NICHQ National Institute for Children's Health Quality

**Insights**

# Alaska Shows Perinatal Regionalization Works to Reduce Infant Deaths

When Stephanie Birch, RNC, MPH, MS, was a new nurse in 1982, Alaska's infant mortality rate was the highest in the nation. More than 30 years later, Alaska sits at the opposite end of the spectrum, with the lowest rate of infant deaths. While it wasn't a quick fix, Birch says Alaska shows significant improvement is possible. "You have to be willing to be open to the possibilities for improvement," she says. "And, don't give up."

The NICHQ-led Collaborative Improvement and Innovation Network to Reduce Infant Mortality ( Infant Mortality CoIIN) seeks to increase the number of deliveries of higher risk infants (defined as weighing less than 1,500 grams or less than 32 weeks gestation) at appropriate level facilities. The approach, known as perinatal regionalization, ensures the transfer of patients to hospitals where they can receive appropriate care. However, it comes with many challenges.

"Regionalization is the way that care should be delivered, particularly when you are working with a very rural environment where women and babies do not have access to a neo-natal intensive care unit or trained perinatologists," says Kate Mohr, NR, NEA-BC, MSN, executive director of Children's Hospital Providence in Anchorage, Ala. "The vision requires a commitment from all the hospitals to come together, without a competitive approach."

That can be challenging in the current healthcare environment, particularly when institutions see themselves as the best place for care, according to Birch, the Title V Maternal Child Health director and section chief of Women's, Children's and Family Health for the Alaska Department of Health and Social Services. "The components that have led to our success are a direct result of institutions putting aside their competition and recognizing what's in the best interest of the population and working together to solve the underlying problems."

Alaska's efforts toward risk-appropriate perinatal care began in the 1980s. In recent years, Birch and Mohr credit a collaborative, statewide approach to continued success. For example, the Alaska Pediatric Partnership, a group of public health leaders, hospital administrators and nurse leaders, and community clinicians meets once a month. In addition to reporting on what's happening at individual hospitals and clinics, the team reviews state data on infant morbidity and mortality and establishes priorities.

“First, the fact that we share data is really important,” Mohr says. “Second, when you focus on what’s happening in the state overall, that really changes the conversation, and it is what has made us really successful.”

When the group identifies a particular community or region that needs attention, a team of providers and specialists are tasked to outreach to the community clinicians. Perinatologists, pediatricians, and other clinicians are available to be dispatched to provide onsite training, support and best practices. The annual statewide Pediatric conference also addresses topics relevant to areas of concern each year as a strategy to engage the community of providers to improver practices or look at ways of improving outcomes in their community.

“This training is essential so that staff can stabilize patients for transport to a higher level facility. For people in rural communities, where it’s hard to get advanced training, it’s made a difference,” Birch says.

But there is one aspect training and education may not always address—trust. Some smaller facilities may not want to transfer a patient because they don’t want to lose a patient, or because they do not feel fully informed about a patient’s care after they leave the community.

Since Children’s Hospital Providence has the only Level 3 NICU in the state, Birch says it’s made it even more important for the hospital to develop relationships with other clinics and to ensure that high-risk mothers and babies who may need this high level of care are transferred. However, the extensive work done in rural communities to identify early high risk pregnancies has also meant that more patients than ever before can stay close to home.

“It’s important that rural clinicians don’t look at it as a failure if they can’t care for patients,” Birch says. “The Children’s Hospital at Providence as well as the Alaska Native Medical Center have improved their communicating back about a patient’s status and letting the initial community know what a good job they did. But you also need the quality check too—what didn’t go quite as well, what should have gone better?”

Nurses also play an important role in training and maintaining relationships. Early in the development of the perinatal/neonatal regionalization system, teams of neonatal nurse practitioners traveled to hospitals and clinics in rural areas to provide hands-on support and training. As national standardized training has developed, community hospitals have adopted this training and certification as a required part of their clinical staff training. This has helped to build a community standard for care, resulting in improved outcomes. Also a perinatal nurse consortium meets regularly, providing educational competencies and simulations so that clinicians at smaller hospitals can be ready for the occasional, high-risk birth.

“These traveling nurses are key to maintaining our relationships,” Mohr says. “We are constantly building relationships with clinicians, even within the competitive landscape. We really want to have babies and moms in the best place possible and get them back to an appropriate level of care close to home. That can be challenging but it’s the right thing to do.”