



Strong Start for Mothers & Newborns
Reducing Early Elective Deliveries Webinar

Final Transcript

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PRESENTATION

Doyin Idowu:

Good afternoon, Ladies and Gentlemen. I'm Doyin Idowu from the American Institutes for Research, and welcome to the Strong Start for Mothers and Newborns, Reducing Early Elective Deliveries, hosted by the Center for Medicare and Medicaid Innovation.

The full presentation slides, audio, and transcript will be available on the CMS Innovation Center website approximately a week after the webinar. We strongly encourage participants to use the audio on their computer speakers to hear the presentation. If you do not have the computer speakers or are unable to hear via your computer speakers, please call the following number: 888-776-9631, passcode: 9100747#.

A few housekeeping items before we proceed with the presentation. All participant lines are in listen-only mode during the presentation. We will be answering only typed questions during the Question-and-Answers portion of the webinar following the conclusion of the slide presentation. Participants may submit questions via the general chat feature at the bottom of your screen at any time, and questions will be visible only for the moderators and speakers.

With that, I will turn it over to Ray Thorn with the Center for Medicare and Medicaid Innovation. Thank you.

Ray Thorn:

Thank you, Doyin, and good afternoon everyone, and thank you all for joining. Again, my name is Ray Thorn and I'm with the CMS Innovation Center. We are really excited that you have joined today's webinar on the Strong Start for Mothers and Newborns Initiative and the effort to reduce early elective deliveries.

Strong Start, which was announced earlier this year, is an Initiative to reduce early elective deliveries and to offer enhanced prenatal care to decrease preterm births. This Initiative is built on decades of work by organizations such as the American College of Obstetricians and Gynecologists, the March of Dimes, and many others, showing that elective deliveries before 39 weeks increase the risk of significant complications for both the mother and baby as well as long-term health problems.

We have a great line-up and a very packed agenda today. Today's webinar will focus on the importance reducing early elective deliveries has on improving the health of mothers and newborns across the country, and we're fortunate to have expert speakers with us today to share some of the best practices on how to reduce

early elective deliveries and convey examples of success and how reducing early elective deliveries can be accomplished.

CMS would like to thank the American College of Obstetricians and Gynecologists, the March of Dimes, the Association of Women's Health, Obstetric and Neonatal Nurses, and the Alliance of Community Health Plans for their assistance in putting this webinar together today. We especially want to thank today's presenters for taking the time out of their busy schedules to be with us on this important issue.

Just a few additional housekeeping items. As Doyin previously mentioned, this webinar is being recorded and will be posted on the Innovation Center's website, at innovation.cms.gov in approximately a week. The transcript and slides of today's webinar will also be posted.

If you are a member of the press, this webinar is off the record, and if you have a question, please contact the CMS Press Office at 202-690-6145 or press@cms.hhs.gov.

Let me quickly go over the presenters before we begin. First, we will have my colleague, Erin Smith, who is one of the Strong Start program leads, and she will provide a brief update on the Initiative, then Dr. Hal Lawrence from the American College of Obstetricians and Gynecologists (ACOG) will discuss the importance of reducing early elective deliveries, followed by Dr. Scott Berns from the March of Dimes, who will discuss their efforts in reducing early elective deliveries. We will then have expert providers and payers, including a state hospital association, that will share some of the best practices and success on reducing early elective deliveries in their communities and state. The speakers are: Dr. Kenneth Brown, who is an OB/GYN from Women's Hospital in Baton Rouge, Louisiana; Dr. Kathleen Simpson, a Perinatal Clinical Nurse Specialist in St. Louis, Missouri; Vi Naylor and Lynne Hall from the Georgia Hospital Association; and Dr. Stephen Barlow from SelectHealth in Murray, Utah, which is affiliated with Intermountain Health; and he will provide a payer's perspective on the importance of reducing early elective deliveries.

At the conclusion of the presentation, we will have a Question-andAnswer period in which we will answer questions that have been submitted during the chat feature at the bottom of your screen. We will not be taking any questions over the phone. It's most likely that we will not get through every question, so if you do have a question that we were not able to answer today on this webinar, you can always e-mail CMS at our e-mail address, which is strongstart@cms.hhs.gov. In addition, there's more information on the Strong Start Initiative on the Innovation Center website at innovation.cms.gov under the "What We're Doing" section of the website.

And with that, I will turn it over to my colleague, Erin Smith.

Erin Smith:

Thank you, Ray. As Ray said, I'm going to give a little bit of background on the Strong Start Initiative, and then also some updates about where we are right now in the process. So many of you probably have already been to our webinars and may already know this information and for some of you it will be new, so let me give an overview of the Initiative.

It's made up of two different strategies, but they relate, and the first one is what we're really talking about here today, Reducing Early Elective Deliveries. It's a test of a nationwide public-private partnership, and an awareness campaign that spread to adoption of best practices that can reduce the rate of early elective deliveries before 39 weeks. This is for all populations.

The second strategy is our funding opportunity for delivering enhanced prenatal care, and this is for providers, states, and other applicants to test the effectiveness of specific enhanced prenatal care approaches. And this is really aimed at women who are covered by Medicaid or CHIP.

So to give you a little more detail about reducing early elective deliveries or Strategy 1, we've really taken this on by three different activities. The first is promoting awareness. We're looking at a broad-based awareness effort, and we've been working with a lot of partnership advocacy groups, and some of those are on the phone with us today.

The second activity is spreading best practices. We've gotten the support of Partnership for Patients, and their HEN network accounts for about 3,700 hospitals, and many of these hospitals have policies in order to support the reduction of early elective deliveries.

Our third activity is promoting transparency. And we've been working with our Hospital Compare Group here at CMS in order to put out new measures for early elective deliveries.

I'll talk about each one of these activities in a little more detail. The first is promoting awareness. We've been working really closely and collaborating with March of Dimes and ACOG on a large outreach effort to educate providers and consumers on reduction of early elective deliveries. Right now we are planning six awareness and visibility events that will be across the country. These are still in the planning phases, so unfortunately I can't give you dates and locations yet, but as soon as that information is available, we'll be publicizing that so people can possibly attend these events if they're in their area.

The second activity which we are actually underway with right now is in media outreach. We have some media going out in TV, radio, press, in-store audio, which would happen like over a grocery store PA system -- you'll hear those announcements, search engine marketing on Google, and also waiting rooms in OB/GYNs' actual practice, when they have the TVs in the waiting room. So we have advertising going out on all these different forms right now. And those started around the second week of November and a lot of these activities will be rolling through the second week of December, and some of them, including the waiting room TV will actually carry on through January. So hopefully some folks have seen these. There's ads in People magazine, for instance, and some major TV channels, like MTV, Lifetime, Bravo, Oh! and Oxygen. So keep your eyes peeled for those advertisements.

We're also right now working with Medscape and WebMD. The WebMD will be the consumer page that will give a lot of information for women who are looking for information on what the risks are of scheduling an early elective delivery and also what the benefits are of completing 39 weeks of pregnancy. This is in development right now, and we're looking at probably around a January release date.

Our second activity for Strategy 1 is spreading best practices. The Strong Start Initiative is leveraging the existing infrastructure of the Partnership for Patients. This includes the hospital engagement network, and it's really a large network of hospitals that kind of work with the hub-and-spoke system, where we work directly with the HEN and then the HENs disseminate information and coordinate with all the hospitals. And this accounts for over 3,700 hospitals. And the HENs have set individual goals related to reduce early elective deliveries and improving maternal and infant health. They're actually reporting back to us on a regular basis about these improvements and their progress. It's really in the early stages right now, that as we get more information we're learning from what the effectiveness can be if they've had networks. And we actually have a speaker who can speak indirectly to their experience, and just at that.

And then the other piece that we're working on currently is a Medscape piece. So the couple to the WebMD piece is the provider side, which is Medscape, and we're working on a few different continuing medical education opportunities for both physicians and nurses and other types of maternal providers. And so we should be launching our first CME opportunity at the beginning of December. And so these will be available for everybody and will really hone in on the messaging of reducing early elective deliveries and when it's medically appropriate to induce labor and when it's not.

And then our third activity for Strategy 1 is promoting transparency. And the 2013 IPPS Final Rule, CMS actually finalized the addition of a new measure to the Inpatient Quality Reporting Program. And this measures for early elective

deliveries prior to 39 completed weeks of gestation of the NQS No.0469, and this will be effective for payment determinations for fiscal year 2015, and then the results will be included in the Hospital Compare system.

And then I also wanted to give an update on our strategy to funding opportunity. I know that many people are curious about what's going on with that. We are still in the application review-and-selection process. Awards have not yet been made, and unfortunately we don't have an anticipated award date for you today, so I won't be able to give you updates on that, but I just wanted to let folks know that process is still ongoing, and we are very encouraged by the quality of the applications that we've received. Thank you.

Ray Thorn:

Great. Thank you, Erin, and I will now introduce Dr. Hal Lawrence, who is the Executive Vice President of the American College of Obstetricians and Gynecologists. CMS is really pleased to be working with ACOG on this Initiative, so Dr. Lawrence, the floor is yours.

Hal Lawrence:

Thank you. And I'm very pleased to be here and part of the working discussion today about Strong Start and preterm birth. ACOG represents the nation's women's healthcare providers and physicians. And we also provide education and clinical guidance, not only to our 57,000 members but to many other partners around the country and literally around the world. We are truly dedicated to ensuring the safest possible pregnancy and birth for all women and for their babies. With that in mind, we are very committed to Strong Start. I want to start literally at the start of this, and look at how prematurity got us to this position. When you look at this chart, the take-home part of this is that the deliveries that have occurred before 32 weeks or even before 34 weeks, have really not changed in any significant amount over the last basically 20 years, but the deliveries between 34 and 36 weeks and some of the elective deliveries between 37 and 39 weeks have changed. We first focus in on what we call the late preterm babies, those 34- and 36-weekers, and that went up significantly and brought our total preterm birth rate from around 10½ to over 12½ percent. When we recognized that, it became very worrisome, because preterm birth is the leading cause of neonatal mortality in this country. We spend over a third of all the dollars spent on infants on preterm infants, and in fact babies are born prematurely, 10 percent of all the dollars spent on children are for preterm children. And we continue to have about a half million babies born each year out of the little over four million deliveries, and sadly, two-thirds of all infant deaths occur among preterm babies. Prematurity is really a tough issue because it's not generally a single factor that causes a preterm birth, and unfortunately we need to learn even more and more about these different factors and how they interplay with each other. But what we

do know is that preterm delivery cuts across all social, racial, ethnic, and economic groups, and some of these groups, especially African American groups, have a much higher incidence. Preterm labor is the most common cause of antenatal admissions, so it's a real driver of hospital costs and hospital admissions. A preterm baby, as I just said, is at increased risk for infant mortality. When I trained, and Dr. Berns, and Dr. Brown, and I suspect many of the people listening in today, we felt that if we could get a baby with a mature LS ratio or PG that would not be going to have respiratory distress syndrome, those babies will be fine. But we've learned we were wrong. We've learned that the continual growth and development over the last part of pregnancy is crucial to a baby's health, and the earlier that baby is born the greater the chance that he or she is going to have problems, and their problems outside of just respiratory area. There are retinal issues, there are nervous system issues, and there's learning and behavioral problems. These late preterm babies are twice as likely to die of SIDS, they have an 80 percent increased chance of having attention deficit or hyperactivity disorders, and they have multiple factors of increasing likelihood of having other ongoing lifelong medical conditions. The neonatal mortality rate is significantly higher among preterm babies than term infants, there are subtle things, too. There are what these children will then do in school. They have increased chance of being referred for special needs, they have problems with school readiness, they have a 20 percent increased incidence of behavioral problems by eight, and so there are a lot of other things going on affecting these infants that we don't see in babies who have been able to get truly to term or 39 weeks gestation. Now, Strong Start recognized this and looked not only at these late preterm infants but at the 37- to 39-week infant also.

About 22 percent of all pregnancies are induced in this country. Whenever we start an induction, our goal as an obstetrician, is to achieve a successful vaginal delivery. All inductions are not bad. There are always going to be mothers who are going to need to be delivered because of the mother's fetal maternal indications, and there are going to be babies who need to be delivered because they're having problems and their intrauterine environment is no longer the safest place for them. But we have been clear -- in fact, we've been clear since all the way back in 1979, that unless a medical indication exists, a labor induction or a scheduled elective delivery should not occur before 39 weeks of gestation. Now, I think this is a very important chart, and I want everybody to remember it, because the increase in preterm birth obviously has a lot of concerns which I just outlined, but there have been some significant benefits. You can see the aqua line there is the dramatic decrease in infant deaths and the gray line is the decrease in fetal deaths and stillbirths at the same time we had this increase of late preterm birth. What happened there is more aggressive, more intensive obstetrical care, improved and ongoing neonatal care as well as pediatric care, combined to have an increased survival for these kids. But as I said earlier on, there were other problems that we have now since recognized and are trying to further deal with. To do that, though, when we say that patients should not be delivered without a

medical indication before 39-weeks gestation, we're obligated to talk to the patients and to the providers about when should they be delivered, or what are the indications that they should be delivered? Medical indications can be maternal or fetal. Most of the maternal ones deal with underlying comorbidities like diabetes or hypertension or preeclampsia or eclampsia or HELLP syndrome, and most of the fetal ones deal with growth issues for the baby or ongoing congenital issues that need to be dealt with. So there are indications that affect these deliveries, and ACOG and Society for Maternal Fetal Medicine, SMFM, as well as NICHD, last February had a session on trying to make sure we could list for everybody what those indications are. So we do recognize that occasionally a labor may still need to be induced without a classic medical indication, and I mention that in rural areas of the country who have history of very rapid labor or some mental health issues, which I think really can be medical indications. ACOG has published criteria that everybody should use to be sure that they're at 39-weeks gestation. You can do it by having Doppler or ultrasound, fetal heart tones for more than 30 weeks, a gestational age ultrasound done before 20-weeks gestation, that validates 39-weeks gestation, or that 36 weeks since a Pythagorean Theorem or urine pregnancy test.

The key is that next bullet; that just because we have a pregnancy with a positive pulmonary function test for the baby, unless there's a maternal or fetal medical indication, a positive fetal lung maturity is not an indication for a delivery, and that every time we should look carefully at the individual patient, their clinical situation, and their baby situation. I will say that there have been several institutions around the country and you're going to hear from some a little bit later than have been very successful. Actually, Geisinger called me yesterday. They heard we were going to be doing this, and they said, you know, we had a hard stop in labor and delivery and we have our 39-week induction rate without an indication down to zero, which I think is just a great statement. So I am going to wind up here and point out how wonderful I think the Strong Start program is, and I think it represents a great partnership between medicine and I put ACOG there, and the public and you'll hear shortly from Scott Berns from the March of Dimes and CMS, working together. I think this is a national issue and it requires a multi-prong approach, and we're just very proud to be part of it. Thank you.

Ray Thorn:

Great. Thank you, Dr. Lawrence, and I will now introduce Dr. Scott Berns, who is the Senior Vice President and Deputy Medical Director of the March of Dimes and another great partner of the Strong Start effort. Dr. Berns?

Scott Berns:

Thank you, Ray. I want to send out a thanks to you as well as Erin Smith and everyone at CMS for inviting me and the March of Dimes to participate in this

webinar today. And what I'm going to focus on is the March of Dimes' effort and partnership with you all to reduce early elective deliveries, and sort of how and why we're involved in this. So I'm just going to sort of start right from the beginning here in terms of the mission of the March of Dimes.

Our mission is to improve the health of babies by preventing birth defects, premature birth, and infant mortality. And in fact, we are coming up on our 75th anniversary in 2013, and so we're getting ready for a big year with lots of activities and celebrations to come. Our most recent campaign is the Prematurity Campaign, and we launched that campaign in 2003. We have three key partners with lots and lots of other colleagues and alliance members, just to mention the American Academy of Pediatrics, the American College of Obstetricians and Gynecologists, and the Association of Women's Health, Obstetric and Neonatal Nurses have been with us right from the beginning in 2003 when we launched this national campaign.

Dr. Lawrence presented some of this data, but I just want to note that preterm birth rates peaked at 12.8 percent in the U.S. in 2006, and we have seen a five-year decline to 11.7 percent now, which is the preliminary data from 2011. And this slide also notes the 2020 goal for the March of Dimes, which is 9.6 percent. This next slide also sort of recaps what Dr. Lawrence mentioned, in terms of the largest numbers of preterm births are actually the late preterm births, and I'm going to focus in on this as we get to the March of Dimes' interest in reducing early elective deliveries. So these are our goals. You'll note, we actually have two goals here, one that I mentioned already which is that 9.6 percent, but we also have an interim goal, which is an 8 percent reduction for every state in the U.S. from a 2009 baseline, that baseline number of 12.2 percent. And I just want to mention the importance again of partnerships.

We are partnering with the Association of State and Territorial Health Officials in this 8 percent challenge by the end of 2014. We've also had our Premature Birth Report Card released for the past five years, and this is really when five years ago, as part of the call to action in the Premature Birth Report Card, we asked hospitals to look at reducing these elective inductions in C-sections and non-medically indicated inductions in C-sections before 39 weeks, and it's actually still in what are called now are the contributing factors. This is also in the Premature Birth Report Card. The Premature Birth Report Cards -- and I'll show a map of the entire country in a minute -- are based on preterm birth rates. We also list contributing factors which are not directly used to calculate the grade, per se, but show states sort of where they are in terms of these three factors: uninsured women, late preterm birth, and women smoking. And so you still see here the fact that these rising rates of late preterm births can be at least partially attributed to these non-medically indicated inductions and C-sections before 39 weeks. And so here is the map of the U.S., and you can see I'm sure, your state here if you want to peruse. If you want to actually get your Premature Birth Report card, you

can log onto marchofdimes.com/peristats, where you can find your state in the U.S. But this gives you a sense of where we are in 2012, and I'm very proud to say that 16 states received a better grade this year and actually four states received an "A." If you're curious, they're Maine, New Hampshire, Oregon, and Vermont.

So getting to Strong Start, I just want to say it was an incredible day in February, and we heard a little bit about it earlier, when Secretary Sebelius announced Strong Start, and I really had the privilege of being on stage with Secretary Sebelius and Dr. Lawrence and others from CMS to talk about Strong Start and to hear the Secretary talk about the importance of reducing preterm birth. It was such an important moment for maternal and child health in our country. And so as part of the Strong Start Initiative and in the context of what Erin Smith mentioned earlier, the March of Dimes patient educational materials are being co-branded with HHS as well as ACOG. I'm going to show you these materials in a few minutes.

We are collaborating on media coverage, as you heard about, and we also have a time-lapse public service announcement. I'm going to have an opportunity to show you that. I'm hoping the technology works here, so Doyin is ready to help in a bit. I do want to mention that we had talked about some of the media outreach and we heard about some of the networks that we were going to be targeting, and specifically wanted to mention that we are targeting some networks and media outlets that specifically reach out to the African American community as well as the Hispanic community. And so some of the other networks that you will see, some of these public service announcements, include networks like BET, Telemundo, Univision, Galavision, and others and in many markets throughout the country.

So at this point, I wanted to talk a little bit about the Partnership for Patients piece of this and the Hospital Engagement Networks and what the March of Dimes has been doing over the past year in reaching out to the Hospital Engagement Networks. So what we've been doing, and many of you I know are on the call today, and thank you for logging in -- we actually did two kinds of outreach in trying to reach the Hospital Engagement Networks. Just to make sure they were aware of some of the materials I'm going to show you here and then a menu of items which is actually listed in this slide. We actually went to the national content developer and got on the listserve there, which is great, but I also reached out to every single Hospital Engagement Network with a packet of information, including this menu and followed up with phone calls. And I think I reached almost every one of you. There are lots of interesting things happening. Before I get into one of the examples, and I wish I had more time -- I would love to give more examples of what's happening with the Hospitals Engagement Networks and partnership with the March of Dimes, there is a menu of opportunities. Partnership option 1 is around a 39 Weeks Quality Improvement Service Package. This is really built upon the lessons learned through what we call our Big 5

Initiative, our Big 5 Hospital Network, which included hospitals from the Big 5 States -- those are the states with the largest numbers of births. That includes California, Texas, Florida, New York, and Illinois. And so that is basically a package for hospitals who want to reduce non-medically indicated deliveries before 39 weeks, all the pieces they would need to do that. In this menu, we have a March of Dimes grand rounds, our educational materials, the opportunity to co-brand educational materials as well as television, radio, print and outdoor ads. Before I go on and show you some of the educational materials and then the video, I do want to give a shout out to one of the Hospital Engagement Networks, among the many we're partnering with. And I know that Dr. Simpson will be talking about Michigan a bit later -- this is a great example, I think, of successful collaborations with the Michigan Hospital Association and the Michigan Department of Community Health. This actually started after a couple of phone calls with the leadership there, at the Michigan Hospital Association, Janis Biermann from the March of Dimes National Office. Our Senior Vice President, Education and Health Promotion went out for the announcement of this partnership in September. We're actually tri-branding materials, so it's March of Dimes, Michigan Hospital Association, and the Michigan Department of Community Health, were out there with educational materials. And just a couple of weeks ago, there was a joint press conference with the Michigan Hospital Association, Michigan Department of Community Health as well as the March of Dimes out in Michigan, which is actually just four days before World Prematurity Days, which was November 17 this year, and we're actually in the midst of Prematurity Awareness Month, so this call is well-timed I think. So there are lots of other great partnerships out there that are happening, and I'm so glad the response we've gotten from the Hospital Engagement Networks as well as our work with CMS and Strong Start and many of the other partners on the call here today. So here's one of the key materials that I mentioned earlier co-branded. You can see at the bottom here, along with HHS and ACOG. This is our late preterm brain development flyer based on something that we call the brain card. I just want to note that these materials are all available in English as well as Spanish. This has been a very powerful tool to show the development of the infant's brain. This shows 35 weeks compare to 39 or 40 weeks. At 35 weeks the brain is only two-thirds in terms of the weight it'll be at 39 or 40 weeks. We have other materials here, which include this poster in English and Spanish, which shows some of the development that occurs right through 39 weeks that Dr. Lawrence mentioned in his talk. And then this is a print PSA. We call this the Cupcake PSA, and the basic message here is that babies aren't fully developed until at least 39 weeks; if your pregnancy is healthy, wait for labor to begin on its own. So at this point I'm going to ask Doyin to show the 60-second Public Service announcement, and you guys should hear it through the audio of your computer. Doyin?

Video (Song):

"Every day it's getting closer. Going faster than a roller coaster. A love like yours would surely come my way. Hey, hey, hey, every day it's getting closer. Going faster than a roller coaster. A love like yours would surely come my way hey, hey, hey."

Video (Message):

"Babies aren't fully developed until at least 39 weeks, which means babies born even a few weeks early can have breathing, feeding and learning problems. If your pregnancy is healthy, wait for labor to begin on its own. A healthy baby is worth the wait."

Scott Berns:

Great, thanks, Doyin. So I just want to conclude by thanking everyone on this webinar for all the great work you're already doing around reducing preterm birth and eliminating non-medically indicated deliveries before 39 weeks, and please do not hesitate to contact me. This is my contact information, if you have any questions that we aren't able to get to today or if you're interested in some of the materials that I presented. So Ray, I'll hand it back to you.

Ray Thorn:

Thank you, Dr. Berns, and it's great to see that some of the public service announcements are already on the air on some channels such as the Lifetime movie network, and other cable stations as well. At this time, I would like to introduce Dr. Kenneth Brown, who is the Medical Director at Women's Hospital in Baton Rouge, Louisiana, who has had some great -- Louisiana has had some great results on early elective deliveries, and at this time I will turn it over to Dr. Brown.

Kenneth Brown:

Thanks, Ray, and hello, everyone. Appreciate this opportunity to be able to tell our story. As Dr. Lawrence noted, the American College of Obstetrics and Gynecology has long discouraged elective deliveries, whether induced for vaginal births or Caesarean sections before 39 weeks of pregnancy without a medical indication. And as ACOG says, we don't know very much about the cause of preterm labor, but we do know that there is a link between preterm birth and infant mortality. So on this ACOG has been clear. Unless a medical indication exists, labor induction or a scheduled elective delivery should not be performed before 39 weeks gestation. So at Women's Hospital, we've tried to reverse the trend of elective deliveries before 39 weeks, that we saw steadily increasing here as well as nationally. And we also found, and it was shown, that the earlier the delivery the higher the rate of morbidity for both moms and babies. So a little bit about Women's Hospital. Women's Hospital delivered more babies than any

other birthing facility in Louisiana. We delivered nearly 85 percent of all babies in Baton Rouge and nearly 11 percent of all babies in Louisiana. We operate a Regional III obstetrical and neonatal unit with statewide transport capabilities. Except for five maternal fetal medicine specialists and five OB/GYN hospitalists who take care of unassigned patients, all other obstetrical providers are private practitioners. In 2006, the year following Katrina, Women's Hospital launched a project to eliminate or at very least reduce, early elective deliveries. To do this, we knew it would take education and a lot of buy-in from physicians and staff. We began by providing literature to the medical staff about other successful programs in other parts of the country. We provided educational tools and consent forms for physicians to share with their patients. A lot of this information we got and gathered from March of Dimes and we also used some information from Intermountain Health. We became one of the earlier participants in the Institutes for Healthcare Improvement Perinatal Design Collaborative. Using their induction and augmentation models, it helped to guide and develop criteria for elective induction in oxytocin management. Physicians were asked to be team players, to assist in policy development, and to voluntarily abide by those policies. Initially there was opposition from the obstetricians, which appeared to be related to being unaware of the neonatal morbidities associated with elective inductions prior to 39 weeks.

So we developed a multi-disciplinary team and came up with agreed-upon definitions for active labor and augmentation. We used ACOG guidelines and developed a list of medical indications with some modifications. For instance, a pregnancy with multiple fetuses did not have to adhere to the 39-week rule. We developed a separate protocol and guidelines for HIV moms and developed guidelines for worsening oligohydramnios as examples. We established baselines and began data collection and sharing with the medical staff. During the same time, we began tweaking an enforcement of our oxytocin policy. Although we achieved some success, by 2009 the Medical Review Committee, our QA committee, consisting of physicians, nurses, a biostatistician and administrative leaders, realized that the information gathered showed a flat or slight uptick in the monthly data. The information was marched up to medical staff and hospital leadership chain all the way to the board. The board of directors agreed a hard stop policy was warranted. No elective delivery or Caesarian section less than 39 weeks' gestation would be allowed without review by the medical director. A prewritten script was provided to the schedulers. So here are some of the results of our efforts. Although we started our elective induction rates were as high as upper 30s, lower 40s in some cases, this graph illustrates where we were by 2008, at 28 percent. We saw an increase to 32 percent in 2009. We instituted the hard stop policy in early 2010, and have had a steady annual decline to five percent in the second quarter of 2010, and for the past four months we have been at zero. One of the unrealized statistics by the obstetricians was the short-term admissions of neonates to the intensive care unit. This data helped in convincing the obstetricians to adhere to the 39-week policy. The top slide shows admissions of 1,076 in 2007 and down to 743 in 2012, a 37 percent decrease. The bottom slide

shows discharges from the unit as a percentage of total neonatal discharges. This went from 2007-2012, 15.8 percent, down to 9.1 percent. Also as a consequence of our 39-week policy, we think this was also a result of having experienced a decrease in our primary Caesarian section rate. We see that the graph illustrates a decrease from 27 percent down to 24 percent. Other data that we have been tracking include the rate of operative deliveries, including forceps and vacuum extractions. We found another downward trend of 15.9 to 9.6 percent. Of note was the obstetricians' concern that delaying elective to later than 39 weeks could increase the term stillbirth rate. However to date, although the numbers are small, we have not seen a change in that rate. So in November of 2010, as we were making demonstrative progress, the State Department of Health and Hospitals approached us to assist with the dubious award that they had just received. In April 2010, Louisiana ranked 48th in infant mortality and preterm birth, 49th in percentage of low birth weight and very low birth weight, and had a preterm birth weight of 15.4 percent. So in November, the March of Dimes gave Louisiana an "F" on birth outcomes. The state, aware of our success, asked for our help. As a result, statewide help ensued with a summit that was held in October of 2011. The State Department, with the assistance of IHI, Louisiana March of Dimes, Louisiana Hospital Association, the Louisiana Medical Mutual Insurance Company, which is the largest malpractice carrier in the state, and Women's Hospital and a number of other hospitals that included the LSU OB/GYN Department, Oslo Health Systems, East Jefferson General Hospital and several others, a cohort of 22 hospitals that delivered at least 1,000 infants annually, agreed to participate in the IHI Perinatal Design Project, meet monthly, develop policies, and collect data. All 58 hospitals that deliver babies in Louisiana signed a pledge to work on eliminating elective deliveries prior to 39 weeks' gestation. The hospital teams self-reported data monthly on a community extranet set up by IHI and Louisiana Perinatal Cohort. There is a clear signal of improvement in data using a weighted average statistical process control p-chart. There are two downward or positive shifts in the data from a baseline mean of 15.78 to a mean of 5.63, and then to the mean of 2.39. This indicates a definite downward trend. Because of this improvement, by July 2012, the Secretary of DHH received a March of Dimes President's Prematurity Leadership Award on behalf of the state for progress and policies health officials have implemented over the past two years. In August, Louisiana preliminary preterm birth rate was reported at 12.4 percent, down from the F rating of 15.4 percent, and our goal is to reach 8 percent by 2014. Thank you.

Ray Thorn:

Great. Thank you, Dr. Brown. That's really wonderful that you and Louisiana have achieved some great results on reducing early elective deliveries. And at this time I would like to introduce Dr. Kathleen Simpson, who is a perinatal clinical nurse specialist from Mercy Hospital in St. Louis, Missouri, and who is a member of the Association of Women's Health Obstetric and Neonatal Nurses,

who has been another partner in the Strong Start effort with ACOG, March of Dimes and others with us, and she will discuss Mercy's successes as well as give the nurses' perspective on reducing early elective deliveries. Dr. Simpson?

Kathleen Simpson:

Good afternoon. I am from Mercy Hospital in St. Louis and it's a similar type hospital that Dr. Brown just talked about. We had about 8,300 births last year. It's a community teaching hospital, and generally most of the physicians who care for our patients are private attendings out in the community, and we've been working on this project for many years and have been fairly successful. So our elective birth lists of 39 weeks are hovering about three percent, and of course we could get it down to zero, and we've been working on that. It seems like this last couple of percents may be due to coding. However, I'd just like to talk about some of the things that we have done that can be very challenging, getting everybody on board. So we in 2006 started working on this very hard, and gathered an interdisciplinary Practice Committee, looked at all the evidence and the standards and guidelines, et cetera, and then developed a policy, decided when to adopt it, let everybody know. And the key thing was having leadership support, not only from the nursing group but the physicians and the administrators. And so when everybody was on board and said we won't be doing this anymore, it was much easier than just saying, well, we'd sure like you not to be doing this. So that was very helpful getting everybody on board and having leadership support. And then we continued on with teambuilding, trying to get consensus. Everybody wasn't completely on board, so we had a few people still kind of pushing the envelope, but by monitoring the situation and providing feedback, we were able to be fairly successful. One of the things that was a barrier was our scheduling process, and so we re-evaluated the scheduling process to make sure that those who felt that we were being rigid, would now feel that we were being very flexible. And so we said, well, if it's not convenient for you to have a Caesarian or an elective induction at a certain time, how about the weekend? How about an evening? We can have an evening slot for a Caesarian, or we can -- we're a 24-hour operation here. We can have inductions on the weekends, no problem. And even though people had complained that we didn't have these options available, when we made those options available we didn't have that many takers, but it just empowered people to feel like we were being flexible and there was a lot more goodwill, I guess engendered. We also during that time began talking about OB Hospitalist Program and in the last couple of years have implemented the OB Hospitalist Program, which is very helpful in being an attending right on site, on the unit anytime to be able to help with answering some questions if there is a concern that whoever has scheduled an elective birth, may be pushing the envelope and it might be really 38 and six or 38 and five, or they've scheduled a birth with a medical indication that might be soft, so that's been very helpful. The other thing is keeping on top of the situation and making sure that everybody knows what's going on. We have added patient

education as a key component of our process, and that has been extremely helpful. We re-evaluated all of our prenatal classes. We actually did it as a study, and we had over 3,000 patients in our study, and we looked at providing very specific education to patients during the prepared childbirth classes about why they should wait for labor to begin on its own and why they shouldn't ask their physician for an elective induction, and if they did, at least wait till 39 weeks. And we did see some success with that, and our elective inductions for women decreased 20 percent over that 7-month period, and then our elective inductions before 39 weeks also decreased by 40 percent. Now, that's an individual hospital. There's also been lots of success with hospital systems. So here is a very forward-thinking, quality healthcare system, Trinity Health. They have 26 hospitals with OB services in nine states, and they began their process in 2009 to eliminate early term births and were very, very successful. What they did is they implemented a system-wide policy, and then they said, we're going to have a hard stop in all of our hospitals, and they were able to bring it down from 15 percent in 2009 to less than 1 percent now, so that was very impressive. And it's this power of groups and administrative support that can be very helpful. Now, this is an example of a statewide project. So this is the Michigan Hospital Association OB Keystone Project. We have 68 hospitals in Michigan with an OB unit involved in this study. And they have been working since 2008 to get this. We have a number of things that we are working on, but the elective early term births is a major situation that they were trying to improve, including not only for elective inductions but elective Caesarean births. And this has also been very successful. Again, the power of a group and everyone sharing and working together and measuring, and you can see that. The first group of hospitals, after a couple of years of working on this, were very low in terms of elective induction less than 39 weeks, and once the rest of the hospitals came on board, they immediately got better, and just looking at highlighting the project and looking at what's going on with the situation was very successful. And so it's been very successful as a statewide project to virtually eliminate elective inductions before 39 weeks. Now, I'd like to talk about A1's campaign. And this is a really innovative campaign that's going straight to the consumer. And A1's campaign is very complimentary of what ACOG is doing and what the March of Dimes is doing, and it's really cute and innovative, and it's collaborative. They say, there's 40 reasons to go to full 40. And you can go to this website that I'm showing you and download any of this information and print it. It has A1's logo on it, but you can print any of this. There's no charge. You just have to print it yourself. It's very clever, and patients really like it. They like to go through the reasons of why they should stay pregnant, why they should wait for labor to begin on its own. And here are some other slides about this. The goals are to increase the percentage of women who complete at least 40 weeks of pregnancy. They will go the full 40. And the goal is let labor begin on its own if you're a healthy woman and you have a healthy baby. And we want to increase the nurses' effectiveness to reduce the number of elective inductions and elective births, so really have chosen to focus on education, bringing this directly to the consumer. So these are the themes: full-

time babies, spontaneous labor, breast-feeding promotion, and just reduction of elective procedures in general for healthy mothers and healthy babies. Here's some of the campaign materials that you can go to the website and download. At our hospital we downloaded some of these and sent them to our print shop and they made very large posters and laminated them. We put some in patient rooms. We made a lot of copies of the brochures and put them in our clinic office and in some of attending physician's office and it's been very positive. We also got some little buttons and handed them out to some of the physicians and the nurses, and everybody's very excited about this campaign. And then here's just some more pictures of this, so there's a lot of cute things that you can see on the website. It's part of the Healthy Mothers and Babies Magazine. It also is sponsored by A1, and I think that you'll find all of these materials very helpful if you want to find something that goes directly to the consumer. And this really does compliment everything that ACOG is doing and the March of Dimes is doing, and it really can be very helpful. This our goals. We hope education about benefits of full-term and spontaneous labor leads to women having, feel empowered to make collaborative decisions and really have better outcomes for both mother and baby. Thank you.

Ray Thorn:

Great. Thank you, Dr. Simpson, for that wonderful presentation. I would like to introduce Vi Naylor, Executive Vice President and Lynne Hall, who's a Quality Improvement Specialist at the Georgia Hospital Association. I will note that Dr. Berns had worked with all of our Hospital Engagement Networks and the Georgia Hospital Association, and one of those Hospital Engagement networks and one of the key partners in the Partnership for Patients efforts to reduce hospital-acquired conditions and remissions as well as early elective deliveries and Vi and Lynne will share those experiences with you all. So Vi?

Vi Naylor:

Thank you so much. The program we're going to talk about has been made so much easier because of the fine work that all of the speakers before us have done. We started with our program following a CMS request that we reduce emergency -- early elective deliveries as one of the first focuses of the 40/20 by 13 effort. We agreed to do that at the March meeting. We took a pledge that we would do that. We came home, began to create what we needed to do to be successful, and one of the things that we did was immediately send out some information to hospitals to encourage them to participate. We had already been contacted by March of Dimes regarding the program that was discussed earlier, and we were going to work with them to find some pilot hospitals in Georgia. We had had some discussions with the Department of Public health months earlier about baby-friendly hospitals, and we knew of their interest. So we contacted the Commissioner and asked if she would serve as the chair of a statewide group to

reduce early elective deliveries. And we put together, with our HIN partners in the state, a list of people that we needed to involve in the effort, and you see some of those people listed there -- the Georgia Chapter of the OB/GYN Society, Certified Nurse Midwives, Nurses Association Health Plans -- the list must have had about 15 or 16 stakeholders that we invited to our first meeting in April. We created the State Action Group, and Public Health was able to provide some early elective delivery data, and it was just overwhelming to see what our rate was. And it really got us all energized to try and do something. We knew that the OB/GYN Society had already been sending out information. We know that the Department of Public Health had been talking about this around the state. March of Dimes had been doing work, so really what our big focus here was to get the hospitals on board. And of course, that was made easier when we could say that the state was supporting it, that the OB/GYN Society was supporting it. So we immediately had a huge number of hospitals that were ready to move forward to reduce the early elective deliveries. Our goal was ultimately zero. We knew that by August of 2012 we were probably unlikely to have a zero rate for the state, and so our success by August was going to be measured by five percent or less. We had a number of hospitals that had heard about the March of Dimes and the IHI programs, and had already been implementing. We were able to use their successes as some information to help hospitals know that it could be done. We had our first meeting. This is a picture of the group that came to GHA in April, and I think we had close to 100 people here. And they all actually signed another pledge. We had media coverage, and I'm going to ask Lynne if she will pick up and talk about the journey from that point on.

Lynne Hall:

Good afternoon, everybody. I'm Lynne. We did have an in-person meeting and we invited all the birthing hospitals in Georgia. We also invited March of Dimes, the Department of Public Health, and then we looked around for some best practice hospitals that had already been doing well in early elective deliveries. We chose WellStar, Athens General and Liberty Medical Center. They came in and told their story of how they decreased early elective deliveries because for a lot of the hospitals they were like, no way, this isn't going to happen. Our physicians aren't going to go for it. And having Pat Coda, who is with the OB/GYN Society of Atlanta, she had already brought in a letter that was written to physicians, encouraging them and showing them best practice really does involve early elective deliveries, eliminating them. So the way we did this was we -- after we met in person, we came across telnets, webinars, one-on-one calls, and we had several different speakers from around the country. We had one even from Amerigroup, and he talked about reducing C-sections and then we had Mark Stein speak a couple of times, showing the products that they have available and talking about what's best for the babies. This is Commissioner Fitzgerald and Vi, and that's the first signing of the pledge that they are committed to eliminating early elective deliveries. We also had WSB Channel 2 news cover the event.

WSB had done a video called labor of love, and I've put the web address there if you want to see that. And then they came in and covered our in-person meeting. After we went through this process of starting in April and ending in August, not really ending but having that short time span to show to CMS that we could make progress in our state, WSB came back and they did a follow-up with the results. We had Dr. Fitzgerald interviewed, and then Atlanta Medical Center was featured as well, because they got to zero and sustained it for several months. This is some of the hospitals signing our pledge and the WSB guy covering it, the event. So we did have good media coverage, and it was already out there. Several hospitals requested the video that WSB had done. Then as we did our best practices, we had several different speakers, and we had several best practices hospitals come and show how they could do it, because they still were meeting a little bit of resistance, this isn't going to work in our hospital, our hospital is special we have special doctors, blah, blah, blah. But having that backing of all of the Societies in Georgia saying, no, we have to develop these hard stops; we have to eliminate these early elective deliveries that are not medically necessary. So we encouraged as many hospitals that could share their best practices and how they did it. We also set up a resource page that had best practice hard stop examples. We encourage the use of the March of Dimes toolkit. We also had references towards the IHI bundles, which is the induction bundle. And the results are pretty great. I was very excited that the hospitals worked so hard. They paid attention to what was being said out there. They adopted the best practices that were among the hospitals. They actually looked at their procedure and diagrammed it out so that they could see where the cases may have been falling through the cracks. We have 83 birthing hospitals in Georgia. Fifty-eight of those hospitals or 70 percent turned in their data for us. Nineteen were already at a zero EED rate, so they were some of our best practice hospitals. And of the 39 hospitals that still needed improvement, about half of them showed statistically significant gains. Three of those hospitals went from a 14 percent or higher early elective delivery rate down to zero and sustained it for three months. One of the hospitals, Habersham Medical Center, which is a small rural hospital, went from a 30 percent EED rate down to zero, and they have sustained that for six months now. It says four, but I asked them about it the other day and they're still at zero. Also, what's really disturbing for us, as I'm sure that we got an F in 2009, was we had a 65 percent overall state average for early elective delivery, so more than half of our babies were being born between 37 and 39 weeks. In 2010, that rate decreased to 35 percent. In August, which was our goal date to decrease these deliveries, we were down to 3.67, and then our year-to-date for 2012 was 5.9, so we made some significant improvement in early elective delivery, a 58 percent decrease in early elective deliveries. This just shows from -- is a run chart from March 2012 to our August, and you can see -- and these are incidents, not rate. So we had about 150 incidents in March, and by September we were down to less than 20 incidents. According to Managed Care Magazine, it costs around 41,000 for a late preterm NICU visits. Like I said, our incidents went down, and that was a decrease of about 117 incidents. Well not all of those babies would have gone to NICUs, so I

did a conservative estimate that even if a fourth of those 117 babies went to NICU, we still saved Georgia Healthcare over a million dollars. This shows the histogram of January through August, and you can see that we had one hospital that was doing 100 percent elective deliveries. It was a critical access hospital, and there were only a couple of deliveries in that, but we have some work to do. This shows from our March data, where our highest hospital was at about 65 percent down to our highest hospital in August was at about 20 percent. So even from the highest hospital in March to the highest hospital in August, we still made a significant decrease. And as the data keeps coming in for September and October, we still are doing very well. This shows a run chart of where we were in 2009, where we were in 2010, and as of 2012, here's the run chart of our progress from the Initiative. We started the Initiative in April of 2012. We had a lot of education on what is a hard stop, how can we develop a hard stop, and then the rate keeps continuing to look really good. I also have to emphasize that since this data has come out, we have also had several hospitals who were not submitting data say that they wanted to get on board and submit data. It did cause our rates to go up just a little bit, not -- it was like right at five percent, but that's exciting to me because they're willing to work on the issue and get their rates down so that they're comparable with the rest of the state. The lessons that we learned from this Initiative is it's important to work as a team. You have to have physician buy-in, you have to have a physician champion, you have to have the support of your C Suite, you need to empower your nurses and your schedules so that when they say, no, I'm sorry, this woman doesn't qualify for an induction, that they feel like that's okay for them to say, I like the idea that -- the speaker before us had talked about having a script for them. The other success that we've had is we found that any non-medically necessary early elective deliver has to go to peer review. We even have some hospitals that are sending all delivery between 37 and 39 weeks to peer review, to make sure that we're not having the pre-eclampsia come in with a blood pressure of 110 over 70. We started educating patients early, and by having the WSB run the ads and March of Dimes has had it on the radio a couple of times, and then as a follow-up, WSB once again came, and we've had a lot of education with patients and getting information out to physician's offices. And it's always best to collaborate with others, to share best practices, share forms, use IHI. Of course, we have relied heavily on March of Dimes. They have been an invaluable service to us. We also have used data to sustain the game to get other hospitals on board to help us. We think it's a great idea to make sure that the data is presented to administration and physicians, and it's always important to celebrate our successes. Vi, do you have anything else?

Vi Naylor:

I just want to talk a little bit about transparency. For the four to five months that we were focusing on early elective deliveries, we had as many run charts as we could get from hospitals and stories of how they had reduced early elective deliveries, and each of our weekly newsletters that went out to members, that

generated calls and interest, as Lynne has alluded to. Double-edged sword, as she said. We had had people on board from April, and then our data started getting diluted with the ones coming on later that had time enough to make the differences, but being transparent and providing the shared learning, was very helpful in having our success in Georgia.

Ray Thorn:

Great. Thank you Vi and Lynne. It's great to see that you are having successes in Georgia, and thank you very much for sharing those with us today. We are running short on time, but last but not least I want to introduce Dr. Stephen Barlow, who is Vice President and Chief Medical Officer of SelectHealth in Murray, Utah. And I will note that SelectHealth is affiliated with Intermountain Healthcare, which is another Hospital Engagement Network in the Partnership for Patients. Dr. Barlow?

Stephen Barlow:

Yeah, so Intermountain Healthcare has 22 hospitals in Utah that delivers 30,000 babies a year. About one-third are delivered by obstetricians, nurse midwives, maternal fetal medicine doctors employed by Intermountain and about two-thirds by community physicians. And Intermountain started this many years ago, and the initial issue was to convince the practicing physicians that it made a difference. The differences were small enough that in physician's own practice, in their own mind, it didn't make a difference. So the first thing was to run the data on the Intermountain deliveries that show that there were -- for those elective deliveries prior to 39 weeks, there were more NCIU admissions, more event days, more hospitalizations, lower Apgar scores. And SelectHealth had approached at the same time, the clinical OB leadership to say, we're concerned about the C-section rates, and they said the largest intervention that could be made was to reduce the number of elective inductions. The Intermountain data showed that for 38 to 39 weeks and otherwise uncomplicated deliveries, there were 15 percent more likely to have C-sections than those from 40 to 41. We then showed the OBs their own data for what was their elective C-section rate, and as other people have mentioned, got the whole system aligned from having it be a corporate board goal to having the clinical leaders, obstetrical leaders in the different hospitals supportive, having the nursing staff in labor and delivery support of this with the local champions. We have not gone to hard stops except for one hospital. I think that there was such resistance historically and so much effort to convince people, but it's a direction we're headed. The OB department, they've asked us to implement an incentive program so that if an obstetrician has no elective deliveries less than 39 weeks, there'd be a small incentive in the range of 1,500 to 2,000 dollars that we would pay. For anything that we have an incentive, we also have a publicly reported website, which is not as much visited by the public as it is by physicians and their competitive nature. So the elective delivery slide there

shows how it dropped down to where we're approximately two percent now. The only other slide I have is the slide tracking the total C-section rate and the primary C-section rates where Intermountain Hospitals are around 20 percent for the C-section rates. And my last point is that some of the remaining issues that we have is that there's been some adjusting of dates during pregnancy that has aroused the concern of the obstetrical leaders and some of the softer indications for medical reasons for inductions, and then the internal guidelines for elective inductions slightly vary from CMS, so there will have to be another sort of educational effort for the OBs and nurse midwives to get the agreement on that. So that's the end of my presentation.

Ray Thorn:

Great. Thank you, Dr. Barlow, and I will also want to say I want to thank again -- excuse me first one second -- I want to thank the Alliance of Community Health Plans for their assistance, and Dr. Barlow's assistance --in providing the payer's perspective.

We have about five minutes before 4:30, and we have received a lot of questions today through the chat feature, and thank you all for submitting those questions. Some of them have been really informative and very enlightening. And one of the common things that we've seen today is -- one of the questions that we've received is Erin mentioned the CME opportunity in December, and there were a lot of questions on how that will be publicized. So Erin?

Erin Smith:

Sure. We will be sending out an update whenever that's available through the Innovation Center listserv, which anybody can sign up for at Innovation.cms.gov, and we'll also be posting it on the Innovation Center webpage that's specific to Strong Start. And that's at innovation.cms.gov/initiatives/strong-start/index.html. You can also easily Google it, which I would prefer.

Ray Thorn:

Great. Thank you, Erin. And another question is that we received, will the materials be posted on the Innovation-- will the materials be available after this webinar?

And the short answer is yes, they will be posted on the Innovation Center website at innovation.cms.gov within approximately about a week. There are some processes we have to go through before we post them, and we have to meet some governmental rules and regulations. That usually takes about a week to complete

that process. So we ask that you be patient and thank you for your patience on that.

Another question that we received through the chat was -- this is for Dr. Berns and Dr. Simpson. In your presentation, you presented some materials for consumers to help educate and make them aware of the importance of carrying the pregnancy at least to term. Can providers use these materials in hospitals and their offices, and if so where can they get copies if they wish to do so? And I think most importantly, are they free? So I will first turn to Dr. Byrnes on that.

Scott Berns:

Thanks Ray. Well, the materials are not free. I certainly would encourage you to reach out to your local March of Dimes chapter. I think they are reasonably priced and certainly we're not looking to make money here; we're basically looking to at least cover our costs, and certainly there are bulk discounts available. The best place to go would be your local chapter. You can certainly e-mail me at sbyrnes@marchofdimes.com or you can go to Marchofdimes.com/catalog. Ray?

Ray Thorn:

Great. Thank you, Dr. Berns, and Dr. Simpson?

Kathleen Simpson:

Yes, the materials that are offered by A1 are free, but there's a catch. You have to print them yourself. So there's no problem going to the website, download them, and they're available at no charge, and you can just print them. Again, as I mentioned that we made posters at our house full of them and put them in the clinic, put them in the OB triage unit, we made some little brochures and handed them out to patients. So the cost of printing them was ours, but downloading them and using them is free and we encourage you to do that. Patients really like them. They're very cleverly designed. They're really focused on how a pregnant woman and that age of childbearing women would be thinking. So I think you'd go to the website and you'll really like them.

Ray Thorn:

Great. Thank you, Dr. Simpson. Another question that we received through the chat box, which involved the community involvement, buy-in from various groups. And we all know that it's important to reduce early elective deliveries, and this question is primarily for Dr. Brown, Dr. Simpson, the Georgia Hospital Association and Dr. Barlow. Once the problem was recognized, how did you and your organization go about entertaining buy-in and help facilitate change from

providers, nurses, hospital executives, payers, and the community. And let's start with Dr. Brown?

Kenneth Brown:

Well, yeah, sure. Well, one of the things that was realized early on, we have a high percentage of deliveries that are actually funded by Medicaid. About 70 percent of all the deliveries in the state are funded through Medicaid. So the State Department initially had very much interest, not only in terms of getting those numbers where we knew clinically it needed to happen, but also in terms of financial incentive to make that happen. So because of that, the state also -- we used the state as well to get out into the community and get buy-in on a statewide basis.

Ray Thorn:

Great. Thank you, Dr. Brown. Dr. Barlow?

Stephen Barlow:

Yeah. We showed the data that the health of the newborn was not as good and then had -- the clinical leadership team consisted of local leadership for all the areas of Intermountain Health, and then they went back and presented it in their hospital department, meetings, to get the buy-in.

Ray Thorn:

Great, thank you.

Lynne Hall:

Ray, this is Lynne from Georgia, and I just wanted to say one of the biggest buy-ins for us as far as hospitals getting involved and physicians getting on board, was our Department of Public Health did a study on infants that were born between 37 and 39 weeks and found that by third grade they were scoring on their test scores were lower than their counterparts that were born after 39 weeks, and I think that was a big impact.

Ray Thorn:

Great, thank you, Lynne. Dr. Simpson?

Kathleen Simpson:

Yes, what we did is engage the leadership team first to make sure that they were all on board, because if you don't have the leaders on board it's very difficult to do much. So we had physician leaders, nursing leaders, hospital administrators, we looked at the data, we knew this was something that we should do based on the evidence, based on national standards and guidelines and everybody got on board. And then knew that if we said, this won't be happening here anymore, we would have support all the way up, and that was one of the keys to success. The other is looking at the data, showing the data, giving it to individuals and saying, hey, you're kind of an outlier here. Everybody else is doing this. What is different about your patients and how can we make this work better for you, and then the flexibility that I discussed earlier so that everybody would have a time convenient for them for babies that wanted to be born electively after 39 weeks -- well, not the babies, but the people who wanted to do them. So it's not just one thing; it's the multiple effort.

Ray Thorn:

Great. Thank you, Dr. Simpson. And we're running almost out of time, and this will be the last question. And this question can be for Dr. Lawrence and Dr. Byrnes. Do you all have any thoughts on obtaining community buy-in and reducing early elective deliveries, and how important is it to inform and educate the general public as opposed to reaching out to providers? And Dr. Lawrence?

Hal Lawrence:

Well, thank you, Ray. I think that you have to have a multi-prong approach. From a medical organization we have to educate not only our members, but we have to educate their patients and we also have to inform hospital administration because you just hear the other people say how important it was to have that team all together. And we do that through patient education pamphlets, which are available on our website, and we have developed checklists for scheduling, both for reductions of labor and for sections that are available on the public side of the website, then we set up all the hospitals to help them have a methodology for a hard stop. And the one other thing that I saw, a couple of the questions that popped up that I think was really crucial was the long inductions, if people who have unfavorable cervix. And we're on record as saying, even if it's 39 weeks, if the cervix is not favorable and there's no medical indication, don't be inducing that patient because that's where you're just setting up for an increased Caesarean section. So we send that information we're pushing out also. So multi-prong approach, checklist, hard stops, and don't induce somebody unless they're ready to be induced based on their cervix.

Ray Thorn:

Great. Thank you, Dr. Lawrence. Dr. Berns?

Scott Berns:

Yeah, I would just, I agree with Dr. Lawrence. I would just add that community buy-in is absolutely critical, so March of Dimes, consumer education and public awareness campaigns that I talked about are absolutely key. A lot of you out there, particularly through the Hospital Engagement Networks, as well as some of the payers out there, are very active in terms of engaging the community. And then the last piece I wanted to add to what Dr. Lawrence said is that I really think that we should all stay away from blaming here, I mean in terms of whether it's the consumer or the provider. I think everyone is together here on the same team, should be on the same team. You hear from providers that it's the consumers, the patients, they're asking to be delivered and then we hear the other side, that the doc scheduled me. So I would really try to avoid the blame game here and raise awareness and educate throughout our communities. Thanks, Ray.

Ray Thorn:

Great. Thank you, Dr. Berns. And with that, that will conclude our presentation today. I will want to say that if you did ask a question and we were unable to get to it, please feel free to e-mail us at Strongstart@cms.hhs.gov. I wish we had all the time in the world to continue this conversation, but we will continue it nonetheless in many different ways beyond this webinar.

Hope this webinar really has been informative to everyone out there today, and I really do want to thank our presenters again for their great insight and also thank the American College of Obstetricians and Gynecologists, the March of Dimes, the Association of Women's Health Obstetric and Neonatal Nurses, and the Alliance of Community Health Plans again for their assistance. And with that, I will say thank you and hope everyone has a great day. Bye.