

Office of Disease Prevention and Health Promotion
Healthy People 2020: Who's Leading the Leading Health Indicators?
Maternal, Infant, and Child Health Webinar, July 18, 2013, 12:00 p.m. ET

DON WRIGHT: Thank you for joining the July installment of our "Who's leading the leading health indicators?" webinar series. This series brings attention to important issues related to the health of our nation. Over the year we focus on critical public health issues ranging from the social determinants of health to clinical preventive services.

The series provides an overview of the monthly LHI topic, noting the most recent data entry and trends, and showcasing states, communities, or organizations that are addressing the LHIs in an innovative way. Each month we distribute an electronic bulletin focusing on one of these high-priority issues and every other month we host a webinar on one of these critical issues.

This month we're focusing on maternal, infant, and child health. During today's webinar, you'll hear from our distinguished panel. First of all, Dr. Howard Koh, HHS Assistant Secretary for Health will give an overview of this month's LHI, topic maternal, infant, and child health. We will hear from Ms. Barbara Rose, Program Director of the Ohio Perinatal Quality. She will discuss the strategies behind a statewide collaborative to reduce the occurrence of preterm birth and improved infant health. During our roundtable discussion will be joined by Dr. Henderson, Medical Officer at the Center for Disease Control and Prevention Division of Reproductive Health. Dr. Henderson will help address questions related to our two maternal, infant and child health leading health indicators: pre-term births and infant death.

I'd like to remind you that during the course of the webinar you may submit questions for our speakers and panelists using the chat feature to the right of your screen. We will address these questions during our roundtable discussion. At this time I'd like to turn invite Dr. Howard Koh to give an overview of our featured LHI topic.

HOWARD KOH: Thank you very much, Don. Thank you for your leadership, and many thanks for everyone who's joining us on this webinar. And let me stop and thank our Office of Disease Prevention and Health Promotion. These webinars are very important for national conversation about health goals, and I'm very appreciative to everybody that's made these monthly meetings such a vibrant and productive form of conversation throughout the country.

So next slide, please. So today we're very pleased to be talking about maternal, infant, and child health. And this slide summarizes the two leading health indicators that we'll be reviewing: first, infant deaths or infant mortality, and secondly pre-term births, otherwise referred to as premature births. We're very pleased that we have some colleagues from Ohio who are gonna be talking about how they have taken a systems approach, a statewide approach to making a difference in this critical area of public health. Next slide, please.

The next slide summarizes the impact and context of our topic of discussion today, preterm births and infant deaths. First, though, we should note that preterm births are defined as birth before 37 weeks of gestation, and more infants die from pre-term related problems than from any other cause. We know that nearly half a million babies in the United States are born premature each year, and that's one out of nine births that are premature births each year. So that's a big burden on our public health system, and the health and financial consequences are very important. First of all, pre-term infants are less likely to survive to their first birthday than other infants, so it's an important contributor to infant mortality, and then long-

term disability is also a major issue. It's been estimated that the costs to the US health care system are approaching twenty six billion dollars a year so this is a critical public health issue for multiple reasons.

Next slide. This slide shows the impact and context, and describes briefly some other factors associated with preterm births. There's a wide array of factors that impact the outcome, whether they're behavioral, social, personal, or economic. Some examples include low maternal income status, a high blood pressure during pregnancy, tobacco and alcohol use, and late prenatal care. So medical and pregnancy conditions – there are many that can impact on this outcome. On the other hand, there are action steps for prevention and public health that relate to pregnant women in terms of making sure that they stay tobacco-free, to quit smoking if they are smokers, to avoid alcohol or illicit drugs, make sure that pregnant women are getting regular high quality prenatal care throughout their pregnancy, and also are seeking medical attention for any warning signs or symptoms of preterm labor. Next slide.

The slide summarizes infant deaths over a 10-year period, 1999 to 2009. So the good news is that from 1999 when the infant death rate was seven per 1000 live births, it has dropped by almost nine percent to 6.4 per thousand in 2009. We hope we are on our way to our Healthy People 2020 target of six deaths per 1,000 live births in the upcoming decade. Having said that, we do not rank well internationally. In fact, we are the fourth worst among the developed countries according to the Organization for Economic Cooperation and Development, after Mexico, Turkey and the Czech Republic. So these are very important measures to track and monitor over the upcoming years.

The next slide shows the very important impact of pre-term birth on low birth-weight and then subsequently death. They are all interrelated as you can see, so powerfully on this graph. Pre-term birth is the primary cause of low birth weight so if an infant was born with low birth weight, defined as less than 2500 grams, or very low birth weight, defined as less than 1500 grams, the risk of dying increases. You can see here on the slide that for premature kids under 1500 grams the rate of and risk of death is much greater than if a child is born between 1500 and 2500 grams or is not a low birth-weight baby. So this triad of low birth weight infant death, and preterm birth are something that we gotta keep in mind as this discussion moves forward. Next slide.

We're always very grateful to our colleagues from Healthy People to track disparities, and so we see these trends over and over again. Here we're showing preterm births on the left and infant deaths on the right by race and ethnicity, and then also a total that's seen in green. If you look at the overall outcome they are somewhat close to the Healthy People 2020 target, but of course there are wide disparities. The Asian and Pacific Islander subpopulation have the lowest percentage of preterm births and infant deaths. That's noted in grey. But all the way on the other hand we see that black non-hispanic mothers have the highest rates of preterm births and infant deaths, and so we obviously have to keep addressing these key disparities as a major overarching goal of Healthy People. And next slide, please. And my last slide.

This shows total preterm births over a decade from 2000 to 2010. From 2000-2007 that rate of total preterm births went up somewhat, but has since declined. And so we are hoping that we can get closer to our Healthy People 2020 target are of 11.4 percent total preterm births. That's why we need systems that work more closely in terms of improving quality, and that's why organizations like the Ohio Perinatal Collaborative is so important. So at this point like to turn the program over to Ms. Rose who's gonna discuss Ohio's very important work in this area. Thank you.

BARBARA ROSE: Thanks for joining today's webinar featuring the work of the Ohio Perinatal Collaborative. Thank you, Drs. Wright and Koh, for introducing the Healthy People 2020 leading health indicators related to maternal and child health. I'm Barbara Rose, the program director for OPQC and have been since its inception in 2007. I have no financial disclosure to make. The only disclosure I have

is that the picture on the screen is of my former 27 and a half week week premie triplets born in 1990 who have inspired my passion in this work. Next slide, please.

Dr. Bill Callaghan from the CDC published this article a few years ago and the graph is a good reminder to us that the most common cause of infant mortality is from preterm birth. And as Dr. Koh said today, we'll talk a little bit about the work of how OPQC is addressing these two leading health indicators to reduce the rate of all infant deaths and to reduce total pre-term. And just for reference, in Ohio we have approximately 137,000 to 140,000 births per year. Next slide please. So what is OPQC? Briefly, it's a statewide network with private and public partners, and clinical teams from hospitals across the state, engaged in rapid cycle improvement, reviewing their psych data regularly, and communicating with each other and the central team on a regular basis. OPQC is also known for OB and pediatric working together to improve perinatal outcomes, and also for using birth registry data to measure improvement in those perinatal outcomes. Next slide, please.

So some of quality improvement processes that have contributed to our success include working together on a shared aim, the importance of rapid data feedback at the site level, as well as the collaborative aggregate, a very high level of communication and monthly webinars site-specific coaching calls and in in-person learning sessions usually held in the Columbus, Ohio area which is about a two to three hour drive from anywhere in the state. Next slide, please.

So this diagram shows the extent of our current improvement projects in OB and Neo. We are developing the foundation for future projects that may include progesterone administration for women at risk of preterm delivery, and best care practices for neonatal abstinence syndrome.

Next slide, please. So today I'm just going to touch briefly on our clinical improvement projects. The first is reducing late onset infection in 22 to 29 weeks gestation infants. Next slide. This is a graph using Vermont Oxford network data from all 24 level 3 NICUs in Ohio, showing a decrease in late onset infection in 22 to 29 weekers, from 18 percent to 14.3 percent in the first phase of our project. Our goal is to get below 10 percent, so we've added a human milk and medicine component to the infection intervention bundle. Next slide, please.

So the current Neo late onset infection project is focused on increasing human milk, preferably mothers' milk, for all premature infants in the NICU. This is the patient education piece that we developed with the help of our partners at the CDC and Burnett communications. Next slide, please.

OPQC is a leader in the country in an effort to reduce scheduled deliveries without a medical indication. Next slide. This graph uses Ohio birth registry data to illustrate that since September 2008 31,600 births have been shifted from 36 to 38 eight-week gestation to 39 and greater weeks gestation. Next slide. So Ohio is often referred to as swing state, but with 31,000 fewer births between 36 and 38 weeks gestation since OPQC's inception, we conservatively estimate that 948 fewer NICU admissions have occurred for a savings of at least 19 million dollars. Next slide.

So a few details for you today about some of the practice changes that have occurred in our at maternity hospital across the state. In the late onset infection project in the neonatology unit, we have developed two evidence-based catheter-care bundles for insertion and for maintenance. The human milk and medicine project has worked to remove logistical barriers to obtaining mother's milk, such as making sure that breast pumps are immediately available after delivery, training moms early to hand express milk, and working with transport teams to ensure that colostrum or milk is transported along

with the baby to the higher level of care. Educating moms of premature infants regarding the importance of human milk in preventing infection is also a strategy that has been working well. Also, working with labor and delivery nurses, transport teams, and physicians around the important of human milk in premature infants to reduce infections. In our special delivery without medical indication project we've helped develop new forms for patient consent and for scheduling deliveries. We've documented and standardized early pregnancy dating, and the gold standard being an ultrasound before 20 weeks, and we've worked to improve communication between institutions, data clerks, and clinicians. Next slide.

So you've heard about many of the components that are factored in to the success of OPQC over the last five years. This slide summarizes some of those key elements. I'd like to emphasize the rapid data turnaround and feedback, clinical leadership in pediatrics, obstetrics, and body improvement science, our partnership with state and many other organizations, our strong administrative infrastructure, and the really important improvement Science Foundation impact. Next slide.

So great partnerships have been essential in the collective success of improving birth outcomes in the state of Ohio. Early in the project we took road trips across the state for face to face meetings and engagement with our potential partners and clinicians to build a community of participation and working together. The Ohio Department of Health has been a partner in improving birth outcomes since the late 1970s when the state worked together to regionalize maternity care.

Our partners at Ohio Department of Health Vital Statistics were eager to work with us to improve the birth registry data. Ohio Medicaid was interested in better outcomes and cost savings for their patient population, and we have a shared mission in common with our colleagues at ACOG, the March of Dimes, and the American Academy of Pediatrics. Next slide, please.

And lastly I'd like to say that we've demonstrated tremendous value in bringing together public and private entities. This quote from Karen Hughes whose the Ohio Department of Health Division Chief in maternal and child health also noted that our founder, the founder of OPQC, Dr. Edward Donovan, ignited interest in clinicians and spoke eloquently of population health improvement. The Ohio Perinatal Quality Collaborative was created and six years ago and remains a national model for statewide birth outcome improvements. Some of my team on the call today who will be addressing questions that come up during the roundtable include Dr. Carol Lannon, who is our Quality Improvement faculty lead at the University of Cincinnati and Cincinnati Children's Medical Center; Dr. Jay Iams, who is our OB statewide lead, and faculty at the Ohio State University; and Kelly Friar, who is the director of the Vital Statistics division at the Ohio Department of Health. Thank you.

DON WRIGHT: We already have a number of questions queued up, the first one is for you, Dr. Koh. Dr. Koh, one of your slides displayed infant death by birth weight. Can you give us the information on the risk factors of low birth weight?

HOWARD KOH: Sure, so just to address again, low birth weight is defined as less than 2,500 grams, or five and a half pounds. And so a low birth weight infant can be born too small, too early or both. And there are a whole host of conditions and factors that can result in low birth-weight infants.

Just to review again in terms of very practical terms, a woman can decrease her risk by staying tobacco-free or quitting smoking, making sure she is connected with a regular provider before pregnancy even and then of course during pregnancy, controlling comorbid diseases such as diabetes and making sure blood

pressure's under control, taking multivitamins to make sure that they're getting enough folic acid intake, and just having a system that's gonna work well for the mom and the baby to come. So that's why a systems approach is what we're trying to stress through our public health efforts, and that's why we're also very pleased that we're hearing from our colleagues at Ohio who have made the whole state work together on this important initiative.

DON WRIGHT: Thank you, Dr. Koh. The next question is for you, Ms. Rose. Can you talk about the different areas and locations across Ohio where the thirty-nine week project has been implemented?

BARBARA ROSE: Sure, I'd be happy to. Can I have a slide of the map of the great state of Ohio, please? So this is a great way that we demonstrate to our partners within the state, as well as visits that we go on, how we got started, and we have about 120 maternity hospitals in the state. And the red stars show the initial 20 maternity charter sites that were in the initial project of the thirty-nine week without medical indication. And they represent the six largest metropolitan areas in the state: Cincinnati, Dayton, Columbus, Toledo, Cleveland, and Akron Canton.

These also fall in to the six perinatal regions in the state. The yellow stars represent the 15 pilot sites that came on after the initial phase, and they were chosen based on geographic location, patient demographics, a percent of medicaid births. We're now in three waves of further dissemination. The blue and the green stars are in waves one and two from earlier this year, and we have a third wave that is under recruitment. So by the beginning of 2014 we will have reached out and worked specifically with each of the maternity hospitals across the state of Ohio around the thirty-nine week scheduled delivery project.

DON WRIGHT: Thank you, Ms. Rose. Dr. Henderson, I think we have a couple of questions queued up for you. First of all, can you comment on reasons behind the rise of preterm births during the last decade? Would you attribute these increases to elective caesarian sections and an induction of labor? Or are there other things to consider when describing this trend?

ZSAKEBA HENDERSON: Thank you for your question. This is actually a very important question, and highlights some of the successes that have been seen with the Collaborative. Most of the increases in preterm birth since the 90s were seen with late preterm birth, and that is a gestational age of up to 34-36 completed weeks gestation. And part of the increase can be attributed to an increase in multiple births, which includes twin births and higher-order births, and those births are more commonly preterm, although preterm births increase during this period among singleton births, as well. Virtually all the increases in singleton preterm births during this time was among late preterm birth. And part of what was discussed earlier, the main source of the information that we use regarding indications for delivery in a birth certificate isn't perfect.

However, birth certificate data has shown us that most of the increases in singleton preterm births are due to increases in non-spontaneous births, or births that were indicated. Although we don't know for sure, this suggests that either the indications for delivery before term, which has primarily been hypertensive disorder evident of fetal compromise, these indications either become more common or more commonly recognized or that the threshold for intervening has lowered over time. We've even conducted a survey here at CDC of subject providers that also suggest that nonclinical factors may have contributed to the rise in preterm births due to concerns regarding malpractice and litigation.

Although it's not really possible to know whether an infant is born late preterm - umm... it's not really possible to know whether an infant is born late preterm... will be born pre-term if it was not induced or delivered by c-section. However, recent studies do suggest that the rate increase of late preterm births also coincided with an increase in inductions of labor and c-sections at that time. And it's important to just point

out that these are really two different issue - the issue of deciding whether or not a baby needs to be born and how that baby is born. And so it's thought that an increase seen over the past decade was due to increase of indicated delivery and not necessarily due to an elective c-section or induction of labor.

DON WRIGHT: Thank you Dr. Henderson. One other question for you. It looks like the increase in preterm births has leveled off and the preterm birth rates are now decreasing. What do you think the reasons are for this change?

ZSAKEBA HENDERSON: Yes, you are correct. The pre-term birth rate has fallen, actually for the fifth straight year in 2011. The most recent rate is 11.72 and it's 2 percent lower than the previous year, and actually 8 percent lower than the peak that was seen in 2006. And the preterm birth rate rose by more than a third from the eighties, from around 1981 to 2006.

And also, the most recent rate recorded in 2011 is the lowest seen in more than a decade. The rate of preterm births is still higher now than rates reported during the eighties and most of the nineties. However, the declining rate in preterm births seems to coincide with many of the efforts being made to draw attention to the reasons for why babies are being born, and ensuring that infants, especially during the late preterm period, are being formed for indications, for solid medical indication. And a lot of the efforts that have drawn attention to reducing non-indicated births have resulted in shifting the gestational ages of babies being born from before 39 weeks to greater than 39 weeks.

DON WRIGHT: Thank you Dr. Henderson. Dr. Koh, we have a question here about the federal Response to this issue. What is HHS doing to address elective deliveries across the nation, in turn addressing preterm births?

HOWARD KOH: Well thank you for the question. There are two important initiatives I'd like to highlight. The first called Partnership for Patients which is getting a lot of national attention, a really high priority for the Department and the country, and this is an effort to decrease hospital readmissions and also to decrease preventable harm. Some 3,700 hospitals have signed up to achieve these two overarching goals and when we talk about the nine core areas of harm that we want to prevent one key area is the area of obstetrics and early elective deliveries. So we are working with these several thousand hospitals and groups like the American College of Obstetrics and Gynecology, and March of Dimes and others to again build best practices and show that prevention can work in this key area.

Another initiative that our Centers for Medicare and Medicaid Services (CMS) has put forward is something called Strong Start Initiative, and this focuses particularly on reducing early elective deliveries, stressing quality improvement in many ways just like Ohio has exemplified right now and then spreading those best practices around the country. So if you want to hear more about both the CMS Website is www.cms.gov. And this is really an overall effort through the Affordable Care Act, actually to improve quality and improve outcomes in some very substantial ways.

DR. WRIGHT: Ms. Rose we have another question for you from one of our listeners. What are barriers to human milk feeds for the premature infants? How many babies get their feeds at the breast, and how is milk fed when not from the breast?

BARBARA ROSE: I'm gonna ask Dr. Lannon to take the first crack at that question.

CAROL LANNON: Sure, hi. This is a Dr. Carol Lannon. I'm a quality improvement person and pediatrician. Our neonatologist is out of the country right now and so let me share with you some thoughts, and we'd be glad to follow up if I don't answer all your questions. There are multiple barriers

for human milk feeding of these premature infants. I think some of it has to do with the often chaotic environment of a baby being born early and the process of focusing on the baby's health and on what's going on. There may not be attention to starting and initiating human milk, especially quickly. I think there has often been some concern about the introduction of human milk and the thought that maybe very premature babies did better if they were kept NPO or had nothing by mouth. There is much evidence now that very small amounts of human milk, even coating the baby's mouth, and beginning tiny feeds are quite helpful in priming the gastrointestinal tract. So some of what I think that would say is there needs to be some attention to how this is presented to families early when they come in. Some of this is what happens in the hand-off from the delivery room of a really premature infant to the nursery and then there are some other logistical factors that I think Ms. Rose mentioned about the cost of human milk. If the mother chooses not to breastfeed, we would suggest that one use a milk bank but sometimes there's logistical challenges with that - and then just the process of making sure there's a lot of support for the mom to do this. So we actually have developed some things to work at those different levels and some of those are available on our Website which is www.opqc.net. I'm going to ask Dr. Iams if that there's anything that he would add to that.

JAY IAMS: Just, Carol, that we intended to track and promote breast feeding on the anti-natal side not only throughout pregnancy but even in labor and a part of admissions and a part of service before premature delivery are all opportunities to remind pregnant women who are about to deliver that providing human milk to their baby is a really key step and it can make them contribute significantly to the health of their baby, their preterm baby.

BARBARA ROSE: Thanks, Jay.

DON WRIGHT: Thank you Dr. Lannon, Dr. Iams.

We have a number of questions from our participants today for Ms. Rose and her colleagues there in Ohio. The next question: what is OPQC doing to address the racial disparities in healthy birth outcomes?

BARBARA ROSE: I'm going to let Dr. Iams start with that question.

DR. IMES: I think the unfortunate answer is not enough and not as much as we like. The data we have around the thirty-nine week project is gathered largely so far from the largest 20 hospitals, as you heard, accounting for about half the births in the state. And a disproportionate number of those births that we have moved I would say disproportion, but a large number of births we have moved from less than thirty-nine to greater than thirty-nine weeks have occurred in women who were not African-American. So we probably had a greater effect to some degree in that population, although it's been seen in both. Probably the best we can say about our work towards that end is that we've created a culture where people are worried about, thinking about, and talking about indications for when it is and is not okay. And of course African American women frequently have more indications, more possible reasons for early delivery, so any effort we have applied toward making that a more thoughtful decision is probably going to benefit African Americans perhaps more than others but I can't unfortunately at this point say that we have directed anything specifically at closing the gap. That's not to say we're not interested in that. We have collaborated, are working with other entities within Ohio, specifically the Ohio Collaborative to prevent infant mortality; the major focus in that effort is the issue of disparity. Our progesterone project that will, we hope, about to start up soon will, because the rate of premature birth is higher in African American women, that project would be

expected to help narrow that gap. But that's a gap that's narrowed really because of the higher rate in African Americans, and we hope we can fix that, so it's a work in progress.

DON WRIGHT: thank you Dr. Iams

Dr. Henderson a good question for you from one of our listeners. Is there an increase in low birth weight associated with in vitro fertilization procedures?

ZSAKEBA HENDERSON: Thank you for your question. I'm actually not sure if the question is about individual increase with or they're referring to increases in national rate of low birth weight due to IVF procedures. However, regarding the former, there is an increased risk of multiple births with in vitro fertilization procedures. As a matter of fact, as IVF has become more common there has been a higher prevalence of multiple births, and along with increases in multiple births there is an increased risk of preterm delivery and low birth weight. So if you look at increases in IVF and multiple births, there is an association with increases in low birth weight for infants.

DR. WRIGHT: thank you Dr. Henderson. Ms. Rose. An execution question here: Can you give details on educational materials you found useful for your project and are you willing to share those with others?

BARBARA ROSE: Sure, absolutely. We have designed and published a number of pieces. The very first one was just a one-page patient education piece describing the issue of scheduled delivery without medical indication that we adapted from a couple other sources, and that is available on our Website. We piloted the March of Dimes brain card in a number of our practice sites to determine how best to use that brain card in the discussion of a scheduled delivery. We've had a great working relationship with Burnett Communication which is a group outside of Washington DC that works with a lot of federal and nonprofit agencies, and have three really great pieces that were briefly featured in my slide set. We have a thirty-nine week project document.

We have the "Human Milk is Medicine for Premature Infants." And then we've also got a relatively new and thirteen key variables in improving birth registry data. And then of course, our public Website which keep up-to-date and have many many many of our materials available. So I invite people to check that out and if there is something that they can't find to let one of us know. We do make all of our materials widely available.

DON WRIGHT: Dr. Henderson, another question for you. What factors contribute to African American babies being born preterm? Is the age of the mother a factor?

ZSAKEBA HENDERSON: That's actually a great question which addresses two issues:

One, risk factors for preterm birth and also racial and ethnic disparities in preterm birth and infant mortality. I'll address the risk factor issue first. And there are many risk factors for preterm birth, things that may be or may not be altered that can increase your chances of having a preterm births.

And of those that you can't really alter include race or age. African American women are at higher risk for having a preterm birth and also at the extremes of age, very young women and older mothers are also at increased risk. In addition to those risks that you can't change -the actual number one risk for having a preterm birth is having had a prior preterm birth, or other health issues that can contribute to increased risk including having a urinary tract infection, sexually transmitted infection, certain other

vaginal infections, diabetes, high blood pressure, blood count problems, the list goes on. And at times black women tend to have yet higher risk for some of these other risk factors.

And I also want to point out that pre-term birth rate is much higher among black women. Nearly one in five infants of non-hispanic black women are born preterm in 2007, which was 50 percent higher than non-hispanic white women. And coinciding with that increased risk, there's an increased risk for infant mortality among black women. And it's about 2.4 times higher the rate than for white women. And along with a lot of the work that's being done with the collaborative in addressing some of the issues with babies being born early are addressing some of these populations that are at higher risk. We don't have all of the answers of why black women are at higher risk. It's not just a socio-economic issue, because black women across various socioeconomic strata may have increased risk over non-hispanic white women. So I haven't completely answered your question but black women indeed are at higher risk of having preterm birth and are indeed at higher risk for having an infant mortality. And we are trying to find the answer to why, and whether it's something that's biological, whether it's something that a policy or social determinate, but it's probably a mix of all of the above.

DON WRIGHT: Thank you Dr. Henderson. We're coming to the end of our time, but I have time for just a couple more questions. I'm not sure whether to direct this to Dr. Iams, Dr. Lannon or Barbara, but can one of you discuss the collaboration between the obstetrician and the pediatrician that's been so crucial to your work?

BARBARA ROSE: Jay, how about if you take that?

JAY IAMS: I'm an obstetrician who is looking out for a pediatrician so I guess I can answer that. I think we influenced each other largely so far in the design of our projects that occurs in an environment where we get to comment on each other's work and design. We come together in these collaborative meetings repeatedly, and we do talk to each other about what we're doing.

We recognize what the outcomes are on the OB side and what the pediatric outcomes. I think our pediatric colleagues are recognizing some the barriers and obstacles that we face in OB. We haven't yet created an obstetrical perinatal intervention that is a complete OB intervention where the measure is entirely pediatric. That's all ultimately our goal; we talk about that. But the fact that we're working together, talking about, "What are you doing? Why are you doing it? And why aren't you doing this?" has steadily improved that conversation. We really do feel like partners in OPQC. I would say we always feel that way in our hospitals, but in OPQC it feels a little more like a team than it does in hospitals.

DON WRIGHT: Thank you Dr. Iams. One more question for you, Barbara.

How have consumers been involved in the development of your materials?

BARBARA ROSE: So that's a great question. We have just, say within the last six to nine months, really upped our approach to getting parents involved, not just at the site-specific level, because many of our NICUs have parent representatives at the table. We do use that partnership with the Ohio Department of Health and some of their outlets due to that content and the reading level of the pieces, and as we add parent representatives to really be in some of the planning and feedback stages of that project, we'll continue to use those parents who sit around the table to give us that input. But I think in the meantime really having a partnership with the maternal and child health folks at the Ohio Department of Health has been very instrumental in giving us that good feedback.

DON WRIGHT: Thank you Ms. Rose.

Dr. Koh, one question for you that relates to the Affordable Care Act. What is the Affordable Care Act doing to help pregnant mothers and improve the health of newborns?

HOWARD KOH: Well, thank you. That is such a timely question, because October 1st is coming up. That's when open enrollment in the marketplaces begins, and then January 1st, as you know, starts new coverage. So this is a very exciting, actually historic time. So of course pregnant moms need good insurance coverage so they can have the best outcomes possible for themselves and their newborn babies. We want to make sure that every pregnant mom has good care throughout their pregnancy. While they're getting their care, the Affordable Care Act gives them access to preventive health services like gestational diabetes screening, hepatitis C screening, obviously counseling for tobacco and being tobacco-free, counseling and advice about upcoming breastfeeding support.

And then we should stress that the plan, as part of essential health benefits has to provide some level of maternity care, and of course newborn care in order to be offered in these new marketplaces. So this is a good opportunity for following all these trends in the next number of months. And we also stress that our Website healthcare.gov has just been redesigned, and there's also a call center - 1-800 number call center - that's been opened up in June for people who want to get more information.

DON WRIGHT: Thank you, Dr. Koh.

I want to field just one last question that we've had from a number of the registrants for today's webinar. The question is will the PowerPoint be available after the presentation? Let me say we work to archive all of our Healthy People webinars, including those on the leading health indicators.

They will be located on the healthypeople.gov Website. And I encourage you to visit our Website and to learn about the leading health indicators, and in the coming weeks the archive of this webinar should be on healthypeople.gov. Unfortunately, we have a large number question that we're going to be unable to answer on today's webinar, but I want to take just a minute in closing to thank you for joining today's webinar.

We hope that you will continue to join us for the Healthy People 2020 activities throughout 2013.