

SUMMARY STATEMENT

Prematurity is the second leading cause of infant deaths in the District, accounting for 12.5% of infant deaths in 2015-2016. In DC, during 2015-2016, the percentage of preterm live births among Black women (12.8%) was significantly higher than white women (7.8%). The rates of preterm birth is also significantly higher (26.9%) for births to mothers who did not initiate prenatal care compared to mothers who initiated prenatal care during their first trimester (10.2%). For mothers with a previous preterm, nearly one-third (31.5%) experienced a subsequent preterm birth in 2015-2016. Medicaid data for Fiscal Years 2015-2016 shows that only about 16% of District pregnant women with a previous preterm birth received 17 alpha-hydroxyprogesterone caproate (17P), a medication that can prevent the recurrence of preterm births by 33%. Through collaboration with local hospitals and federally qualified health centers, DC Department of Health (DC Health) has identified and begun implementing strategies to ensure women who are at risk for preterm birth are offered evidence-based, high quality care. Two hospitals and two federally qualified health centers, serving large portions of publically insured Black women, are creating sustainable systems approaches to preterm birth reduction through clinical quality improvement initiatives. The initial phase of this project focuses on improving the identification of eligible women and streamlining the administration of 17P. Subsequent phases of the project plan to increase the use of aspirin when indicated to prevent preeclampsia and early engagement in prenatal care.

ACTIVITIES AND RESULTS

During the initial phase DC Health, the healthcare organizations and the Department of Healthcare Finance (DHCF) reviewed existing processes for screening for and administering 17P within their respective institutions. This exercise allowed the team to identify and resolve barriers to use of 17P. For example, the team identified varying prior authorization requirements among managed care organizations (MCO) that contributed to inefficiencies for providers and patients. With the state Medicaid agency at the table (DHCF), the groups' efforts led to removal of prior authorization requirement for all MCOs, a practice consistent with the District's Fee-For-Service Medicaid program. This has facilitated more timely and streamlined ordering processes among clinical providers. One health center lacked capacity to monitor and coordinate referrals, and track outcomes for women eligible for 17P. Borrowing a best practice from another health center on the team, the center added a Perinatal Care Coordination Specialist to their team. This has led to improvements in their clinic workflow, including routine patient screening and 17P administration.

As a clinical quality improvement project, each facility is tracking their progress and implementing both standard routine practices and unique innovative approaches to achieve a number of measureable outcomes related to reducing preterm birth. For example, one provider organization is exploring ways to leverage data from their existing electronic medical record to better identify and track women by using a mobile app. Another is exploring the use of social marketing campaigns to target the lack of perceived risk of preterm birth among District women.

This two-year pilot project seeks to demonstrate that collaboration between public health, public insurance, and clinical medicine (birthing hospitals and community obstetric providers), and implementation of scalable clinical quality improvement strategies can reduce occurrence of preterm deliveries among District women at greatest risk.