

**HEALTH RESOURCES AND SERVICES ADMINISTRATION'S BUREAU OF PRIMARY HEALTH CARE
HEALTH DISPARITIES COLLABORATIVES (HDC): PERINATAL AND PATIENT SAFETY PILOT
JUNE 2006**

Background

The Office of the Secretary has implemented a program, the Closing the Health Gap Initiative on Infant Mortality, which is intended to reduce infant mortality among populations most affected. The goals of the Health Resources and Services Administration's (HRSA) component of the Closing the Health Gap Initiative on Infant Mortality are to reduce African-American infant deaths from low birth weight and pre-term birth and to reduce African-American infant deaths from SIDS. In an effort to address those goals, the Maternal and Child Health Bureau (MCHB) is working on a risk reduction pilot and the Bureau of Primary Health Care (BPHC) is led a perinatal care and patient safety pilot using the framework of the Health Disparities Collaboratives. The Bureaus had aligned their projects, partnered, and shared resources where possible. Five health centers were selected for the pilot, representing the states of Mississippi, South Carolina, Illinois, and Michigan (States determined to have the highest infant mortality rates for African-Americans).

Why Perinatal and Patient Safety?

During the 20th century, the U.S. infant mortality rate (IMR) declined by 90%. Specifically, in 2001, the national infant mortality rate reached an historic low of 6.8 deaths per 1,000 live births, and the rate of perinatal mortality declined to a rate of 6.9 deaths per 1,000 live births. Furthermore, the rate of cigarette smoking by pregnant women continues to fall, and infant deaths due to Sudden Infant Death Syndrome (SIDS) dropped 11% from 2002 to 2001. Despite these successes, however, disparities in infant mortality remain among racial and ethnic groups. The infant mortality rate among black children is more than double that for white children. In 2001, infants of black mothers had a mortality rate of 13.3, compared to 5.7 for whites. Many large cities within the U.S. report African-American infant mortality rates as high as 17.6 per 1000 live births. Wide variations in the continuum of perinatal care continue despite published standards and evidence-based prospective management strategies and interventions that are aimed at optimizing pregnancy outcome. This is especially true among low-income and minority populations who tend to be at higher risk of poor pregnancy outcome and are thus more likely to require and benefit from recommended interventions.

Aim, Measures, Process, and Key Partners

The aim of the Health Resources and Services Administration (HRSA) Perinatal and Patient Safety Pilot Health Disparities Collaborative were to enhance partnerships that would reduce disparities, ensure safety in pregnancy outcomes and accelerate the rate of improvement with the focus on the African-American population. Measures that were tracked include outcome measures relating to preterm birth and low birth weight and process measures addressing patient self management, risk assessment, risk screening, follow-up, and the availability of critical data at the time of care. The Care Model was the guiding framework which linked the health system with necessary community resources and focused on leadership and organizational support, strong self-management support, decision support, delivery system design, and clinical information systems. The teams worked together over the course of a year, meeting face-to-face several times, to determine whether evidence-based, or expert-advised, interventions would make a difference in perinatal care and patient safety outcomes. Support was provided in the form of a virtual office, conference calls, listserv, and access to faculty, staff, and peer expertise when needed. Key partners to the Health Resources and Services Administration's Bureau of Primary Health Care included the Maternal and Child Health Bureau, the HIV/AIDS Bureau, the Bureau for Health Professions, the Office of the Secretary's Office of Minority Health, the Centers for Disease Control and Prevention, the Institute for Healthcare Improvement, and the National Initiative for Children's Healthcare Quality.

Outcomes and Challenges

All organizations worked on community partnerships and linkages in an effort to improve safety, outreach, communication, and patient safety. The biggest challenges faced by the teams were data entry and maintenance for the large patient populations. The composition of the improvement team was unique in this pilot and required that hospital administrators and obstetrical providers work on the improvements collaboratively with the HRSA-funded Health Center's prenatal care providers. This groundbreaking effort has proved to be a key component in improving the delivery of optimum prenatal care and examining improved outcomes in Patient safety for this patient population.

Site visits were made to all of the five Health Centers. The faculty teams met with the HC teams, hospital and community partners, taking the opportunity to have the health center/hospital team introduce the faculty to the progress made and the culture and the challenges they face. Opportunities for ongoing improvement were identified at each of the site visits with creation of an outline to accelerate partnerships and improved outcomes.

A critical part of each Pilot in the Health Disparities Collaboratives is conducting a final "Harvesting Session" with the teams and faculty to identify the key change concepts, measures, and other tools/resources that may be brought to the greater health center community. The Harvesting Session for this Pilot was held in Washington, DC on February 10-11, 2006. All five health center teams brought members from their partnering hospitals to the session where participants shared successful strategies developed over the course of the Pilot and helped package "lessons learned" into a resource to share with other health centers after the Pilot.

High leverage change concepts – the change concepts that team members felt had the highest impact in terms of improving perinatal outcomes are as follows:

1. Foster communication and coordination among FQHC, hospital, and other agencies to ensure continuity, quality of care, social supports and patient safety
2. Organize and share information between the hospital and health center
3. Form partnerships with community organizations and specialists to support and develop interventions that fill gaps in needed services
4. Develop a registry system and process to track clinically useful information and data
5. Provide ongoing in-service training for providers and staff, using educational strategies proven to change practice behavior and integrating specialist expertise, knowledge, and standards of care
6. Embed evidence-based guidelines into daily clinical practice with the development protocols, standing orders, and flow sheets
7. Use effective self-management support strategies that include assessment, goal-setting, action planning, problem-solving and follow-up