Prematurity Campaign Collaborative

Clinical and Public Health Practice Workgroup

February 20, 2018
3-4:30pm
Co-Chairs

Christopher Zahn
Vice President, Practice Activities, ACOG

Vanessa Lee
HRSA Infant Mortality COIIN Coordinator
General Housekeeping

Please note the following:

All participants will be muted on entry

To speak to the group, remember to unmute yourself.

1. If you are connected through the computer audio, click the mic in the lower left hand corner of your screen to unmute and mute.

2. If you are connected through the phone press *6 to unmute and mute

Be sure to mute yourself when you are not speaking

Please do not place call on hold

Use the chat box, if you would like a moderator to call on you or share your comments with the group
Agenda for today’s meeting

1. Welcome: Vanessa Lee

2. Low Dose Aspirin Use In a Medical Home Model: Dr. Erica Giwa, Associate Medical Director, Center for Children and Women Southwest

3. 17P formulations and resources: Chris Zahn

4. Birth Spacing and Pre/Interconception Care: Chris Zahn
   • Editorial and articles sent as attachments

5. Prematurity Prevention Summit, planning for CPHP in-person meeting: Katie Sellers

6. Wrap up and adjourn
Meeting Objectives

1. Understand an example of low dose aspirin implementation
2. Understand latest information on 17P formulations and some available resources
3. Discuss approach to birth spacing
4. Learn about content and registration for the 2018 Prematurity Prevention Summit
2. Low Dose Aspirin Use in a Medical Home Model
Implementation of Low Dose Aspirin Protocols in a Medical Home Model

Dr. Erica Giwa
The Center for Children and Women
Associate Medical Director
Southwest Location
The Center is a patient- and family-focused medical home for Texas Children’s Health Plan members.
The Center for Children and Women

Fully capitated, full risk model providing comprehensive and coordinated primary care for Texas Children’s Health Plan (TCHP) members and now women with state-provided coverage

- Medical home model: capacity and accountability, provider-led teams, enhanced access, continuity of care, safety and quality, care coordination & integration, and whole person orientation.
The Center Locations

Greenspoint: Opened August 2013

Southwest: Opened November 2014
Locations

The Center at Greenspoint
I-45 N and Beltway 8
700 N. Sam Houston Parkway West
Houston 77067
Opened in 2013

The Center in Southwest Houston
59 S and Bissonnet
9700 Bissonnet
Houston 77036
Opened in 2014
Services
- Obstetrics/Gynecology
- Pediatrics
- Behavioral Health
- Optometry
- Dentistry
- Radiology
- Pathology
- Pharmacy
- Speech Therapy

Team Members
- Physicians
- Certified Nurse Midwives
- Psychologists
- Pharmacists
- Registered Nurses
- Medical Assistants
- Clinical Therapists
- Social Workers
- Nutritionists
- Health Educators
- Others
## Center Deliveries

<table>
<thead>
<tr>
<th>Total Deliveries</th>
<th>Greenspoint 2,301</th>
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<tbody>
<tr>
<td>3,483</td>
<td>Southwest 1,182</td>
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</tbody>
</table>
The Rate of Maternal Mortality in the U.S. is Increasing

MacDorman M. Recent Increases in US Maternal Mortality. OG 2016
The Rate of Maternal Mortality in Texas in 2014 (32.8 per 100,000) was higher than 45 other US states and than other developed nations.
In Texas, using information collected from death certificates, cardiac events were the most common category of death.
In Texas, and across the nation, African American women bear the greatest risk for maternal death, and the disparity in death rates has widened over the last 10 years.
Approximately 25% of Center deliveries are African American women
Implementation of Low Dose Aspirin
USPSTF Recommendations

- 1996
  - Evidence was insufficient to recommend for or against the routine use of aspirin for the prevention of preeclampsia or IUGR

- 2014
  - USPSTF recommends the use of low-dose aspirin (81mg/d) as preventative medication after 12 weeks of gestation in women who are at high risk for preeclampsia
LOW-DOSE ASPIRIN USE FOR THE PREVENTION OF MORBIDITY AND MORTALITY FROM PREECLAMPSIA CLINICAL SUMMARY OF U.S. PREVENTIVE SERVICES TASK FORCE RECOMMENDATION

| Population | Asymptomatic pregnant women who are at high risk for preeclampsia. |
| Recommendation | Prescribe low-dose (81 mg/d) aspirin after 12 weeks of gestation. |

**Risk Assessment**
- Pregnant women are at high risk for preeclampsia if they have 1 or more of the following risk factors:
  - History of preeclampsia, especially when accompanied by an adverse outcome
  - Multiparous gestation
  - Chronic hypertension
  - Type 1 or 2 diabetes
  - Renal disease
  - Autoimmune disease (i.e., systemic lupus erythematosus, antiphospholipid syndrome)

**Preventive Medication**
- Low-dose aspirin (60 to 150 mg/d) initiated between 12 and 28 weeks of gestation reduces the occurrence of preeclampsia, preterm birth, and IUGR in women at increased risk for preeclampsia.

The harms of low-dose aspirin in pregnancy are considered to be no greater than small.

**Balance of Benefits and Harms**
- There is a substantial net benefit of daily low-dose aspirin to reduce the risk for preeclampsia, preterm birth, and IUGR in women at high risk for preeclampsia.

**Other Relevant USPSTF Recommendations**
- The USPSTF recommends that all women planning or capable of pregnancy take a daily supplement containing 0.4 to 0.8 mg (400 to 800 μg) of folic acid. This recommendation is available at www.uspreventiveservicestaskforce.org.
# Clinical Guideline

## Table. Clinical Risk Assessment for Preeclampsia*

<table>
<thead>
<tr>
<th>Risk Level</th>
<th>Risk Factors</th>
<th>Recommendation</th>
</tr>
</thead>
<tbody>
<tr>
<td>High†</td>
<td>History of preeclampsia, especially when accompanied by an adverse outcome Multifetal gestation Chronic hypertension Type 1 or 2 diabetes Renal disease Autoimmune disease (i.e., systemic lupus erythematosus, antiphospholipid syndrome)</td>
<td>Recommend low-dose aspirin if the patient has ≥1 of these high-risk factors</td>
</tr>
<tr>
<td>Moderate‡</td>
<td>Nulliparity Obesity (body mass index &gt;30 kg/m²) Family history of preeclampsia (mother or sister) Sociodemographic characteristics (African American race, low socioeconomic status) Age ≥35 y Personal history factors (e.g., low birthweight or small for gestational age, previous adverse pregnancy outcome, &gt;10-y pregnancy interval)</td>
<td>Consider low-dose aspirin if the patient has several of these moderate-risk factors§</td>
</tr>
<tr>
<td>Low</td>
<td>Previous uncomplicated full-term delivery</td>
<td>Do not recommend low-dose aspirin</td>
</tr>
</tbody>
</table>

* Includes only risk factors that can be obtained from the patient medical history. Clinical measures, such as uterine artery Doppler ultrasonography, are not included.
† Single risk factors that are consistently associated with the greatest risk for preeclampsia. The preeclampsia incidence rate would be approximately ≥8% in a pregnant woman with ≥1 of these risk factors (1, 5).
‡ A combination of multiple moderate-risk factors may be used by clinicians to identify women at high risk for preeclampsia. These risk factors are independently associated with moderate risk for preeclampsia, some more consistently than others (1).
§ Moderate-risk factors vary in their association with increased risk for preeclampsia.
Aspirin Usage in FY 2013 (Year One)

* In patients with a history of preeclampsia
Preterm Deliveries in FY 2013 (Year One)

<table>
<thead>
<tr>
<th>Denominator</th>
<th>Numerator</th>
<th>Rate</th>
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<tbody>
<tr>
<td>154</td>
<td>21</td>
<td>13.6%</td>
</tr>
</tbody>
</table>

Center Opening 8/2013

USPSTF 2014

Metric Trending

Year Month

12.5% 8.0% 16.7% 26.7% 12.5% 13.0% 11.7%
Implementation at The Center

- Provider education
  - Solidify management protocol
- Facilitate team discussion about high risk patients
- Streamline documentation/communication between providers
- Address patient compliance
Management Protocol at The Center

- Based on recommendations of the July 2016 ACOG Practice Advisory
  - Dose: Aspirin 81 mg/d
  - Candidates: Individuals in the high risk category as listed in USPSTF recommendations
  - Initiation: Between 12 and 28 weeks
  - Discontinuation: Time of Delivery
Facilitate team discussion

- Biweekly high risk huddle led by providers
  - Attended by MDs, MFM, Midwives, Genetic Counselor
  - Discuss the treatment plans for high risk plans
  - Highlight changes in management plans, compliance issues, etc
Streamline Documentation/Communication

Epic Smart sets

**CHTN**

- Medications: ASA 81mg
- Labs/Studies: Baseline PIH panel, 24 hr urine protein, EKG, Retinal Scan
- Consults: MFM, Care coordination referral/ BP logs/ BP cuff
- Ultrasounds: Weekly antenatal testing at 34 weeks, Interval growth scan Q4weeks to start at 26 weeks
- Delivery Plan: 37-39 weeks depending on control and co-morbidities
- Postpartum: Long-term care location

**Pre-Gestational DM**

- Medications: ASA 81mg
- Labs/Studies: Baseline PIH panel, 24 hr urine protein, Hemoglobin A1C, EKG, Retinal Scan, Fetal ECHO @ 22 weeks, Maternal ECHO (if pt also HTNlive and obese)
- Consults: Nutrition, MFM, Care coordination referral
- Ultrasounds: Weekly antenatal testing at 32 weeks, Interval growth scan Q4weeks to start at 28 weeks
- Delivery Plan: 37-39 weeks depending on control and co-morbidities, Reviewed with neonatology
- Postpartum: Long-term care location

**Hx of PreE**

- Medications: ASA 81 mg
- Labs/Studies: Baseline PIH panel, 24 hr urine protein
- Consults: Care coordination referral/ BP logs/ BP cuff
Compliance

- Pharmacy on site
- Prescriptions are sent to the pharmacy during the appointment
- Little to no wait time
- One bottle of aspirin (36 tablets) = 97 cents + tax
YOU get an aspirin
And YOU get an aspirin
EVERYBODY gets an aspirin!!
Aspirin Usage in FY 2016

Average = 14.75 %

* In patients with a history of preeclampsia
Initiation of ASA before 20 weeks

Denominator | Numerator | Rate
--- | --- | ---
303 | 100 | 33.0%
Preterm Deliveries in FY 2016

![Graph showing metric trending for preterm deliveries in FY 2016]

- **Denominator:** 488
- **Numerator:** 37
- **Rate:** 7.6%
Impact of USPSTF recommendations for aspirin for prevention of recurrent preeclampsia

Mary Catherine Tolcher, MD, MS; Derrick M. Chu, BS; Lisa M. Hollier, MD; Joan M. Mastrobattista, MD; Diana A. Racusin, MD; Susan M. Ramin, MD; Haleh Sangi-Haghpeykar, PhD; Kjersti M. Aagaard, MD, PhD

Objective: Evaluate the clinical impact of USPSTF recommendations for low dose aspirin for preeclampsia prevention on rates of recurrent preeclampsia

417 out of 17,256 women with documented history of preeclampsia in previous pregnancy

Outcomes evaluated before and after USTSTF recommendations

Conclusion: Rates of recurrent preeclampsia among women with a history of preeclampsia decreased by 30% after the release of the task force recommendation for aspirin for prevention
Future Directions

- Examine the impact of racial disparities on maternal morbidity and mortality in The Center population
  - Incorporate treatment for patients with moderate risk factors
- Expand patient education
- Development tools to better monitor outcomes in our patients
- Centering pregnancy for high risk patients
Questions?
3. 17P Formulations and Resources
HEALTH ACTION SHEET

Are progesterone shots right for you?

Progesterone shots may help prevent premature birth for some women who have had a premature birth before. Talk to your provider to see if progesterone shots are right for you.

Progesterone is a hormone that helps your uterus grow during pregnancy and keeps it from having contractions. If you’ve had a premature birth (before 37 weeks of pregnancy) already, progesterone shots called 17P may help prevent another early birth if both of these describe you:

☐ You had a spontaneous premature birth when you were pregnant with just one baby. Spontaneous means labor began on its own, without drugs or other methods. Or the sac around your baby broke early.

☐ You’re pregnant with just one baby. Progesterone shots don’t work if you’re pregnant with twins, triplets or more.

If both of these describe you, your provider may prescribe 17P shots. You start the shots between 16 and 24 weeks of pregnancy, and you get a shot each week until 37 weeks.

You may have some discomfort at the injection site (the place on your body where you get the shot). 17P is safe for your baby if you get the shots in the second and third trimesters.

Talk to your provider about progesterone shots before you get pregnant again. The shots don’t always work to prevent another premature birth, but they may help reduce your risk.

How do you get 17P shots?

Talk to your provider. Your health insurance or state Medicaid program may help pay for the shots. You may be able to get a generic form, or you can get brand name shots called Makena®. In some states, you may be able to get a kind of 17P (called compounded) from special pharmacies.

17P stands for hydroxyprogesterone caproate. Look for this name on the product label.

TAKE ACTION

Find out if 17P is right for you.

Ask yourself these questions.

☐ Have you had a premature birth (before 37 weeks) in the past?

☐ Were you pregnant with just one baby?

☐ Was your labor spontaneous (started on its own)?

If all the answers are yes:

☑ Ask your provider about how to get progesterone shots.

☑ Call your health insurance company to see if it pays for progesterone shots.

WATCH A VIDEO

marchofdimes.org/progesterone
4. Birth Spacing and Pre/Interconception Care
Editorial

Interpregnancy Interval and Pregnancy Outcomes
Causal or Not?

Interpregnancy interval—the time from the end of one pregnancy to the conception of the subsequent one—can be potentially modified. The critical question is whether such modification improves the outcome of the subsequent pregnancy. There is extensive literature, going back decades, consistently documenting that women who become pregnant again shortly after delivery of a viable neonate are at increased risk of giving birth to a preterm, low birth weight, or small-for-gestational age neonate in the subsequent pregnancy. Indeed, the World Health Organization recommends an interval of at least 24 months after a live birth for a woman to become pregnant again. The literature on pregnancy outcomes after long intervals is more recent, somewhat less consistent, and more susceptible to confounding by unreported miscarriages or voluntary terminations, secondary infertility, and partner changes, but suggests similar findings. Consistency of results is a criterion for causality, but in applying it we must consider whether consistency might be due to multiple studies sharing a common flaw.

Within-Family Analysis of Interpregnancy Interval and Adverse Birth Outcomes

Original Research

The associations of birth intervals with small-for-gestational-age, preterm, and neonatal and infant mortality: a meta-analysis

Original Research

Interpregnancy Interval and Adverse Pregnancy Outcomes
An Analysis of Successive Pregnancies

Gillian E. Hanley, PhD, Jennifer A. Hutchon, PhD, Brooke A. Kinniburgh, MPH, and Lily Lee, MPH
5. Prematurity Prevention Summit
PREMATURITY PREVENTION SUMMIT: BUILDING A BIRTH EQUITY MOVEMENT

May 21 & 22, 2018
Renaissance Arlington Capital View Hotel

Day 1: Plenary speakers, breakout sessions, social event
Day 2: Collaborative Workgroup meetings and plenary lunch
PREMATURITY PREVENTION SUMMIT: BUILDING A BIRTH EQUITY MOVEMENT

Thought leaders will convene to advance policy and practice, to mobilize community leadership, to share and spread emerging ideas and promising practices, and to energize stakeholders to achieve equity and reduce preterm birth.

FEATURED SPEAKERS

- Wanda D. Barfield, MD, MPH, FAAP, RADM | US Public Health Service, Div. of Reproductive Health, CDC
- Paula Braveman, MD, MPH | University of California San Francisco
- James Collins, MD, MPH | Northwestern University
- Paul E. Jarris, MD, MBA | March of Dimes
- Nat Kendall-Taylor, PhD | FrameWorks Institute
- Kelli Komro, MPH, PhD | Emory University
- David Lakey, MD | University of Texas System
- Michael McAfee, EdD | PolicyLink
- David Stevenson, MD | Stanford University
- Diana E. Ramos, MD, MPH, FACOG | California Department of Public Health Department
- Stacey D. Stewart | President, March of Dimes
PREMATURITY PREVENTION SUMMIT: BUILDING A BIRTH EQUITY MOVEMENT

Registration begins Feb. 22, 2018. A registration link will be emailed to all Collaborative participants.

$400 fee includes:
- Conference fee
- Social event ticket
- Meals during the Summit

Please address any questions to conferences@marchofdimes.org.
6. Wrap Up and Future Meetings
# Collaborative Meeting Schedule *(all times are EST)*

<table>
<thead>
<tr>
<th>2018</th>
<th>Jan</th>
<th>Feb</th>
<th>March</th>
<th>April</th>
<th>May</th>
<th>June</th>
<th>July</th>
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<th>Sept</th>
<th>Oct</th>
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<td></td>
<td>Full Collaborative</td>
<td>28</td>
<td>1:00 - 2:30</td>
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<td>21 - 22 Summit</td>
<td>29</td>
<td>1:00 - 2:30</td>
<td>29</td>
<td>2:00 - 3:30</td>
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<tr>
<td></td>
<td>Clinical &amp; Public Health Practice</td>
<td>20</td>
<td>3:00 - 4:30</td>
<td>17</td>
<td>2:00 - 3:30</td>
<td>21</td>
<td>1:00 - 2:30</td>
<td>22</td>
<td>1:00 - 2:30</td>
<td>18</td>
<td>1:00 - 2:30</td>
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If you are interested in attending Workgroup meetings please email us at [collaborative@marchofdimes.org](mailto:collaborative@marchofdimes.org) to receive specific meeting information.