



1.1: Decrease the infant mortality rate for children under 1 year old from 5.1 per 1,000 births in 2012 to 4.4 per 1,000 births by 2016

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OUTCOME MEASURE 1.1: DECREASE THE INFANT MORTALITY RATE FOR CHILDREN UNDER 1 YEAR OLD TO 4.4. PER 1,000 BIRTHS BY 2016

John Wiesman
Secretary of Health

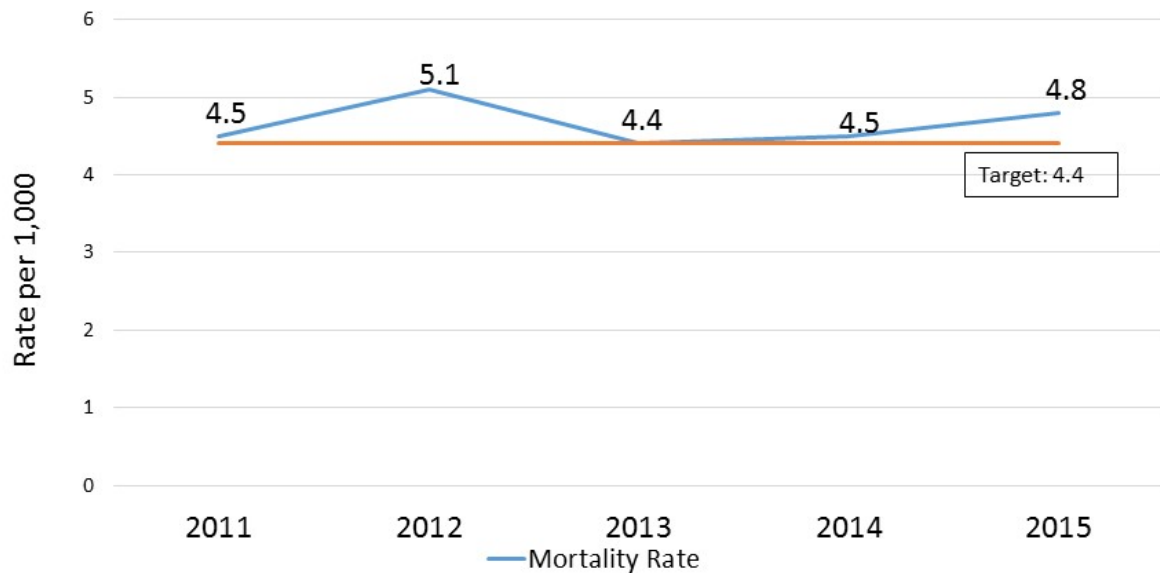
Kathy Lofy
Washington State Health Officer



Kathryn Bateman
WSHA Senior Director, Integrated Care



Measure 1.1: Decrease the infant mortality rate for children under 1 year old to 4.4. per 1,000 births by 2016

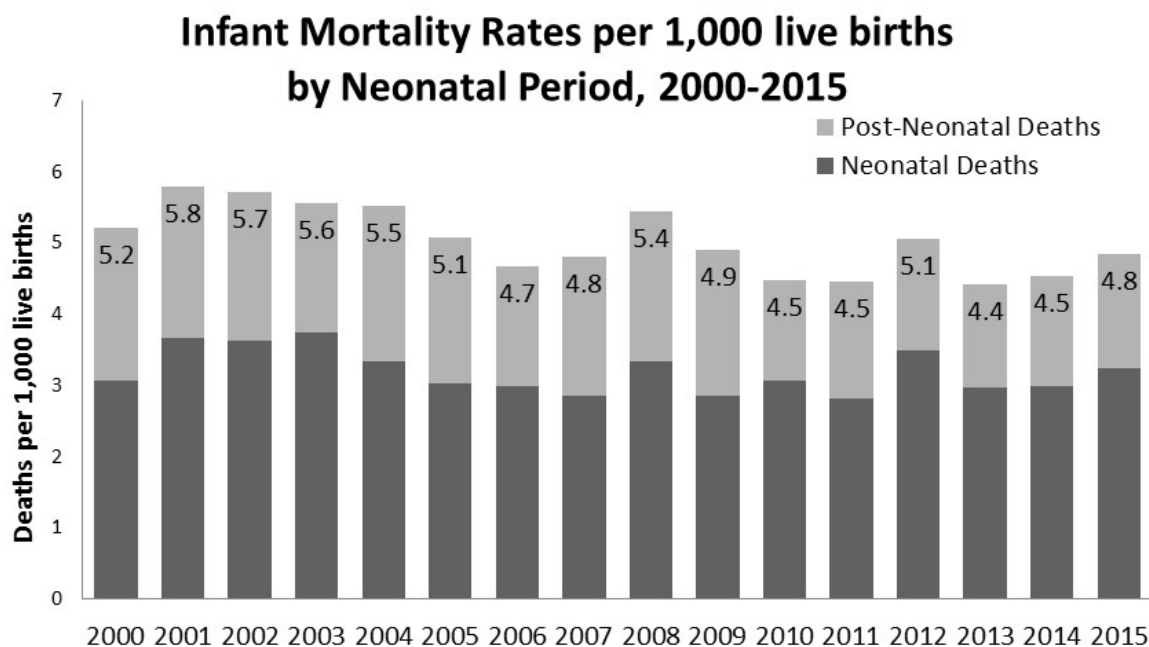


What causes infant death

Top 5 Leading Causes of Death, 2011-2015

Rank	Leading Cause of Death	Total Deaths	Total
1	Congenital Malformations	490	24%
2	Sudden Unexpected Infant Death	334	16%
3	Short Gestation & Low Birth Weight	244	12%
4	Maternal Complications of Pregnancy	161	8%
5	Complications of Cord, Placenta, Membranes	114	6%
	All Other Causes of Death	701	34%
	Total	2,044	100%

How Are we Doing?



How we are doing?

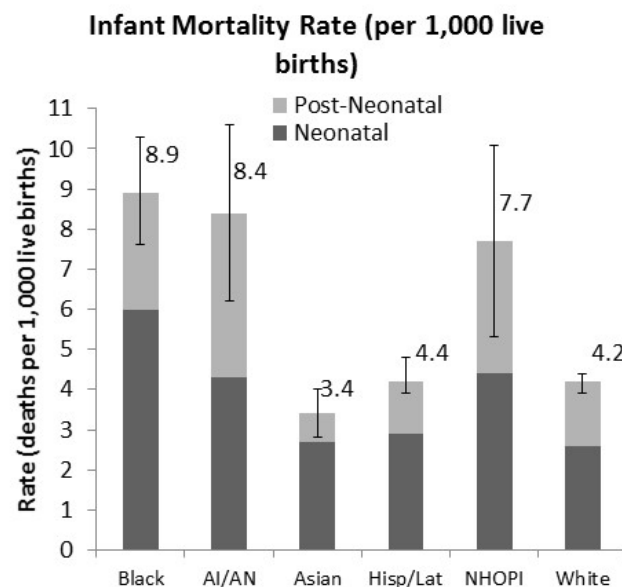
Maternal Age at the Time of Infant Death, 2011-2015

Maternal Age	Total Infant Mortality Rate	Neonatal Mortality Rate (<28 days)	Post-neonatal Mortality Rate (28-364 days)
<20	7.4	4.2	3.2
20-24	5.4	3.0	2.3
25-29	4.4	3.0	1.4
30-34	3.9	2.8	1.1
35-39	4.3	3.3	1.1
40+	6.2	4.8	1.4
Total	4.7	3.1	1.6

How we are doing

Infant Mortality Rate by Maternal Race/Ethnicity, 2011-2015

Race/Ethnicity	Deaths	Births	Infant Mortality Rate
NH American Indian/Alaska Native	55	6,554	8.4
NH Black/African American	168	18,813	8.9
NH Pacific Islander	40	5,185	7.7
Hispanic/Latino Only	347	79,086	4.4
NH White	1,127	270,138	4.2
NH Asian	136	39,746	3.4
Other/Unknown	171	18,951	—
Total	2,044	438,473	4.7



Top Five Leading Causes of Infant Mortality by Maternal Race/Ethnicity, 2011-2015*†

Rank	NH Black	NH American Indian / Alaska Native	NH Asian	Hispanic/Latino	NH Native Hawaiian / Pacific Islander	NH White
1	Short Gestation/Low Birthweight	Sudden Unexpected Infant Death	Congenital Malformations	Congenital Malformations	*	Congenital Malformations
2	Congenital Malformations	*	Short Gestation/Low Birthweight	Short Gestation/Low Birthweight	*	Sudden Unexpected Infant Death
3	Sudden Unexpected Infant Death	*	Maternal Comp. of Pregnancy	Sudden Unexpected Infant Death	*	Short Gestation/Low Birthweight
4	Maternal Comp. of Pregnancy	*	Complication of Placenta, Cord, Membranes	Maternal Comp. of Pregnancy	*	Maternal Comp. of Pregnancy
5	Complication of Placenta, Cord, Membranes	*	*	Complications of Placenta, Cord, Membranes	*	Complications of Placenta, Cord, Membranes
Total Deaths†	168	55	136	347	40	1127

* Cell suppressed because of small numbers; there were fewer than 10 infant mortality cases.

† Total deaths includes all causes of infant mortality categorized by race/ethnicity, 2011-2015; 171 infant deaths are not represented because they are categorized as "unknown/other"

What are we doing

Preventing

- Smoking during pregnancy
- A high pre-pregnancy BMI
- Exposure to environmental chemicals
- Previous preterm birth
- Toxic levels of stress

Educating and Reinforcing

- Planned births
- Taking folic acid prior to pregnancy
- Breastfeeding after birth

<http://www.cdc.gov/reproductivehealth/maternalinfanthealth/infantmortality.htm>

Action Plan

Strategies	Task	Expected Outcome	Task Lead	Status	Due Date
Collaborate with the American Indian Health Commission (AIHC) on implementing and updating the AIHC - Healthy Communities Maternal Infant Health Strategic Plan to reduce preterm birth in American Indian/Alaska Native populations. Preterm birth is a leading cause of infant mortality.	Hold 10 capacity building or technical assistance sessions with Tribes and Urban Indian Health Organizations (UIHOs) during the 2017 calendar year to identify gaps/needs for implementing the AIHC-Healthy Communities Maternal Infant Health (MIH) Strategic Plan.	Collectively, DOH and AIHC will have a better understanding of the gaps present for effectively implementing this plan.	Office of Healthy Communities, Washington State Department of Health	On Track	12/31/2017
Collaborate with the Health Ministers program in Tacoma/Pierce county on the Black Infant Health Project to improve birth outcomes for Black infants.	Maintain a network of at least 20 sites with Health Ministers trained in outreach and education to perinatal African-American women and their infants in Tacoma/Pierce County during the 2017 calendar year.	We will expand the reach of the Health Ministers program in Tacoma/Pierce County.	Office of Healthy Communities, Washington State Department of Health	On Track	12/31/2017
Maintain the Family Health Hotline through WithinReach.	Respond to 16,000 statewide phone inquiries to the Family Health Hotline (FHHL) in the 2017 calendar year and track the top five referrals for each quarter.	Have a better understanding of the needs of callers by tracking the referrals provided.	Office of Healthy Communities, Washington State Department of Health	Ongoing	
Collaborate with Washington State Hospital Association on implementing the Safe Deliveries Road Map.	Pilot implementation of the quality improvement bundles with providers - these are best practices for preconception, prenatal, labor and delivery, post partum and neonatal period. Department of Health will assist with dissemination.	Hospitals and healthcare providers across the state will implement best practices that will improve maternal health and birth outcomes.	Washington State Hospital Association	on track	12/31/2017
Focus WIC outreach on American Indian/Alaska Native and Black populations.	Conduct and evaluate two outreach mailings per year to WIC eligible populations of pregnant women and children under the age of 5 years old.	Prenatal WIC participation is associated with lower infant mortality rates through its effect on the prevention of low birth weight, increased breastfeeding rates and overall positive impact on maternal and child health.	Office of Nutrition Services, Washington State Department of Health	on track	12/31/2019

What are we Doing?

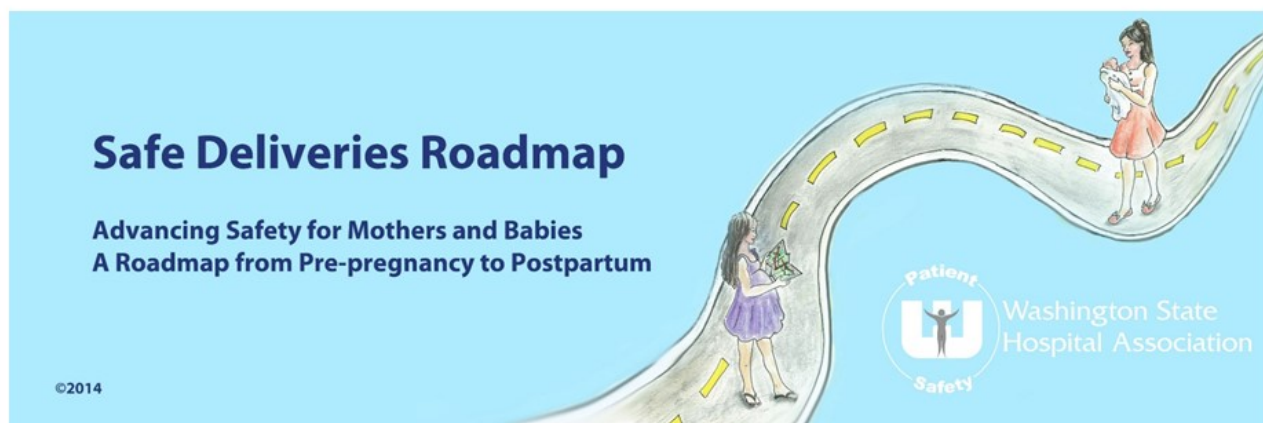
Role of Health Care

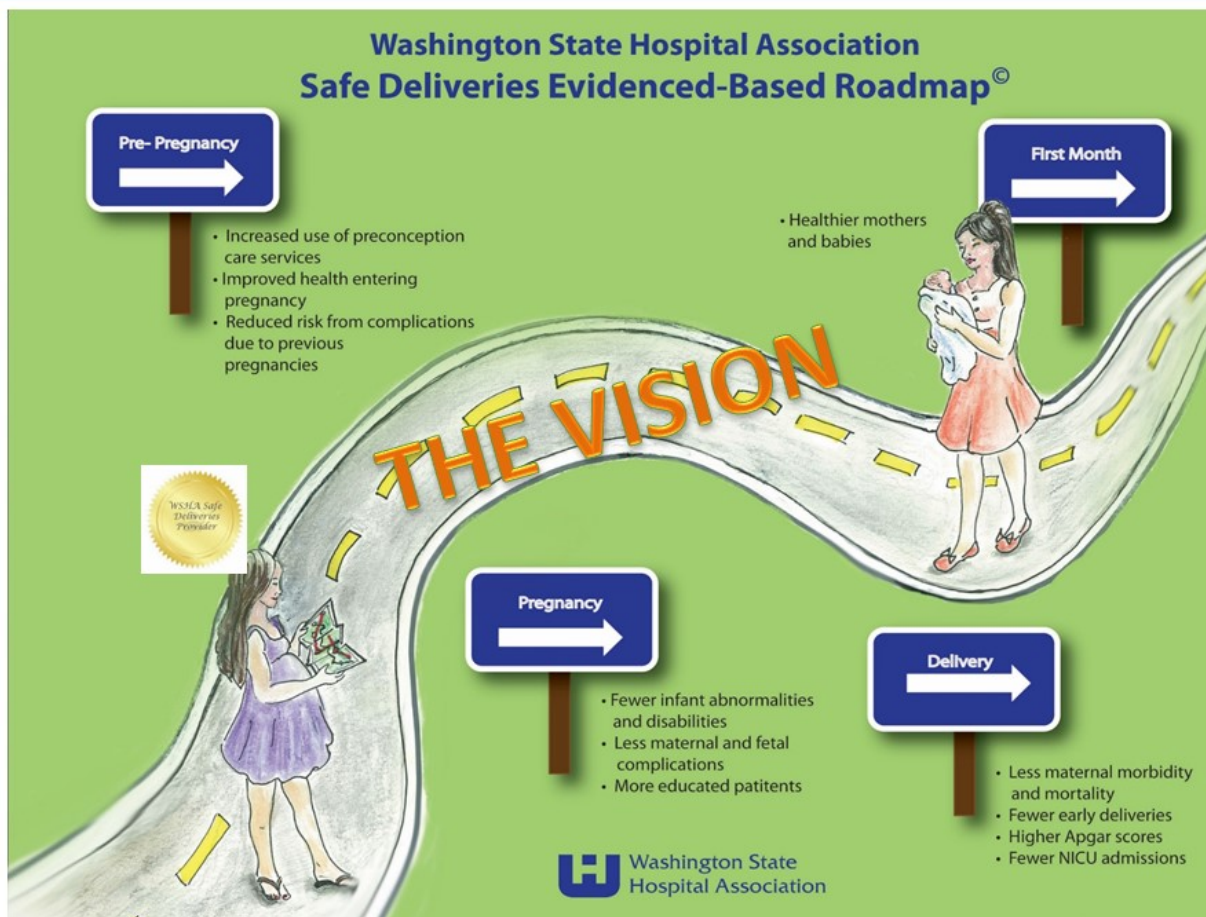
- Access to safe and effective birth control
- Best Practice prenatal, labor and delivery, and neonatal care
- Identification of risks and appropriate referrals
 - smoking, substance use, maternal depression, domestic violence
- Support Breastfeeding after birth
- Provide Social Support from providers and home visiting programs
- Work to assure that every woman delivers at a hospital with the level of labor/delivery/infant services to fit their needs

Washington State Hospital Association

Safe Deliveries Roadmap

Kathryn Bateman, MSN, RNC-OB, CENP
WSHA Senior Director, Integrated Care





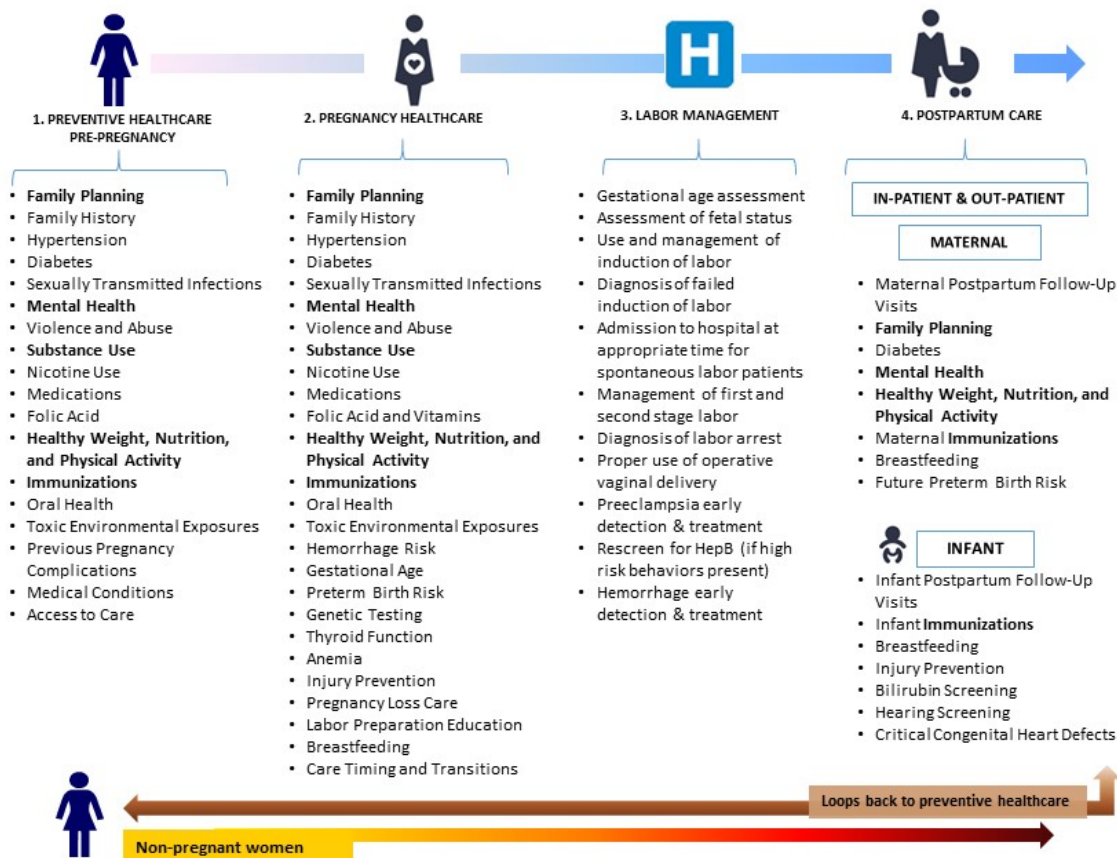
American College of Nurse Midwives – WA affiliate
 American Congress of Obstetricians and Gynecologists
 Advanced Registered Nurse Practitioners United of WA State
 Association of Women's Health, Obstetric and Neonatal Nurses
 Foundation for Health Care Quality – OB COAP
 Foundation for Healthy Generations
 March of Dimes
 Midwives Association of WA State
 Northwest Organization of Nurse Executives
 Planned Parenthood – Great Northwest
 Planned Parenthood – Greater WA and North Idaho
 Seattle University College of Nursing
 University of WA School of Nursing
 WA Academy of Family Physicians
 WA Chapter of the American Academy of Pediatrics
 WA State Department of Health
 WA State Health Care Authority
 WA State Medical Association
 WA State Nurses Association
 WA State Perinatal Collaborative
 WithinReach



foundation for
healthy generations
CREATING ENDURING HEALTHY EQUITY



"I have such faith that we've identified the best practices because of the breath and depth of the expertise we've had participating in this process"
Advisory Group Member...



Bundles

Topic 1: Family Planning

Recommendations

- Take a sexual history at least annually, beginning at menarche.⁴
- Counsel on the patient's Reproductive Life Plan.^{4,6}
- Screen for pregnancy desire in next year, for example by asking "Would you like to become pregnant in the next year?"^{2,3}
 - If NO (never wants to be pregnant): For women at risk of pregnancy (sexually active with men), provide counseling on and access to all contraceptive methods, including long-acting reversible contraception (LARC), sterilization, and vasectomy.^{3,4}
 - If NO (wants to be pregnant later than the next year) or AMBIVALENT (not sure about pregnancy desire in the next year): For women at risk of pregnancy (sexually active with men), provide counseling on and access to all contraceptive methods, including long-acting reversible contraception (LARC), and educate about planning pregnancy/preconception health. Counsel on a healthy pregnancy interval of 18-60 months and risks of pregnancy at advanced maternal age, as appropriate. Encourage woman to return for a visit to address pregnancy planning if she decides to become pregnant before next regular visit.^{3,4}
 - If YES (wants to be pregnant in the next year): Educate about planning pregnancy and preconception health, or health-related preparation for pregnancy. Where relevant, educate about a healthy pregnancy interval of 18-60 months and the risks of pregnancy at advanced maternal age. Emphasize the importance of starting prenatal care once pregnant; educate about how to seek prenatal care. If the woman has a significant medical condition (e.g. hypertension, diabetes), discuss the impact of her condition on pregnancy and plan for optimal management of the disease.
- Consider the patient's potential for experiencing reproductive coercion or interference with her contraception; as appropriate, counsel on methods that are easily hidden and difficult to interfere with.

Special Considerations

- Long-acting reversible contraception (LARC) is the first line choice for all women, particularly for 1) women with chronic medical conditions as there are few medical contraindications to LARC, and 2) women on teratogenic medications or with other high risk preconception conditions, given LARC's effectiveness in preventing unplanned pregnancy.

Implementation Tip

- Provide office based pregnancy testing.
- Do not require pelvic exams that are not medically indicated before initiating contraception. Follow current cervical cancer and STI screening guidelines.

Family Planning Tools & Resources

- A. Guide to Taking a Sexual History (Centers for Disease Control and Prevention (CDC)): <http://www.cdc.gov/std/treatment/sexualhistory.pdf>
- B. Reproductive Life Plan tool for Health Professionals (CDC): <http://www.cdc.gov/preconception/rlp.html>
- C. Reproductive Life Plan tool for women (CDC): <http://www.cdc.gov/preconception/reproductiveplan.html>
- D. One Key Question (Would you like to become pregnant in the next year?) Initiative's website – offers practice change support for providers (Oregon Foundation for Reproductive Health): <http://www.onekeyquestion.org/>
- E. Contraceptive Medical Eligibility Criteria (CDC): <http://www.cdc.gov/reproductivehealth/UnintendedPregnancy/USMEC.htm#>
- F. Poster: Effectiveness of Family Planning Methods (CDC): <http://www.cdc.gov/ReproductiveHealth/UnintendedPregnancy/PDF/POSTER-Effectiveness-Family-Planning-Methods.pdf>
- G. When to Start Using Specific Contraceptive Methods (CDC): http://www.cdc.gov/reproductivehealth/UnintendedPregnancy/PDF/246124_8ox1_App_B_D_Final_TAG508.pdf
- H. QuickStart Algorithm (Reproductive Health Access Project): for purchase at <http://reproductive-health-access-project-store.myschoolty.com/products/quick-start-algorithm>; free download at http://www.calglobal.org/files/downloadable/rhap_QuickstartAlgorithm.pdf
- I. Recommended Actions After Late or Missed Combined Oral Contraceptives (CDC): http://www.cdc.gov/reproductivehealth/UnintendedPregnancy/PDF/246124_Fig_2_3_4_Final_TAG508.pdf
- J. Provider continuing education module on 2013 Contraceptive Practice Recommendations (CDC): <http://www.cdc.gov/reproductivehealth/UnintendedPregnancy/TeenPregTraining.html>
- K. Provider continuing education module on practice recommendations for teen pregnancy prevention (CDC): <http://www.cdc.gov/reproductivehealth/UnintendedPregnancy/TeenPregTraining.html>
- L. Intrauterine Devices and Implants: A Guide to Reimbursement (National Family Planning and Reproductive Health Association): http://www.nationalfamilyplanning.org/files/documents--reports/LARC_Report_2014_R3_forWeb.pdf


Tips

Recommendations

Special Considerations

Tools and Resources

Education




Washington State
Hospital Association

Featured Interview

Yakima Valley Memorial Hospital

- Aimee Borley - Nurse Manager Family Birthplace
- Dr. Kevin Harrington - Senior Attending OBGYN
- Dr. Roger Rowles – Perinatal Unit Medical Director

Presented at Washington State Hospital Association Safe Table Webcast April 30, 2015




Participants

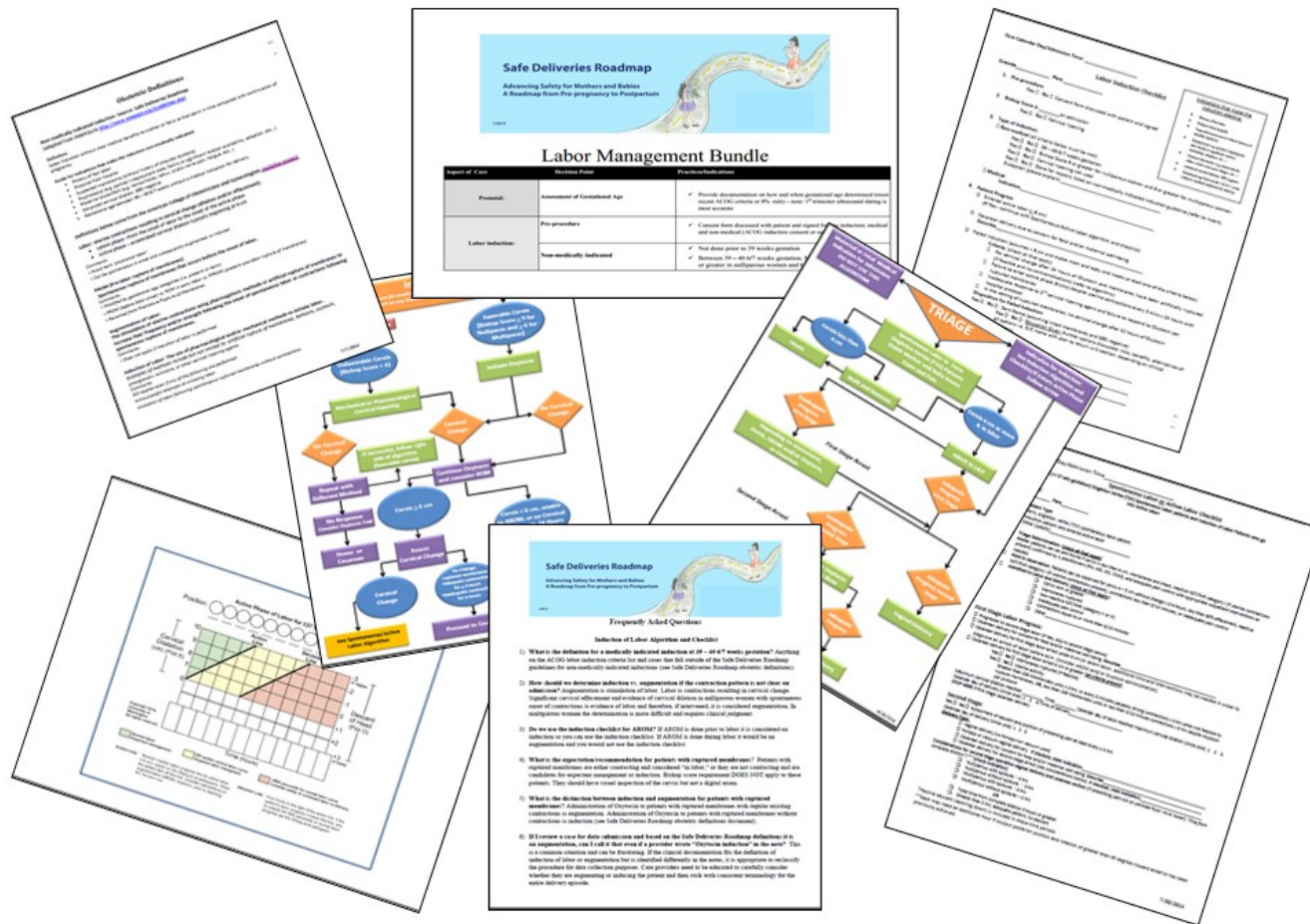
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Heggen Boucher	7:03 AM / 8:05 AM
amedborley	7:03 AM / 8:05 AM
WISH Patient Safety 2	7:03 AM / 8:05 AM
Adrianne Montrose	7:03 AM / 8:05 AM
Melody Peres	7:03 AM / 8:05 AM
Thomas benedetti	7:03 AM / 8:05 AM
Nancy	7:03 AM / 8:05 AM
38 Howie	7:03 AM / 8:05 AM
Katie	7:03 AM / 8:05 AM
Angela Chen	7:03 AM / 8:05 AM
Shelly Fallhee	7:03 AM / 8:05 AM

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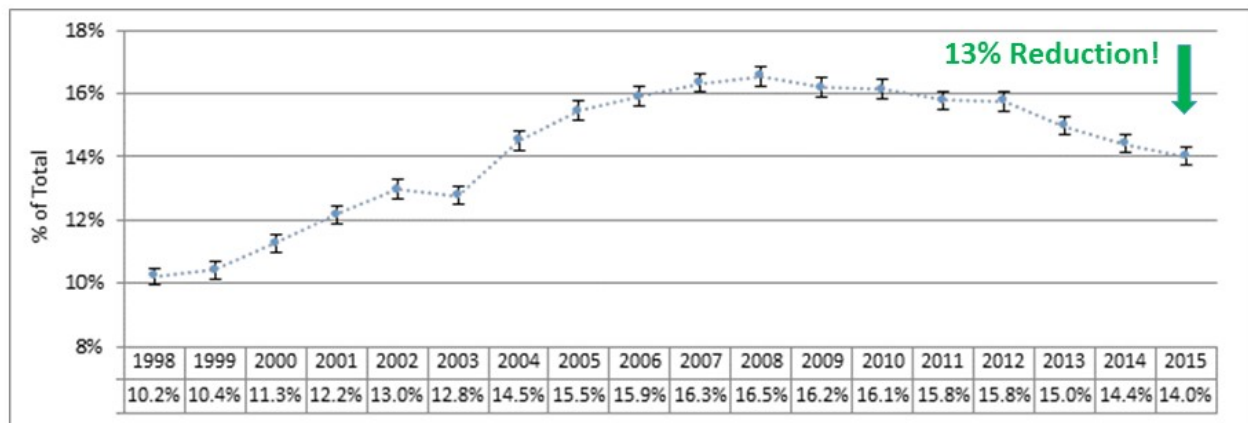
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page 19	00:15:30
page 20	00:15:30
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page 20	00:19:07

Video





Primary C-Sections Among Term Singleton Vertex (TSV) Deliveries 1998-2015 Hospital Rate with 95% Confidence Limits

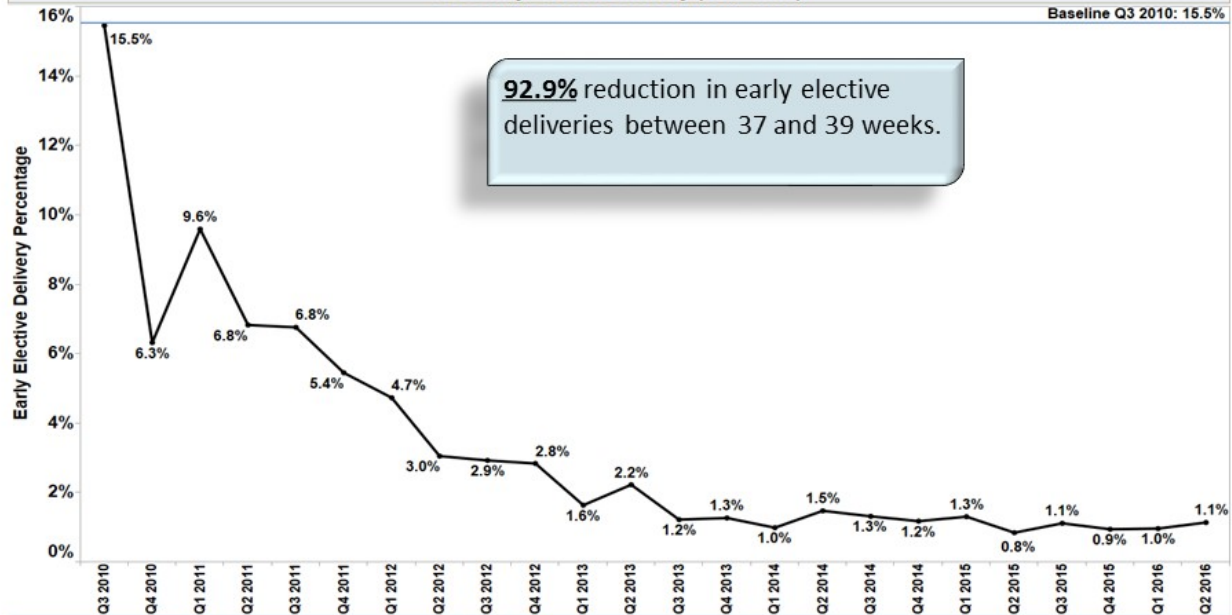


Source: Cawthon, L. Delivery Statistics Report Washington State Non-Military Hospitals, Department of Social and Health Services Research and Data Analysis Division.



OB: Early Elective Delivery (NQF 0469)

Baseline Q3 2010: 15.5%



Definition: The Joint Commission PC-01 and NQF 0469, number of women with elective vaginal deliveries or elective cesarean sections at ≥ 37 and < 39 weeks of gestation.
Data Source: Washington State Hospital Association's (WSHA) Quality Benchmarking System (QBS)

What you can do:

- Maintain Washington's Medicaid Expansion
 - Increases access to both primary and prenatal care
- Support Tobacco 21 Legislation
- Support Expansion of Black Infant and American Indian infant health programs
- Support postnatal interventions such as provider support programs and home visiting programs

END

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