    - Lack of standardized risk assessment and reporting tools
    - Paucity of data on individual/community factors as well as Medicaid vs. Non-Medicaid patient outcomes
- Inadequate enforcement and use of quality improvement initiatives
    - Lack of adherence to ACOG recommendations & guidelines
- Lack of funding and awareness of program
    - Insufficient resources for Medicaid – ineligible poor & new AB bill 954
    - Limited ability to make legislators understand needs
    - Difficult to absorb influx of participants and costs.
    - Lack of information available to the public i.e. RPC resources.
    - Clients lack knowledge about how to navigate the system; not tapping into available community resources (i.e. faith–based organizations, Family Connections, etc.)

General Challenges

- Inconsistent leadership on the issue
- High rates of unplanned pregnancies
- High rates of illiteracy
- Racial/ethnic & geographic disparities in infant mortality rates
- Medicaid enrollment process

OPPORTUNITIES FOR SYSTEM IMPROVEMENT

Based on the discussion of system assets and challenges, participants agreed that there were opportunities to internal and external stakeholders in the system to collaborate in their efforts to address some of the key drivers that will likely result in system improvement.



Many in the group believed that the following were good opportunities for quick wins (low hanging fruit):

- Establishing an overarching perinatal quality improvement initiative that might focus on:
    - Promotion and enforcement of the policy/practice of not delivering babies at less than 39 weeks gestation unless indicated
    - Promoting evidence based breast feeding policy and practice
- Accurately quantifying system capacity (as recommended in the HMA report)
- Finding an appropriate cause champion (e.g. legislator or high profile media personnel)
- Engaging private insurers to be active partners on addressing the issue
- Coordinated efforts by the DPH to standardize reporting by RPCs, and other birthing centers, local health departments and Care Management Organizations (CMOs)
- Promotion of early risk appraisal
- Targeted community outreach
- Marketing campaign to increase awareness about the program and its successes
- Participating in partnerships to support Medicaid changes e.g. CMS back transfers (newborn)
- Semi-structured data sharing across the RPCs

Recommendations for Next Steps

By the end of the meeting, participants were supportive of establishing a Perinatal Quality Collaborative (GPQC) in Georgia. As an immediate follow-up action, the DPH will convene a Task Force charged with the responsibilities of setting up the PQC, engaging appropriate stakeholders and drafting action priorities.

The group made the following recommendations for consideration as the PQC is being created:

- Clearly define the mission and goals of the Collaborative
- Ensure that the right people are participating to make it successful
- Clarify funding stream that will support the work of the Collaborative
- Plan for change management (transition) and sustainability
- Carefully consider which issues to address, as well as timing and approaches that will bring about consensus and likely success :
    - Think about starting with a focus on reducing the incidence of (VLBW) babies.
    - Understand the influence of other confounding factors such as comorbid states (obesity) and multiple births/gestation on perinatal health.
    - How will breastfeeding and perinatal HIV transmission be incorporated into the agenda of the Collaborative?
    - What is the impact of the social determinants of health on preterm labor?
- Develop and track performance measures for quality improvement and culture change.
- Leverage the positive work that is already occurring; capitalize on and build from current successes.

Over the next few weeks, the DPH will provide stakeholders with more information about how they may engage in the establishment and operation of the GPQC.

APPENDIX

PERINATAL HEALTH MEETING INVITEES

LAST NAME	FIRST NAME	AGENCY/ORGANIZATION
Bacon	Mary Joyce	Department of Public Health
Barrentine	Mary Jane	Georgia Health Sciences University
Bishop	Rose	Cobb & Douglas Health
Bond	Heather	Department of Public Health
Bonk	Catherine	Atlanta Gynecology & OB
Browne	Paul	Georgia Health Sciences University
Bryan	Alpha	Clayton County Health
Bugg	George	Grady/Emory
Bush	Karon	West Central Health
Butler	Jennifer	Memorial University
Cannon	Chris	Columbus Regional
Chapple-McGruder	Theresa	Department of Public Health
Clinkscale	Kesha	March of Dimes
Cota	Pat	Georgia OB/GYN Society
Crowell	Tiffany	South Health District
Csukas	Seema	Department of Public Health
Edwards	Michael	Phoebe Putney Memorial Hospital
Ellis	Jane	Grady/Emory
Fitzgerald	Brenda	Department of Public Health
Funk	Margaret	Phoebe Putney Memorial Hospital
Gill	Tommi	Medical Center of Central GA
Gonzalez	Ketty	East Central Health
Graham	Nichole	Phoebe Putney Memorial Hospital
Grant	Jacqueline	Southwest Health
Grubb	Peter	Tennessee Initiative for Perinatal Quality Care(TIPQC)
Hall	Lynne	Ga. Hospital Asso. Research & Education
Hanrick	Louise	District Health (Dalton)
Harvey	David	North Central Health
Hill	Demetrice	Columbus Regional
Hogue	Carol	Perinatal QRC (Emory School of Nursing)
Hudgins	Rebekah	Ga. Family Connection Partnership
Hugley	Iris	Medical Center of Central GA
Jain	Lucky	Perinatal QRC (Emory School of Medicine
Janelle	Marsha	Georgia Health Sciences University
Johnson	Marcell	Ga. Family Connection Partnership
Jones	Chevonnia	North Central Health
King	Patricia	Georgia Health Sciences University

Kramer	Michael	Emory University
Lambertz-Guimarees	Elizabeth	Medical Center of Central GA
Layden	Judy	Memorial University
Levine	David	Columbus Regional
McCollum	Linda	Grady Emory
Mobley	Sandra	Georgia Health Sciences University
Morgan	Tracy	Phoebe Putney Memorial Hospital
Morton	Carla	Medical Center of Central GA
Nelson	Gary	Healthcare Ga. Foundation
Parker	Chris	Georgia Health Policy Center, GSU
Partain	Cornelia	Columbus Regional
Reid	Joyce	Ga. Hospital Association Research & Edu.
Robertson-Beckley	Relda	Department of Public Health
Rodriguez	Mitch	Medical Center
Royek	Anthony	Memorial University
Russell	Tonia	Columbus Regional
Sacks	Linda	Memorial University
Simmons	Bonnie	Georgia Perinatal Association
Simpson	Rhonda	Department of Public Health
Smith	Diane	Medical Center of Central GA
Smith	Rosetta	Department of Public Health
Spencer	Mindy	Phoebe Putney Memorial Hospital
Styones	Connie	Phoebe Putney Memorial Hospital
Tankersley	Marcy	Phoebe Putney Memorial Hospital
Tate	Patricia	Grady/Emory
Trail	Mark	Health Management Associates
Wald	Karen	Columbus Regional
Ward	Rick	Georgia AAP
Weems	Dr. Diane	Costal Health
Wilson	Johnny	Georgia Health Sciences University
Woodham	Dr. Padmashree	Medical Center of Central GA
Youmans	Diane	Memorial University