

Perinatal Hospital Summit:
Linking Science with Practice
Conference summary

September 24, 2010

Sponsored by the Indiana Perinatal Network, the Indiana Hospital Association
and the Indiana State Department of Health

- I. Introduction
 - a. This summit was convened to review specific perinatal practices throughout the state of Indiana. The two practices reviewed were maternity practices in infant nutrition and The Joint Commission perinatal care core measures, specifically elective delivery prior to 39 weeks of gestation.
 - b. 95% of all hospitals with a delivery unit and 99% of all Indiana births were represented at the summit.
- II. Infant nutrition—Presentation by Deborah Dee, PhD, MPH, *Center for Disease Control and Prevention*, which covered the mPINC survey results for Indiana
 - a. Results and survey details available at www.cdc.gov/mpinc
 - b. Presentation covered risks of formula feeding for infants, influence of maternity practices on breastfeeding rates
 - c. mPINC survey is distributed every 2 years; provides assessment at national, state and facility levels; uses single key informant at each facility identified by phone screening; is made up of 52 questions divided into 7 subscales
 - d. Subscales: labor and delivery care, feeding of breastfed infants, breastfeeding assistance, contact between mother and infant, discharge care, staff training and structural/organizational aspects of care delivery
 - e. Dr. Dee then covered components of each subscale, reviewing how Indiana compares to the rest of the nation (see website for further details)
 - f. Summary of results:
 - i. Indiana hospitals perform similarly to the national average
 - ii. Skin-to-skin contact is standard in less than half of Indiana facilities
 - iii. Many healthy, term, breastfed infants are being routinely supplemented with water, glucose water and formula; unlikely that all are medically necessary
 - iv. Mother-infant pairs are separated during maternity stay for many reasons
 - v. Discharge care is typically passive and not in-person
 - vi. Distribution of formula marketing samples to breastfeeding mothers remains common in Indiana
 - vii. Only 6% of new staff in Indiana facilities receive the recommended amount of breastfeeding training
 - viii. While most facilities have a breastfeeding policy, few Indiana facilities have comprehensive policies

- g. Facility reports were sent to 6 people: CEO/Administrator, director of quality improvement, director of obstetrics, director of pediatrics, mother baby nurse manager, survey respondent
 - h. Next steps: dissemination of 2009 reports, benchmarking of practices, repeat survey in Fall, 2011
- III. Perinatal Care Core Measures from The Joint Commission—Presentation by Celeste Milton, MPH, BSN, RN, *The Joint Commission*, which covered performance measure updates and Perinatal Care Core Measure Set
- a. Accountability measures—found in NEJM article
<http://www.nejm.org/doi/full/10.1056/NEJMs1002320>
 - b. Several measures under development currently, going to advisory panels this year for review
 - i. Blood management project: documentation, consent, PRBC/plasma/platelet transfusions, anemia screening, pre-op screening
 - ii. Screening and treating alcohol and tobacco use project
 - iii. Sudden cardiac arrest prevention initiative project: working on identification of best practice
 - c. Perinatal care core measures; manual outlining data and collection process is available online at <http://manual.jointcommission.org>
 - i. Measure development began in 2007, data collection began in April, 2010
 - ii. Core measures in perinatal care are:
 1. Elective delivery prior to 39 weeks of gestation
 2. Cesarean section for nulliparous woman with singleton gestation and fetus in vertex position at >37 weeks
 - a. Excluded populations include medical contraindication to vaginal delivery
 - b. Risk stratified by maternal age
 3. Antenatal steroids for gestational ages 24-32 weeks of gestation
 - a. Woman must receive full course of betamethasone or dexamethasone
 - b. Or documentation of contraindication to steroid administration
 4. Health care-associated bloodstream infections in newborns (sepsis or bacteremia)
 - a. Excluded populations include birth weight <500 grams or length of stay < 2 days
 - b. Risk stratified by birth weight (500-999g, 1000-1249g, 1250-2499g), presence of congenital anomalies, in-born/out-born status and death
 5. Exclusive breast milk feeding
 - a. Excluded populations include admitted to NICU, galactosemia, use of TPN, length of stay >120 days,

enrollment in clinical trial or documented reason for not exclusively feeding breast milk

b. Sweet-ease or other sucrose solution is documented as medication and not supplemental feeding

iii. WikiHealthCare is The Joint Commission's interactive forum for health care professionals: <http://wikihealthcare.joincommission.org>

IV. Afternoon sessions: The group was divided into large-volume delivery hospitals and smaller-volume delivery hospitals. The two groups alternately discussed exclusive breast feeding and elective delivery prior to 39 weeks of gestation with other hospitals of comparable size. Questions were asked of the visiting speakers, as well as comparable hospital systems. Barriers to implementation of policies were discussed, as well as practices that made adoption of policies easier. It was overall a good give-and-take of information between hospitals who had implemented policies, hospitals that were working on implementing policies and those who were wondering how to begin to develop policies.