Southeast Michigan Perinatal Quality Improvement Coalition

March 14, 2017

MINUTES

Welcome and Introductions	*Vernice D. Anthony, CEO, VDA Health Connect*	Meeting was called to order at 1:15 p.m. Vernice Anthony, VDA Health Connect welcomed first time participants: • Velonda Anderson, WIC • Sharon Burnett, Nurse Family Partnerships
Website and SEM PQIC Logo	*Lisa Braddix, Director, Community Health, GDAHC*	The participants were guided through the www.gdahc.org site to the SEM PQIC page under Our Work page. It was suggested and accepted adding a list of the partnerships and organizations. If given permission and a camera-ready logo, the organizations logo will be added to the page. Relative documents will be added to give access to the Coalition members. The Logo was rolled out.
LOCATe Results Gap Analysis	*Alethia Carr, VDA Health Connect*	The criterion of assessed levels of care as identified by the CDC were given: • I – Basic care • II - Specialty services • III – Neo-natal intensive care; sub-specialist available • IV – Regional aspects – offers education and cardiac surgery; sub- specialists available 24/7 The reason some of our Level IV hospitals were seen as a Level III was they didn't have one of the sub-specialist on site 24/7. The information was based on the information that was given in the survey. A primary Goal are standardized assessments used across the nation. Addresses gaps in analysis but needs a deeper dive. Of the 24 birthing hospitals in Region 10, 22 completed the survey.

		The birth data used is from 2015 to complete the LOCATe assessment. Approximately 63% of births were done at Level 2; where 20% were done at Level 3 hospitals. Additionally, neonatal level discrepancies, births by level of care, very low birth weight (VLBW) births, facility self-assessment vs LOCATe assessments, maternal level discrepancies, and care coordination by category were discussed. The results are shown in the attached slides.
		It was found that the hospital staff don't get feedback on the referral and what happens after the pediatric visit; if the appointment was kept. Another discrepancy identified was the mother was given lactation support but then sent home with formula. It creates confusion for the parent.
Cesarean Section	*Dr. Federico Mariona, MD*	Dr. Mariona gave a brief background on Cesarean births in the US: • Cesarean birth is the most common hospital surgery in the US • In 10 years the cesarean birth rate increased 50% in the US • The number of cesareans increased by 71 % between 1996 and 2007 • Once a cesarean birth,90% of subsequent births will be by cesarean • A cesarean birth has acute and long-term maternal risks • **Birth by cesarean has acute and long term risks for the neonate** • Reducing cesarean rate needs a consolidated multidisciplinary effort to overcome professional, institutional and societal issues He asked the question, "Is cesarean delivery overused?" Michigan's rate increased from 20.2% in 1996 to 32% in 2015. He stated there is no evidence that cesarean delivery improves outcomes, yet they continue to rise. However, there are many risks associated with scheduled cesarean births, including respiratory morbidity, higher NICU admission, prolonged stays in NICU, increased asthma risks and difficulty breastfeeding.
Safe Sleep	*Patti Kelly, MPH, MSW, MDHHS Infant Safe Sleep Program Coordinator*	Patti Kelly reviewed Michigan's Infant mortality reduction plan for 2016 – 2019: 1. Achieve Health Equity 2. Implement a Perinatal Care System 3. Reduce premature birth and low birth weight 4. Increase healthy and thriving infants 5. Reduce sleep related infant deaths and disparities 6. Expand home visiting 7. Support health status of women and girls 8. Reduce unintended pregnancy 9. Promote behavioral health Kelly stated what we know about the death rates and what is known about the mothers and babies (as shown in the slides). Then the Michigan Safe Sleep Program approach was given:

		• Trained Partners • Existing Infrastructure • Continuous Quality Improvement Process • Messaging and Methodologies She shared the Michigan Health Endowment Fund activities around safe sleep. • Develop and implement effective messaging and methodologies o Focus groups o Development of new messages – culturally responsive o Market testing • Increase the number of trained partners who provide safe sleep education o Development of training (in person & online) curriculum for home visiting and Children's Protective Services (CPS) staff o Establish and maintain a safe sleep Community of Practice (COP) • Impact existing infrastructure resources o Identify touchpoints and collaborations o Align safe sleep work with Regional Perinatal Care System Quality Improvement Initiatives and Medicaid Health Plans

2017 Meetings - 1:00 p.m. – 4:00 p.m.:

May 16, 2017

July 18, 2017

September 12, 2017