Payer Workgroup Healthy Baby Voluntary Certification Intervention Deliverables
July 18, 2011

Healthy Texas Babies (HTB) Expert Panel (EP) Meeting Attendees: Please review the document below for content only. All HTB workgroup intervention deliverables will be consistently formatted following the July 30, 2011 EP meeting.

1.1 Detailed Intervention Description: A: Healthy Texas Baby Hospital Certification

Goal: Develop Healthy Texas Baby Hospital Certification

Outcome: Voluntary certification by all Texas hospitals with labor and delivery units

Measurement of outcome: Percent certification of hospitals in Texas

Intervention: Create certification template

Activities: Details of the certification:

1. Hospitals distribute information (created by DSHS or agreed upon by this organization) that include information about the benefits of spacing pregnancies at least 18 months or more; the benefits of breastfeeding and the benefits of control of maternal disease such as hypertension and diabetes. This information can include a place for a stamp (or an extra sheet of paper) that references local resources such as their current physician; public health programs and planned parenthood, etc.
2. Hospital must participate in regionalization of perinatal care; i.e., for a hospital to be certified it must participate in the regionalization of perinatal care including the limitation of NICU beds.
3. Designation as either a Texas Ten Step Hospital with registered intent with Baby Friendly USA to work toward Baby-Friendly Hospital Initiative designation or World Health Organization Baby Friendly Hospital Initiative Certification
4. Hospital and/or community partner offer nutritional counseling (such as on-site WIC), emotional support (postpartum depression); childbirth classes; baby care classes, breast feeding classes, postpartum lactation support after discharge from the hospital, community resource referrals, and financial guidance.
5. At a minimum have a certified lactation specialist on staff and for Level III NICU have an International Board of Lactation Consultant Examiners (IBLCE) designation
6. Evidenced based standardized order sets for perinatal care (e.g., magnesium for preeclampsia and magnesium for

neuroprotection) creating efficiencies, virtually eliminating error by all disciplines and thus provide predictable positive outcomes for all our patients.
7. Routine use of drills to specifically reduce morbidity and mortality (e.g., eclamptic seizures, shoulder dystocia)
8. Level III NICUs must have some type of affiliation with an organization that provides family support to families with NICU babies (e.g., "A Hand to Hold", Ronald McDonald foundation, and March of Dimes NICU Family Support Program).
9. Designate levels of maternal levels of care

1.2 Are there best practices associated with this intervention?

Arizona Perinatal Trust (this effort was funded by the Robert Wood Johnson foundation); Wisconsin, New York and California also have programs

1.3 Intervention - Desired Outcomes

Short-term (1-3 years):

A. Have private insurance company, HHSC, Texas Hospital Association and DSHS buy-in (so that there is financial incentive to hospitals to obtain certification)
B. Publicity – we should release media statement and also contact local, state, and national elected officials regarding this initiative. Have a target enrollment of 50% of hospitals with a Level III NICU.

Long-term (5-7 years):

A. Decrease in infant mortality based on the Healthy People 2020 infant mortality marker
B. More accurate designation of NICU levels of care in Texas
C. Increase in number of appropriate maternal/fetal inter-facility transfers
D. Reduction of NICU beds in areas without legitimate need
E. Reduction in incidence of low-birth weight and preterm infants born in Texas
F. Reduction in birth trauma

1.4 Data Elements to be Collected and Evaluated

Pre-Intervention:

- Number of hospitals participating in Texas 10 Steps designation
- Baseline patient and partner satisfaction survey

- Survey of number of hospitals/communities offering postpartum depression services or at least identify community resources
- Number of current lactation specialist associated w/ hospitals

Monitoring: Number of hospitals participating in steps required for full certification; i.e., hospitals that have achieved 10 steps status, hospitals that are participating in regionalization efforts etc. Evaluate insurance company buy-in and input.

Post-Intervention: Enrollment numbers

Process evaluation: Percentage of enrolled maternity hospitals

1.5 Has the intervention been implemented in Texas? If yes, please provide specific details and contact information.

The Texas legislation just passed a bill regarding implementation of regionalization of perinatal health. Our effort needs to be a part of this process.

1.6 Possible Partners (both public and private)

National

- American Academy of Pediatrics
- American Congress of Obstetricians and Gynecologists (ACOG)
- Association of Women's Health, Obstetric, and Neonatal Nurses (AWHONN)
- March of Dimes
- La Leche League
- Institute for Patient and Family-Centered Care
- National Perinatal Association

Texas

- Consortium of Texas Certified Nurse Midwives (CTCNW)
- Texas Association of Health Plans (TAHP)
- Texas Association of Neonatal Nurse Practitioners (TxANNP)
- Texas Association of Obstetricians and Gynecologists (TAOG)
- Texas Department of State Health Services (DSHS)

- Texas Health and Human Services Commission (HHSC)
- Texas Hospital Association (THA)
- Texas Medical Association (TMA)
- Texas Osteopathic Medical Association (TOMA)
- Texas Nurses Association (TNA)
- Texas Pediatric Society (TPS)
- Texas Breastfeeding Coalition
- Texas Certified Nurse Midwives (in general I don't agree with cooperation with lay/"professional certified"/direct entry midwives

Regional and Local
- DSHS Health Service Regions (HSR)
- Local health departments
- Local breastfeeding coalitions

1.7 Recommended appropriate assessment tools (e.g. Perinatal Periods of Risk (PPOR))
- Available information regarding breastfeeding initiation/duration
- NICU usage data
- Birth mortality and morbidity information
- Hospital survey of new-mother support services, including counseling

1.8 Recommended Lead Agency for Intervention
- DSHS

1.9 Target Audience(s) – define for each specific activity included in the intervention

Activities:
- Activity #1 (See 1.1) – Hospital administrators, including marketing professionals; physicians, nurses, professional organizations, breastfeeding advocates
- Activity #2 (See 1.1) - Hospital administrators, including marketing professionals; physicians, nurses, professional organizations
- Activity #3 (See 1.1) - Hospital administrators, including marketing professionals; physicians, nurses, professional organizations, payers

- Activity #4 (See 1.1) - Hospital administrators, including marketing professionals; physicians, nurses, professional organizations, breastfeeding advocates, community clinic managers, MCH social services organizations
- Activity #5 (See 1.1) – Hospital administrators

1.10 Recommended Time Period for Implementation by Activity

1. Define the terms of Certification
2. Determine who/what will be the certifying body
3. Determine how to maintain certification

1.11 Required Resources - (e.g. financial, human, in-kind, etc.)

1. Statistical analysis
2. Accessible database with extrapolation capability
3. Financial support for establishment and data mining
4. Physician input on relevance of criteria
5. Health plans input on relevance of criteria
6. Hospitals input on relevance of criteria
7. DSHS input on relevance of criteria
8. March of Dimes input on relevance of criteria
9. Assessment of cost effectiveness (relative yield combining increased baby health objectives and numbers of affected babies divided into the cost-will require quantitative measures of "health")

1.12 Possible Challenges to Implementation

1. Limited financial resources
2. Access to privileged information (confidentiality issues: health plan data bases and actuarial data, hospital data bases, physician charts)
3. Access to proprietary information (health plan data bases and actuarial data, hospital data bases)
4. Maintenance of the data base
5. Physician orientation is diverse (academic physicians, private practice, government employees-i.e., Indian health service, military)
6. Developing a quantitative measure of "health"
7. Support of hospitals to change practice without financial incentive

1.13 Communication Strategies – including who, what, when, where, how

Web-based/electronic communications interventions

1. Who - Cloud communications to providers and patients
2. What - Updates, reminders, short educational pieces
3. When - Frequently: daily to weekly
4. Where -Emails, faxes, snail mail

Radio –

1. Who -Talk shows, advertising, College campus radio
2. What - Promote self help, where to get assistance, encourage the Medical Home, healthy life styles
3. When - When public service air time is available, some paid spots
4. Where - English and Spanish stations, public radio

Television –

1. Who - Use popular personages who would consider donating services
2. What - Promote self help, where to get assistance, encourage the Medical Home, healthy life styles
3. When - When public service air time is available, some paid spots
4. Where - English and Spanish stations, public television, local city broad casts

Print -

1. Who - Handouts to be used in physician and health department offices, large posters for MC and Chips sign up locations, billboards
2. What - Promote self help, where to get assistance, encourage the Medical Home, healthy life styles
3. When - Daily
4. Where - English and Spanish, target “most needed” neighborhoods- not universal distribution (will require the data base information above)

In-person –

1. Who - Ancillary medical personnel who run the health fairs, school nurses, engage service organizations-ie, Rotary
2. What - Promote self help, where to get assistance, encourage the Medical Home, healthy life styles
3. When - Whenever there is a gathering of parents or potential parents
4. Where - Schools, PTA meeting, malls, parenting and breastfeeding classes,

1.14 Detailed Implementation Steps (how this intervention should be operationalized)

Introductory paragraph on intervention followed by specific steps in order of occurrence.

1. Establish computer base and determine variables to be included. Engage a statistician to help to develop the items and the questions to be asked
2. Accumulate data from physicians, health plans, hospitals, DSHS, March of Dimes-questionnaires online (i.e., Survey Monkey)
3. Run local focus groups in major metropolitan areas, rural communities, Indian reservations
4. Solicit funding and services: grants, charitable contributions, public broadcasting entities, public service announcements
5. Determine the most cost effective outreach (may vary depending upon the target audience)
6. Network with local and regional outreach groups (ie, Cook CMC CCHAPS, a 7 county outreach)
7. Determine criteria to measure effectiveness (will vary by socio-economic factors and location)
8. Based on 1-6, develop educational materials and methods of implementation
9. Selectively test specific markets and communication strategies
10. Facilitate the highest yield formats identified using the criteria in 7

1.15 Plan for sustainability

The overall goals are to improve the health of the population by addressing specific issues in the perinatal period. Effective interventions will eventually be reflected in increased health in the pediatric population, decreased utilization or resources, and cost savings to the insurance plans and the state health services. Funds from these sources could be solicited to provide ongoing education and intervention.

Healthy Texas Babies designation must have some desirable quality to incite hospitals to change practice. The communications strategy must include outreach to professional organizations and hospitals to make the designation as attractive as possible. Institutionalization of the designation is most likely to be successful through some type of monetary reimbursement.

1.16 Plan for scalability to acknowledge that resources available for implementation may vary

Items 1.14 #9 and #10 address this issue. The effective strategies could be generalized to the state level.

1.17 Best Practice Evidence Table

Best Practices Evidence			
Source	**Sample/Study Description**	**Purpose**	**Results/Pertinence to intervention**
Joint Commission. Specifications manual for Joint Commission National Quality Measures (v2011A). Perinatal Care Core Measure Set http://manual.jointcommission.org/releases/TJC2010A/PerinatalCare.html	A set of five measures, selected by the Joint Commission from the National Quality Forum's Consensus Standards for Perinatal Care, to assess quality in perinatal care. Includes literature review for each measure.	Purpose of the manual is to define description, rationale, data elements and specifics, data accuracy considerations, and measure algorithm for each measure.	Results: Birthing facilities are encouraged to voluntarily report performance on five measures of perinatal care, including Elective Delivery, Cesarean Section, Antenatal Steroids, Health Care-Associated Bloodstream Infections in Newborns, and Exclusive Breast Milk Feeding, for quality improvement. Pertinence: Measures may be considered for inclusion as criteria for HTB designation. Measures have been vetted through consensus of experts, and operationally defined. Literature review of relevance is included. Adoption of measures by Joint Commission adds validity to use of measures as criteria for assessment.
National Voluntary Consensus Standards For Perinatal Care Steering Committee Meeting Summary, March 3, 2008 http://www.google.com/url?sa=t&source=web&cd=1&sqi=2&ved=0CBkQFjAA&url=http%3A%2F%2Fwww.qualityforum.org%2FProjects%2Fn-r%2FPerinatal_Care_2008%2FmnPerinatalSC_03-03-08.aspx&ei=gNEATtrTNeHq0gHjubGdDg&usg=AFQjCNEGgUHuRxCE6MXTjkDeTUGukHANFA&sig2=K2t9wyugwGozd	Minutes of the National Quality Forum's perinatal care steering committee at which Consensus Standards were established	Meeting was to deliberate recommended measures for inclusion in Consensus Standards for Perinatal Care	Results: Strengths and limitations of measures were discussed and final recommendations were made. Pertinence: Provides key expert panel's discussion points for feasibility and

Best Practices Evidence			
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OSRMbgQJw			limitations of measures of perinatal care.
America's Health Insurance Plans (2009). Innovations in Recognizing and Rewarding Quality. http://www.ahipresearch.org/pdfs/P4PMonographWeb.pdf	Report highlights innovative approaches "that regional and national health insurance plans have taken to advance quality of care and efficiency through the recognition and reward of physicians and hospitals for achieving national benchmarks, demonstrating outstanding performance, and making measurable improvements over time."	Provides case studies of payer-led incentive programs that have contributed to improved quality, cost reduction, and increased access to care.	Results: Provides background, measurement, results, and lessons learned for a variety of recognition and reward health insurance plan programs. Includes profiles for provider, hospital, and public-private collaborative programs Pertinence: Report provides successful models to borrow from/emulate when creating the HTB designation model. Elucidates lessons learned/potential pitfalls.
Childbirth Connections. Transforming Maternity Care Bibliography for Leading Change http://transform.childbirthconnection.org/resources/bibliography/leadingchange/ Resources by Blueprint Focal Area http://transform.childbirthconnection.org/resources/bibliography/byfocalarea/	Bibliography/listing of literature and resources related to best practices in improvement science, and improvement strategies related to improving perinatal care outcomes.		Pertinence: Resources to review for effective strategies in implementing change to inform communication about quality improvement measures that facilities can implement to achieve HTB designation.
Government of South Australia Department of Health Standards for Maternal and Neonatal Services in South Australia 2010 Available at: http://www.health.sa.gov.au/ppg/portals/0/standards-mns-sahealth-100429.pdf	Outlines the minimum standards required for each of the six recognized levels of perinatal care. Standards include workforce, facilities, and equipment requirements	Guidelines issues by the Government of South Australia	A risk management framework that enables clinical service planning and resource management including requirements to manage risk factors, retrieval and transport services, and relevant models of care

Best Practices Evidence			
Source	**Sample/Study Description**	**Purpose**	**Results/Pertinence to intervention**
Royal College of Obstetricians and Gynecologists Minimum standards for the organization and delivery of care in labor. Available at: http://www.rcog.org.uk/files/rcog-corp/uploaded-files/WPRSaferChildbirthReport2007.pdf	Guidelines for safer childbirth created by the Royal College of Obstetricians and Gynecologists		This report reviews minimum standards of care related to delivery of care for the following activities related to birth: • Organization • Staffing roles • Staffing levels • Education, training, and continuing professional and practice development • Facilities and equipment • Recommended minimum standards
American Academy of Pediatrics and the American College of Obstetricians and Gynecologists Guidelines for Perinatal Care, Sixth Edition, 2007	Guidelines for perinatal care		Guidelines for perinatal care
American College of Obstetricians and Gynecologists Clinical Management Guidelines for Obstetrician – Gynecologists Critical Care in Pregnancy Number 100, February 2009	Practice guidelines		The purpose of this document is to review the available evidence, propose strategies for care, and highlight the need for additional research. Much of the review focuses on the general principles of critical care, extrapolating where possible to obstetric critical care.