Centers for Medicare & Medicaid Services
Medicaid & CHIP
Maternal & Infant Health
Quality Improvement

State Medicaid and CHIP Agencies and Obstetrical Partners

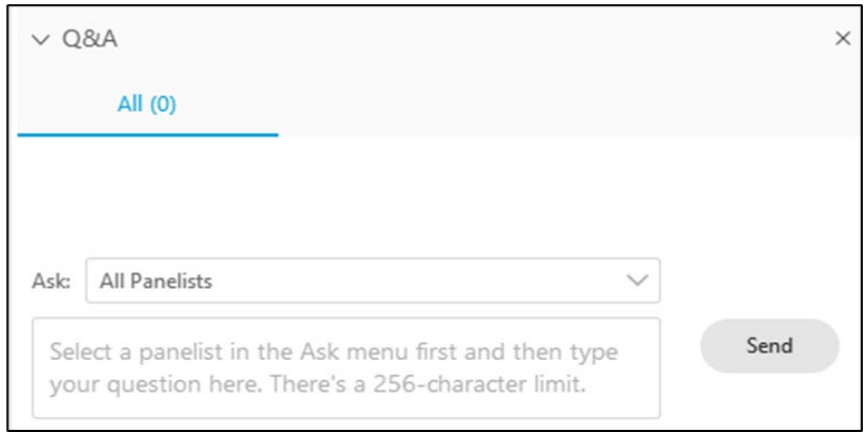
Working Together to Reduce Low-Risk Cesarean Deliveries

June 10, 2022

Lekisha Daniel-Robinson and Kate Nilles, Mathematica
Kristen Zycherman, CMS
Melissa Isavoran and Alicia Bublitz, Samaritan Health Plans
Shin-Yi Lin and Michele Samuels, New Jersey Medicaid State Agency
Ellie Suse, Illinois Perinatal Quality Collaborative
Amy Crockett, Prisma Health and Ana Lopez-DeFede, University of South Carolina

How to Submit a Question

- **Use the Q&A function to submit questions or comments.**
  - To submit a question or comment, click the Q&A window and select “All Panelists” in the “Ask” menu
  - Type your question in the text box and click “Send”
    - Note: Only the presentation team will be able to see your questions and comments
- **For technical questions, select “Host” in the “Ask” menu**



Objectives

- Provide an overview of CMS's Maternal and Infant Health Initiative
- Describe the Improving Maternal Health by Reducing Low-Risk Cesarean Delivery (LRCD) Learning Collaborative
- Understand Medicaid's role in leading, convening, and/or coaching quality improvement partnerships focused on improving maternal and infant health by reducing LRCDs
- Learn about state programs and policy initiatives to reduce LRCD

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Agenda

Topic	Speaker(s)
Welcome	Lekisha Daniel-Robinson, Mathematica
Overview of the Maternal and Infant Health Initiative and Low-Risk Cesarean Delivery (LRCD) Learning Collaborative	Kristen Zycherman, CMS
Oregon's InterCommunity Health Network Coordinated Care Organization Doula Program	Melissa Isavoran and Alicia Bublitz, Samaritan Health Plans
Illinois' Promoting Vaginal Birth Initiative	Ellie Suse, Illinois Perinatal Quality Collaborative
New Jersey's Medicaid Community Doula Program	Shin-Yi Lin and Michele Samuels, New Jersey Medicaid State Agency
South Carolina's Supporting Vaginal Birth Initiative	Amy Crockett, Prisma Health and Ana Lopez-DeFede, University of South Carolina
Questions	Lekisha Daniel-Robinson, Mathematica
Announcements and Next Steps	Kate Nilles, Mathematica

Overview
Maternal and Infant Health Initiative
and
Improving Maternal Health by Reducing Low-Risk Cesarean Delivery Learning Collaborative

Kristen Zycherman, CMS

Maternal and Infant Health Initiative

- Maternal and Infant Health Initiative (MIHI) launched to improve access to and quality of care for pregnant and postpartum persons and their infants.
- The Centers for Medicaid and Medicare (CMS) convened an MIH expert workgroup in 2019-2020 to provide updated recommendations about where Medicaid and CHIP can influence change in maternal and infant health.
- Three MIHI focus areas
  - Increase the use and quality of postpartum care visits
  - Increase the use and quality of infant well-child visits
  - Reduce the rate of low-risk cesarean delivery (LRCD)

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Improving Maternal Health by Reducing Low-Risk Cesarean Delivery Learning Collaborative Webinar Series

- **Webinar 1:** The Role of Medicaid in Reducing Low-Risk Cesarean Delivery: Improving Outcomes and Reducing Disparities

- **Webinar 2:** State Medicaid and CHIP Agencies and Obstetrical Partners: Working Together to Reduce Low-Risk Cesarean Deliveries

- **Webinar 3:** Using Data to Plan and Assess Quality Improvement Strategies to Reduce Low-Risk Cesarean Delivery in Medicaid and CHIP

- **Informational Webinar**: Improving Maternal Health by Reducing Low-Risk Cesarean Delivery Affinity Group Overview and Expression of Interest Process

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Improving Maternal Health by Reducing Low-Risk Cesarean Delivery Affinity Group

- Action-oriented affinity group that will support state Medicaid and CHIP programs and their partners in identifying, testing, and implementing evidence-based change ideas for reducing the number of LRCDs and improving maternal health care.

- Opportunity for states to expand their knowledge of policies, programs, and practices to reduce LRCD rates and advance their knowledge of and skills in quality improvement and address inequities

- Expressions of Interest are due July 15, 2022

- More information is available at https://www.medicaid.gov/medicaid/quality-of-care/improvement-initiatives/maternal-infant-health-care-quality/index.html

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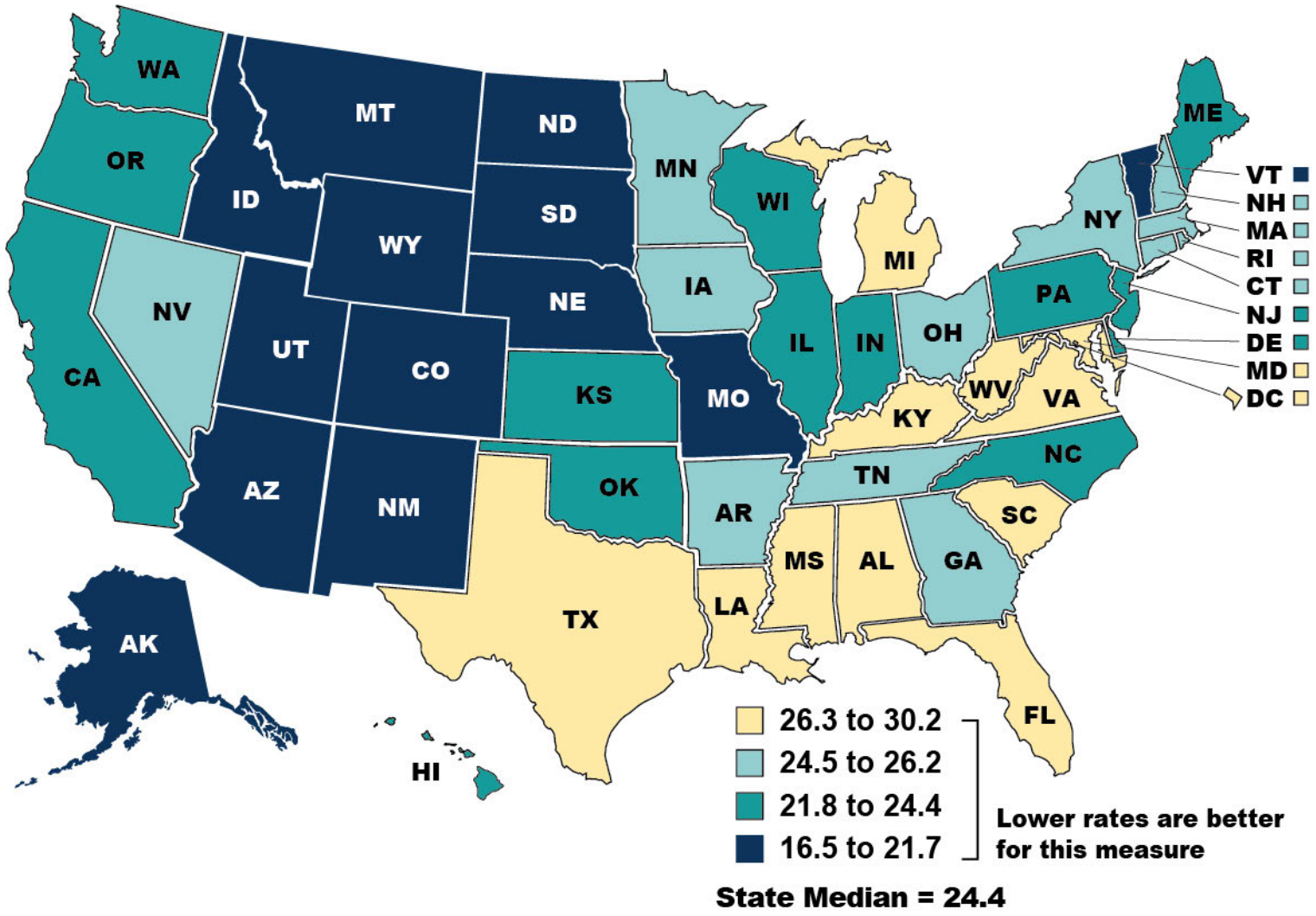
Low-Risk Cesarean Delivery Rate per 100 Deliveries, by State: Births Paid by Medicaid, 2020



Source:
National Center for Health Statistics (NCHS). 2020 Natality Public Use Data on CDC WONDER online database.

Available at:
https://wonder.cdc.gov/

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Low-Risk Cesarean Deliveries Webinar

Community Doula Program

Melissa Isavoran, MS | AVP, Medicaid Operations
Samaritan Health Plans
2300 NW Walnut Blvd | Corvallis, OR 97330
misavoran@samhealth.org

Alicia Bublitz| Traditional Health Worker Liaison
Samaritan Health Plans
2300 NW Walnut Blvd | Corvallis, OR 97330
abublitz@samhealth.org

Community Doula Program

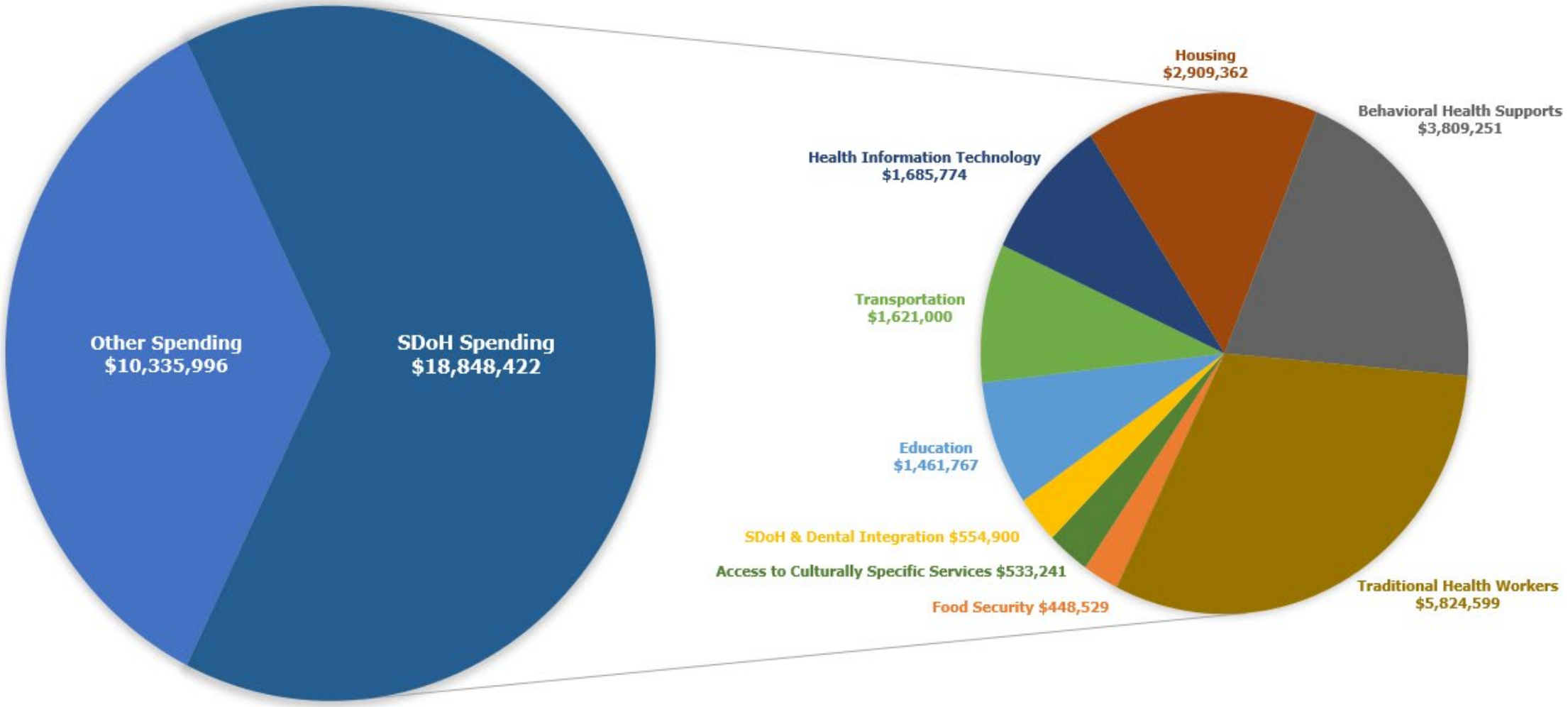
InterCommunity Health Network CCO

InterCommunity Health Network Coordinated Care Organization (IHN-CCO)

- Formed in 2012 by local public, private and non-profit partners to unify health services and systems for Oregon Health Plan (Medicaid) members in Oregon's Benton, Lincoln and Linn Counties
- Serve approximately 80,000 Medicaid members
- Deliver and coordinate physical, behavioral, and oral health
- Provide coordinated care and wrap-around services to members
- Committed to improving population health and health equity
- Invest in social determinants of health (SDoH) and transformation

InterCommunity Health Network CCO

IHN SDOH Investments in the last Ten Years



InterCommunity Health Network CCO

The Role of a Doula

A Doula is a birth companion who provides personal, nonmedical support to families throughout pregnancy, childbirth, and the post-partum experience.
Oregon Administrative Rule 410-180-0300

Traditional Health Worker (THW) Doulas:

- Understand and share parents' cultural perspectives on birth and parenting
- Provide resources, referrals, and community supports
- Facilitate communication with medical staff, family, friends, and resources
- Support parents emotionally and physically through the prenatal, birth, and post-partum period
- Provide Continuity of Care
- Calm parents with their experience and understanding of birth and medical systems
- Provide physical labor support
- Facilitate early bonding strategies
- Support breast/chest feeding
- Support ongoing reproductive health

InterCommunity Health Network CCO

Oregon's THW Model of Doula Care

Traditional Health Worker Doula Certification

- 45 hours of training including Cultural Competency, Trauma Informed Care, Interprofessional Collaboration, CPR, and Oral Health
- Attend to three clients through birth and postpartum care
- Pass a background check
- Comply with healthcare worker emergency health mandates

Doulas are independent billing providers for the Oregon Health Plan

- National Practitioner Identifier (NPI)
- Medicaid provider ID
- Coordinated Care Organization (CCO) validation

InterCommunity Health Network CCO

Benefits of Doulas on LRCD Reduction

- **Early Labor Support**
- **Can Reduce Precipitous Interventions**
- **Assists in Time Management for Labor and Delivery Staff**
- **Continuity of Care**
- **Language and Culture Matching**

Decision analysis modeling found that in a theoretical cohort of 1.6 million low-risk nulliparous, term, singleton births in the US doulas could prevent over 200,000 cesarean births and that doulas were cost effective up to **$1,360 per doula**.

Greiner, K. S., Hersh, A. R., Hersh, S. R., Remer, J. M., Gallagher, A. C., Caughey, A. B., & Tilden, E. L. (2019). The Cost-Effectiveness of Professional Doula Care for a Woman's First Two Births: A Decision Analysis Model. *Journal of Midwifery and Women's Health*, *64*(4), 410-420. https://doi.org/10.1111/jmwh.12972

InterCommunity Health Network CCO

Community Doula Program Summary

January 2018 to December 2020

Purpose:

Improve maternal and infant health outcomes for pregnant people and their families through the provision of culturally-matched community doula services

Increased quality, reliability, and availability of doula care as an evidence-based maternity care best practice to a population that has traditionally not had access to it

InterCommunity Health Network CCO

Budget and Investment

IHN-CCO Invested $264,488.54

- Direct Member Services: 38% ($91,396.84)
- Workforce Development: 42% ($103,489.84)
- Research: 8% ($19,947.63)
- Operations: 12% ($28,570.50)

InterCommunity Health Network CCO

Goals and Outcomes

Recruit, train, and reimburse culturally- and socially-diverse birth doulas to serve pregnant members of IHN-CCO in 3 counties in Oregon

- 126 doulas trained, 37 on the State of Oregon's Traditional Health Worker (THW) registry
- Doulas available in 10 languages: Spanish, Arabic, Amharic, French, English, Punjabi, Tagalog, Portuguese, Vietnamese, and Mandarin
- 28% are bilingual, 40% of doulas are Black, Indigenous or Persons of Color
- 3 multi-lingual doulas trained as State Qualified or Certified Health Care Interpreters
- 2 cross-trained as Peer Support Specialists and THW doulas, 3 cross-trained as CHWs

Improve birth outcomes and reduce health inequities through one-on-one support and advocacy offered by birth doulas

- 25% of total doulas trained are also IHN-CCO Members

Offer doula support services to all who qualify and track outcomes for the doula-supported group relative to standard care (clinical and psychosocial using mixed methods)

- >800 referrals
- >400 clients served

InterCommunity Health Network CCO

Improved Health

- Reduced cesarean rate
  - 15% vs. 23% expected
- Reduced pre-term birth overall
  - 5% vs. 9% expected
- Substantially reduced preterm birth among women of color
  - 2% vs. 11%
- Near universal initiation of breastfeeding at 98%
  - 60-70% expected
- High rates of maternal perceptions of respect and autonomy reported
- Lowered costs via decreasing the cesarean and preterm birth rates and increasing breastfeeding
- High levels of respect and autonomy reported

Community Doula Program Barriers

Reimbursement rates

- Current state rate is $350 for a complete course of care
  - Complete course of two includes two pre-partum visits, birth, and two post-partum visits
- Constitutes poverty wages given the substantial uncertainty in requirement to be “on call”
- IHN-CCO contracted rate is higher but doulas are still unable to bill private insurance

Navigating Certification and Health Care System Integration

- Administrative burden requiring extensive support by the program due to navigation challenges with the Oregon Health Authority (OHA), particularly for immigrant and multilingual doulas, credentialing, training, and billing

Lack of infrastructure support

- Not yet integrated into existing maternity care systems
- Referrals reliant on word of mouth, not part of the medical system process
- Need to develop and integrate tracking and charting options
- Inconsistent support of doula outcomes in medical community

InterCommunity Health Network CCO

The Illinois Perinatal Quality Collaborative (ILPQC) and Opportunities to Engage in Statewide Quality Improvement

Ellie Suse, MPH, MSN, RN

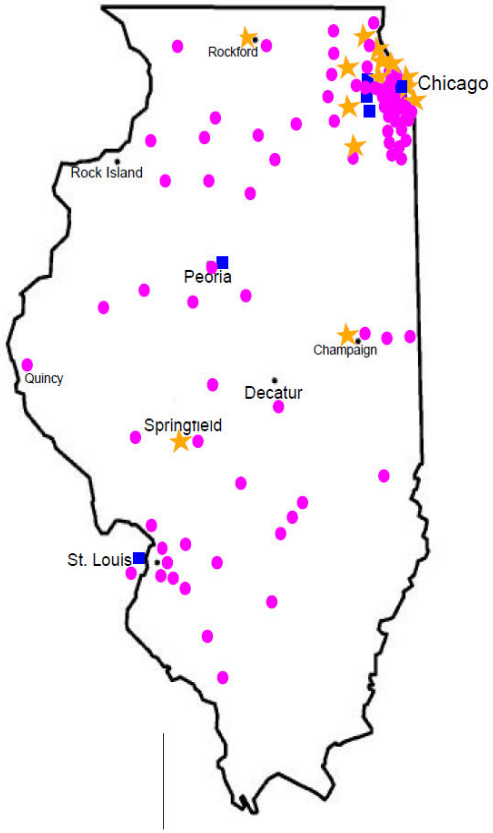
ILPQC
Illinois Perinatal Quality Collaborative

Overview

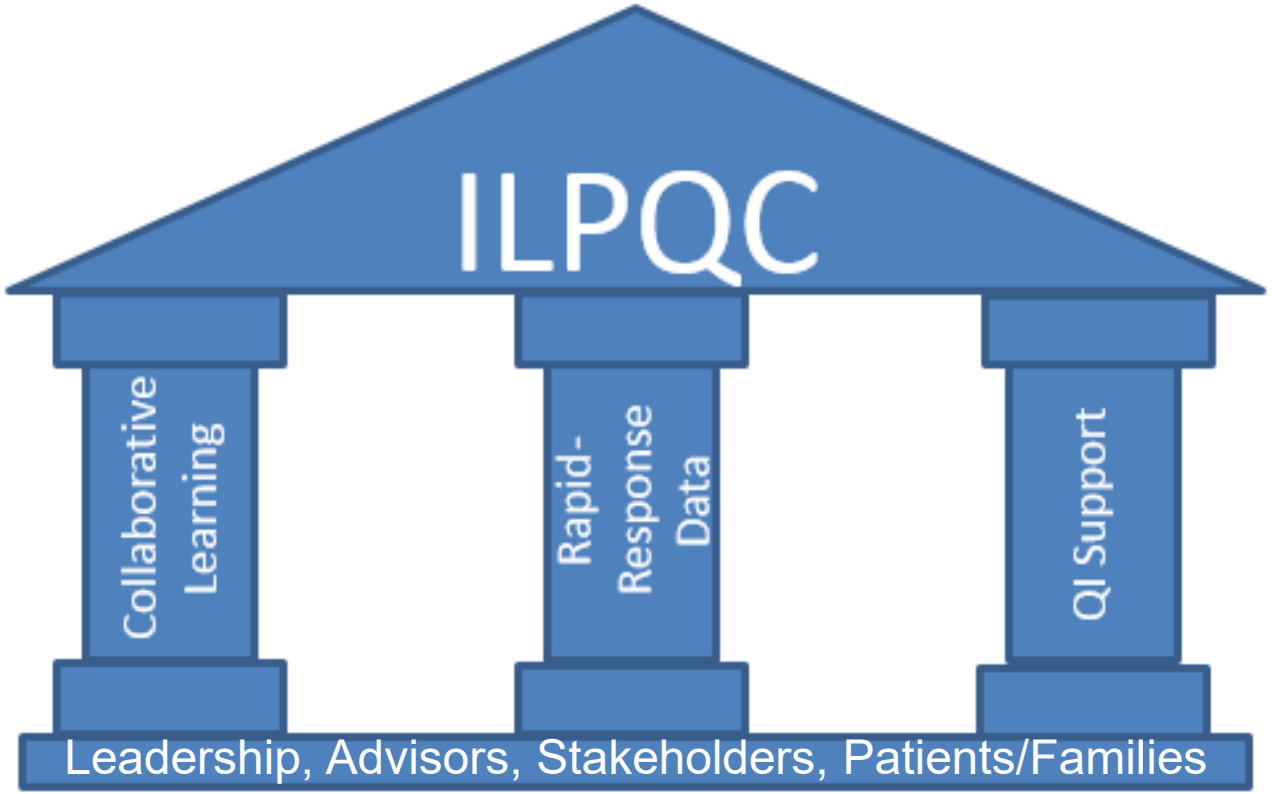
- The role of perinatal quality collaboratives and the Illinois Perinatal Quality Collaborative‘s approach
- Promoting Vaginal Birth initiative
- Collaboration with Medicaid

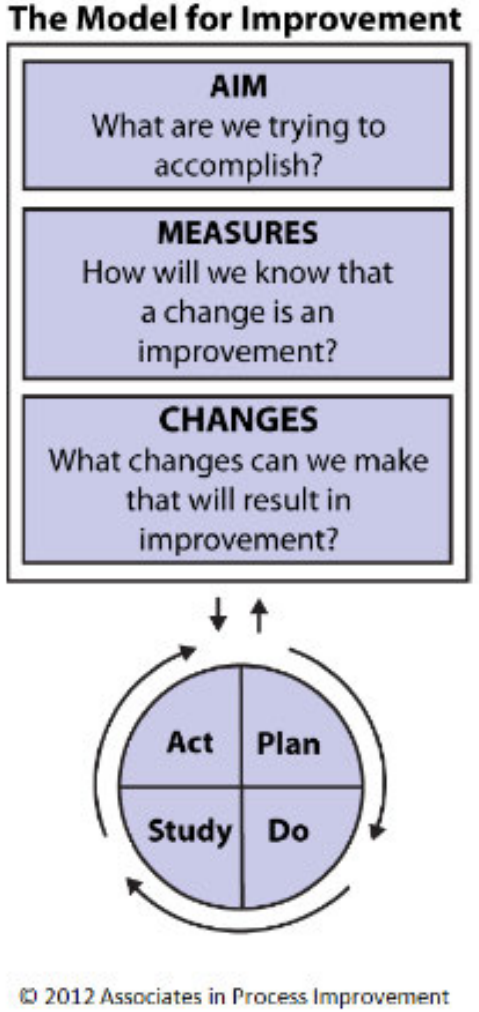
ILPQC Overview

- Collaborative of physicians, nurses, hospital teams, patients, public health and community stakeholder
- Engage delivery hospitals to implement data-driven, evidence-based practices to improve maternal and infant outcomes using quality improvement science
- Over 95% of birthing hospitals and neonatal intensive care units participate in initiatives
- Obstetric and neonatal advisory workgroup participation across the state



ILPQC approach

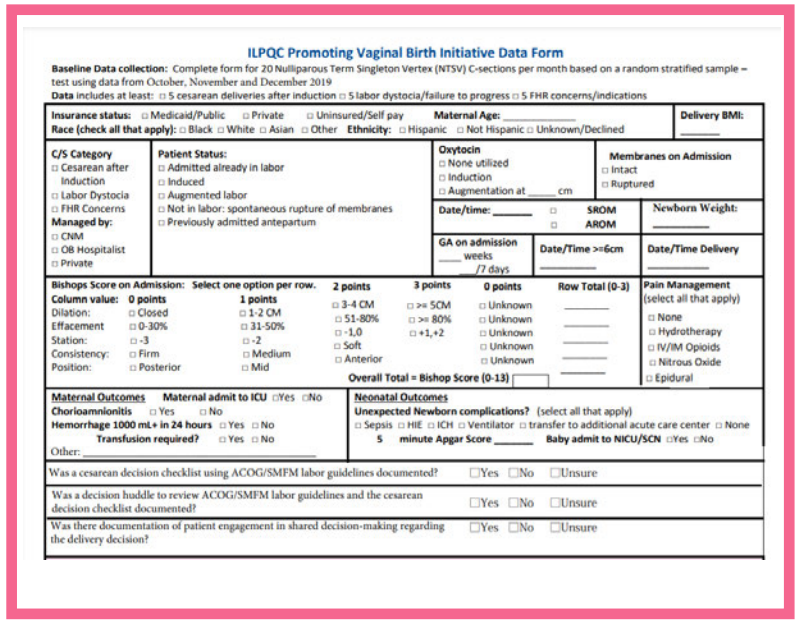




- SMART
- Structure, Process, Outcome, Balancing
- QI Resources

Langley GL MR, Nolan TW, Norman CL, Provost LP,. 2009

ILPQC Data System



ILPQC Promoting Vaginal Birth Initiative Data Form

Baseline Data collection: Complete form for 20 Nulliparous Term Singleton Vertex (NTSV) C-sections per month based on a random stratified sample – test using data from October, November and December 2019

Data includes at least: □ 5 cesarean deliveries after induction □ 5 labor dystocia/failure to progress □ 5 FHR concerns/indications

Insurance status: □ Medicaid/Public □ Private □ Uninsured/Self pay **Maternal Age:** _____
Race (check all that apply): □ Black □ White □ Asian □ Other **Ethnicity:** □ Hispanic □ Not Hispanic □ Unknown/Declined
Delivery BMI: _____

C/S Category
□ Cesarean after Induction
□ Labor Dystocia
□ FHR Concerns
Managed by:
□ CNM
□ OB Hospitalist
□ Private

Patient Status:
□ Admitted already in labor
□ Induced
□ Augmented labor
□ Not in labor: spontaneous rupture of membranes
□ Previously admitted antepartum

Oxytocin
□ None utilized
□ Induction
□ Augmentation at _____ cm

Membranes on Admission
□ Intact
□ Ruptured

Date/time: _____ □ SROM □ AROM

Newborn Weight: _____

GA on admission ____ weeks ____ /7 days

Date/Time >=6cm _____

Date/Time Delivery _____

Bishops Score on Admission: Select one option per row.

	0 points	1 points	2 points	3 points	0 points	Row Total (0-3)
Column value:						
Dilation:	□ Closed	□ 1-2 CM	□ 3-4 CM	□ >= 5CM	□ Unknown	
Effacement	□ 0-30%	□ 31-50%	□ 51-80%	□ >= 80%	□ Unknown	
Station:	□ -3	□ -2	□ -1,0	□ +1,+2	□ Unknown	
Consistency:	□ Firm	□ Medium	□ Soft		□ Unknown	
Position:	□ Posterior	□ Mid	□ Anterior		□ Unknown	

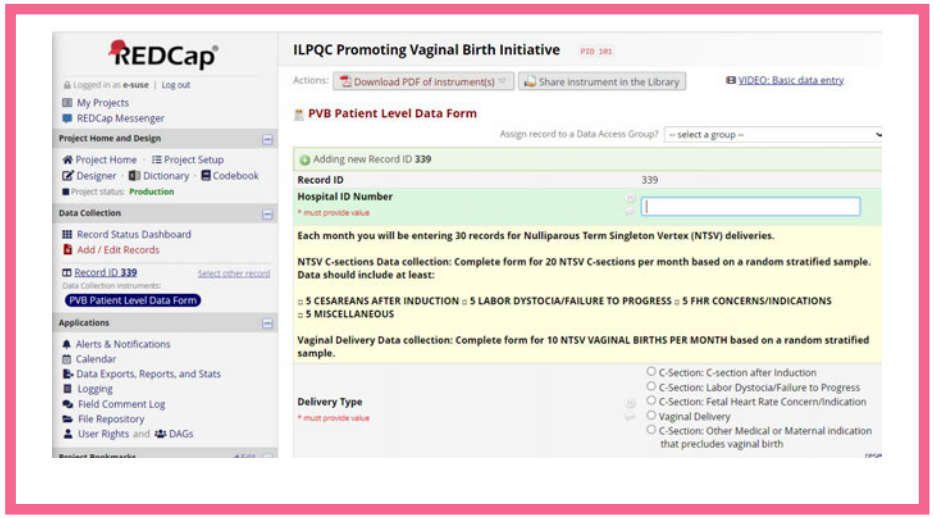
Overall Total = Bishop Score (0-13) ____

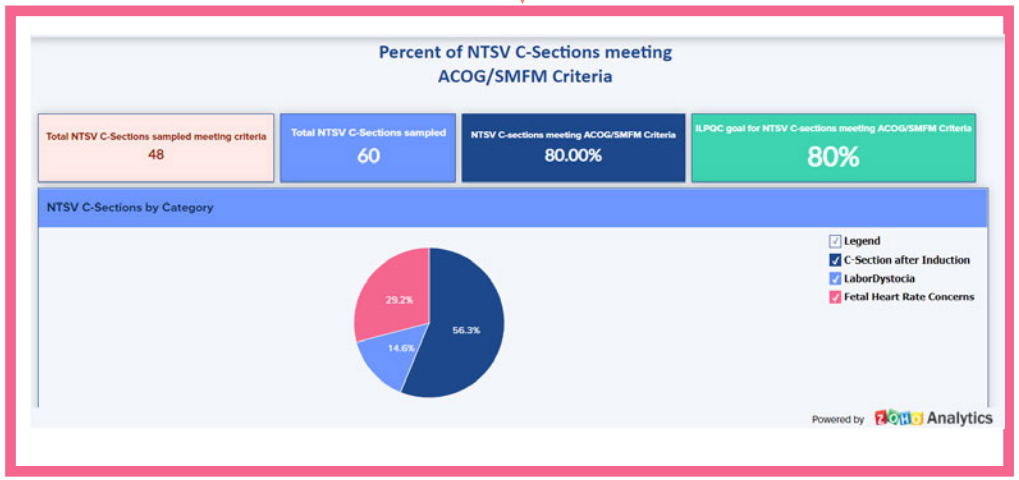
Pain Management (select all that apply)
□ None
□ Hydrotherapy
□ IV/IM Opioids
□ Nitrous Oxide
□ Epidural

Maternal Outcomes **Maternal admit to ICU** □Yes □No
Chorioamnionitis □ Yes □ No
Hemorrhage 1000 mL+ in 24 hours □ Yes □ No
Transfusion required? □ Yes □ No
Other: _____

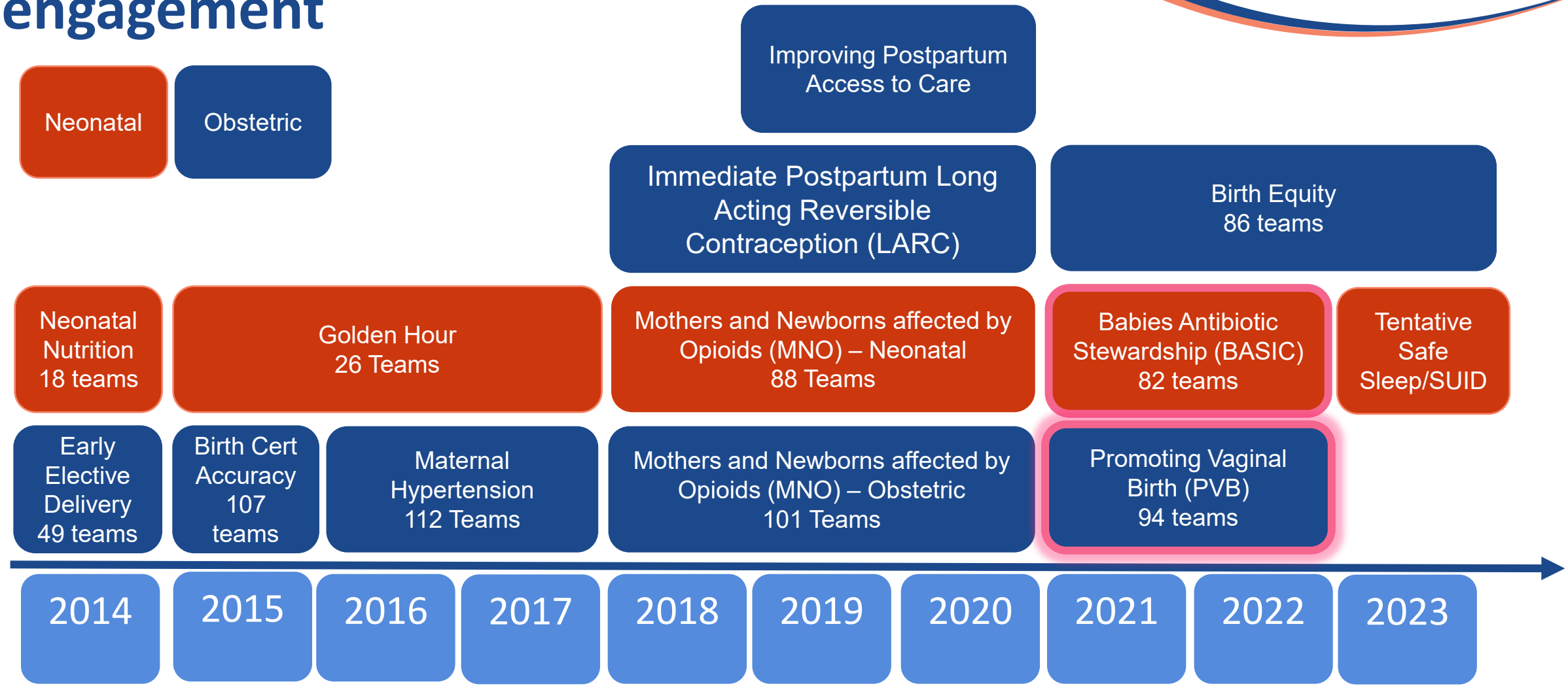
Neonatal Outcomes
Unexpected Newborn complications? (select all that apply)
□ Sepsis □ HIE □ ICH □ Ventilator □ transfer to additional acute care center □ None
5 minute Apgar Score _____ **Baby admit to NICU/SCN** □Yes □No

Was a cesarean decision checklist using ACOG/SMFM labor guidelines documented?	□Yes	□No	□Unsure
Was a decision huddle to review ACOG/SMFM labor guidelines and the cesarean decision checklist documented?	□Yes	□No	□Unsure
Was there documentation of patient engagement in shared decision-making regarding the delivery decision?	□Yes	□No	□Unsure





Timeline initiatives and hospital engagement



PVB Aims and Measures

AIM

≥70% of participating hospitals will be at or below the Healthy People goal of **23.6% cesarean delivery rate** among NTSV births by December 31, 2022

≥80% of cesarean section deliveries among NTSV births that meet ACOG/SMFM criteria for cesarean

≥80% of physicians/ midwives/ nurses educated on ACOG/SMFM criteria for cesarean, labor management strategies/response to labor challenges, protocol for facilitating decision huddles and/or decision debriefs

PVB Key Strategies for Creating Clinical Culture Change

Cesarean Decision Checklist

Supporting Nursing Care: Labor Management Support

Educating Patients and Setting Patient Expectations

Sharing Unblinded Provider-level NTSV C-Section Rates

Cesarean Decision Huddles

Shared Decision-Making: Bringing Patients In

Review of NTSV C-Section Cases Not Meeting ACOG/SMFM Guidelines

PVB Key Resources

Missed Opportunity Review

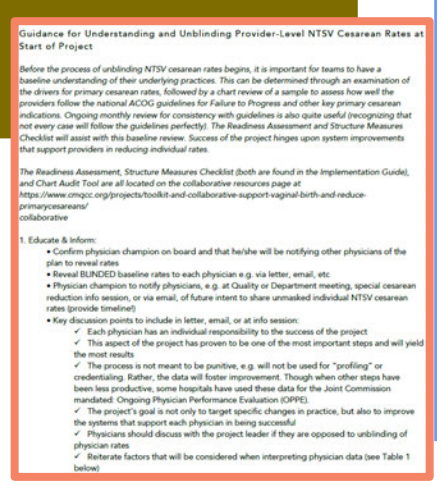
REDCap

ILPQC PVB Dashboard

Provider Education Posters

CMQCC Un-blinding Provider Data

CMQCC California Maternal Quality Care Collaborative

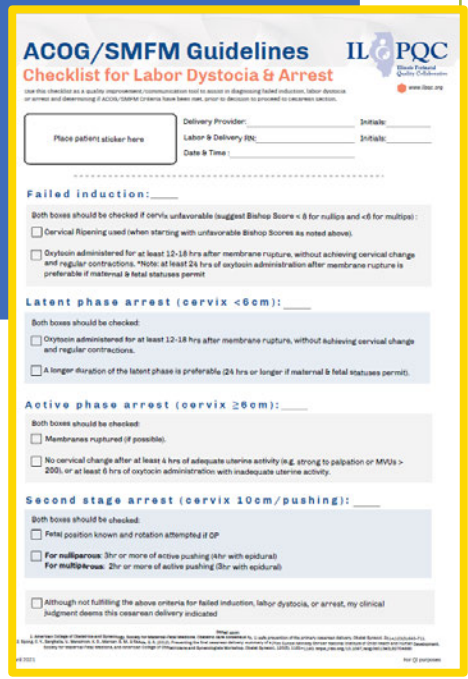

Guidance for Understanding and Unblinding Provider-Level NTSV Cesarean Rates at Start of Project

Before the process of unblinding NTSV cesarean rates begins, it is important for teams to have a baseline understanding of their underlying practices. This can be determined through an examination of the drivers for primary cesarean rates, followed by a chart review of a sample to assess how well the providers follow the national ACOG guidelines for Failure to Progress and other key primary cesarean indications. Ongoing monthly review for consistency with guidelines is also quite useful (recognizing that not every case will follow the guidelines perfectly). The Readiness Assessment and Structure Measures Checklist will assist with this baseline review. Success of the project hinges upon system improvements that support providers in reducing individual rates.

The Readiness Assessment, Structure Measures Checklist (both are found in the Implementation Guide), and Chart Audit Tool are all located on the collaborative resources page at https://www.cmqcc.org/projects/toolkit-and-collaborative-support-vaginal-birth-and-reduce-primarycesareans/collaborative

1. Educate & Inform:
- Confirm physician champion on board and that he/she will be notifying other physicians of the plan to reveal rates
- Reveal BLINDED baseline rates to each physician e.g. via letter, email, etc
- Physician champion to notify physicians, e.g. at Quality or Department meeting, special cesarean reduction info session, or via email, of future intent to share unmasked individual NTSV cesarean rates (provide timeline!)
- Key discussion points to include in letter, email, or at info session:
  - ✓ Each physician has an individual responsibility to the success of the project
  - ✓ This aspect of the project has proven to be one of the most important steps and will yield the most results
  - ✓ The process is not meant to be punitive, e.g. will not be used for "profiling" or credentialing. Rather, the data will foster improvement. Though when other steps have been less productive, some hospitals have used these data for the Joint Commission mandated: Ongoing Physician Performance Evaluation (OPPE).
  - ✓ The project's goal is not only to target specific changes in practice, but also to improve the systems that support each physician in being successful
  - ✓ Physicians should discuss with the project leader if they are opposed to unblinding of physician rates
  - ✓ Reiterate factors that will be considered when interpreting physician data (see Table 1 below)

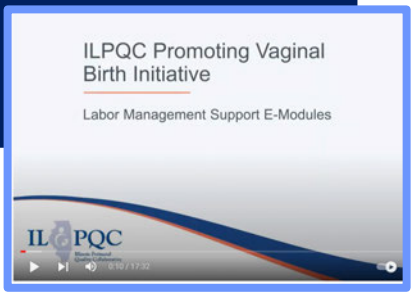
Cesarean Decision Checklist


ACOG/SMFM Guidelines
Checklist for Labor Dystocia & Arrest

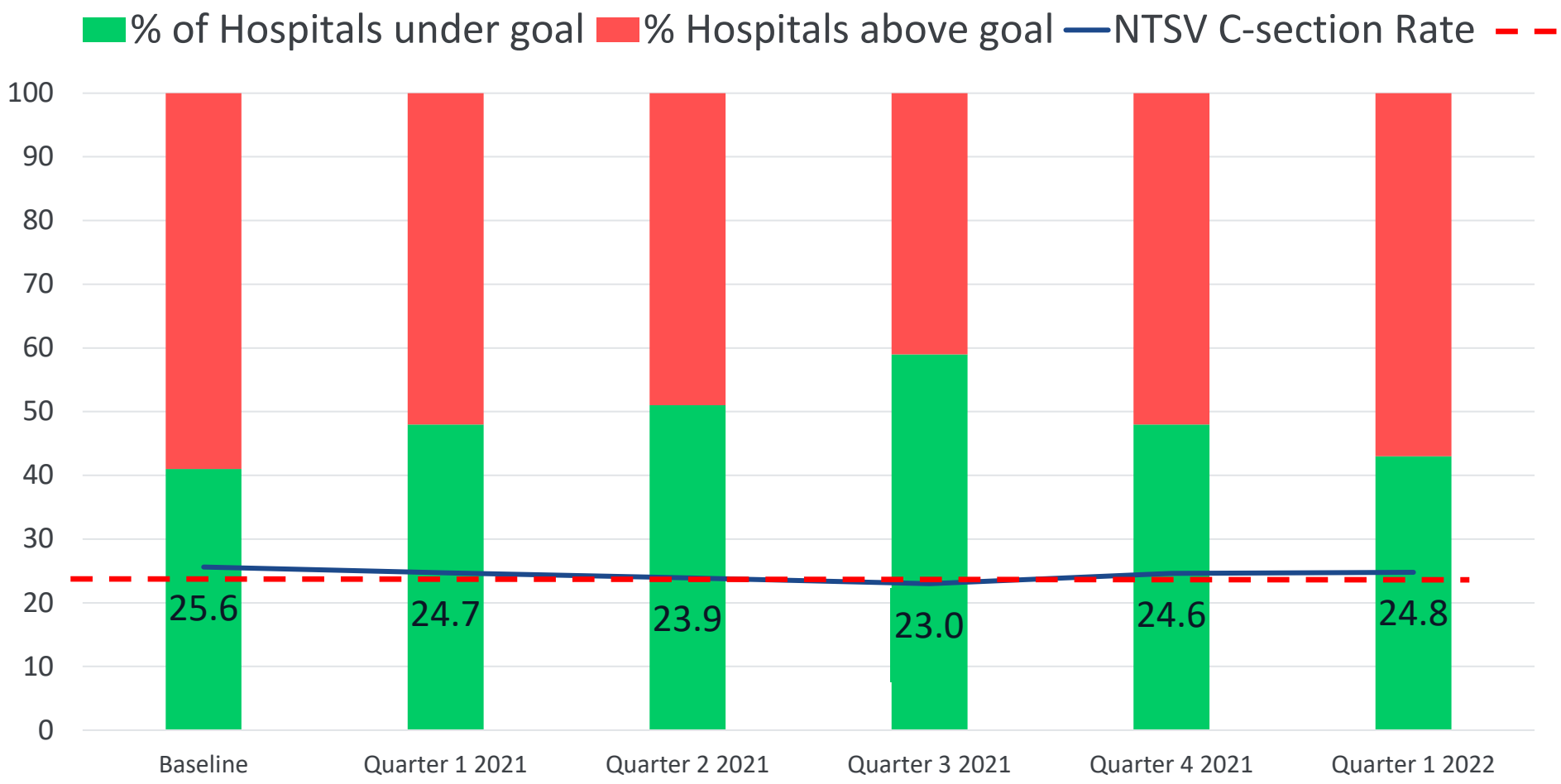
Failed induction:
Latent phase arrest (cervix <6cm):
Active phase arrest (cervix ≥6cm):
Second stage arrest (cervix 10cm/pushing):

Labor Management E-modules

YouTube

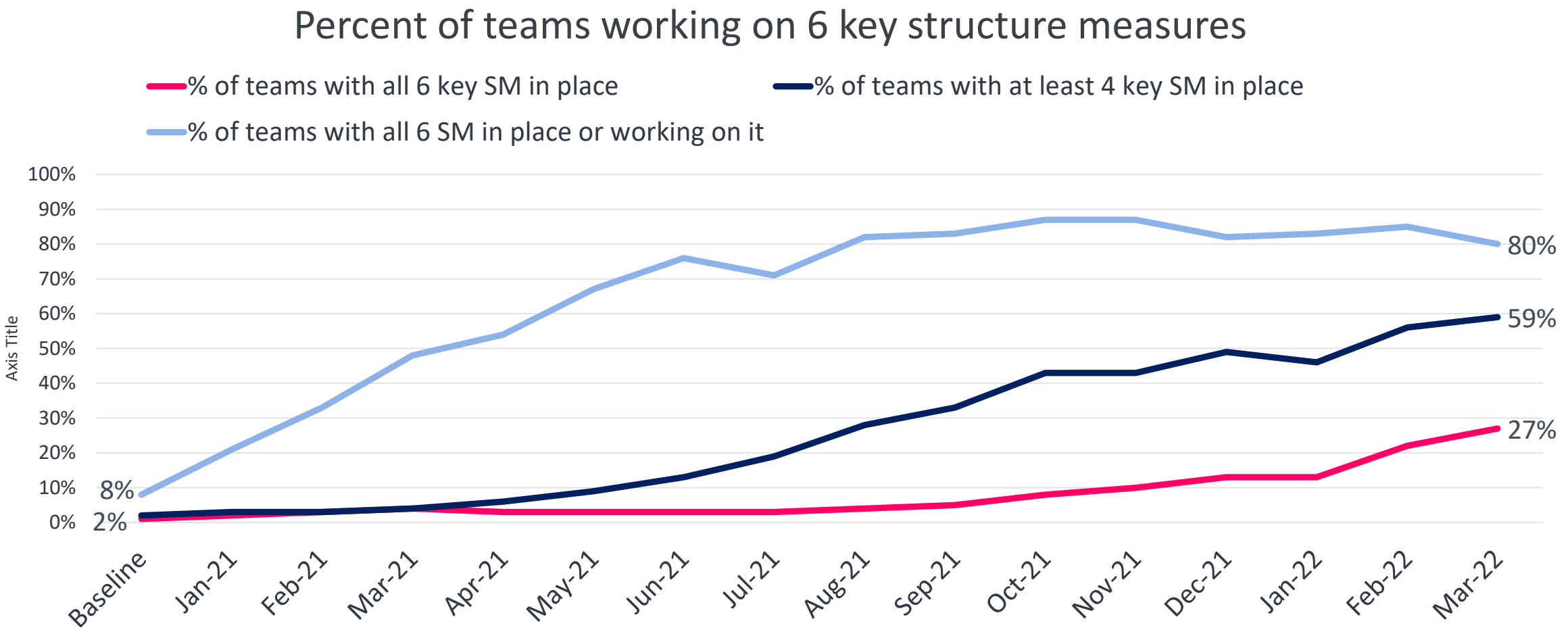


PVB Aim: ILPQC NTSV C-Section Rate

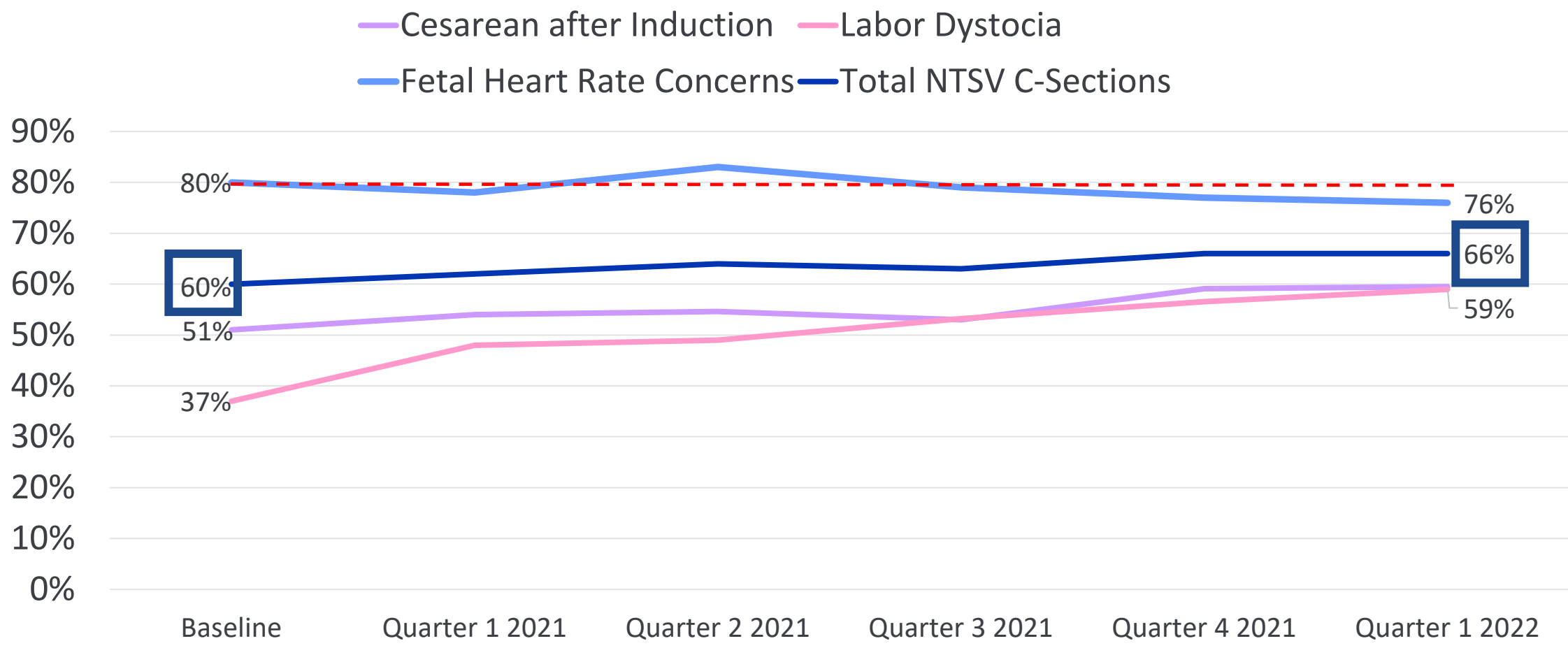


ILPQC is working with hospital teams to collect **NTSV C-Section Rate data by Race, ethnicity and insurance status** to determine and address inequities

PVB Teams Progress on Key Structure Measures



Outcome Measure: NTSV C-Sections Meeting ACOG/SMFM Guidelines (goal > 80%)

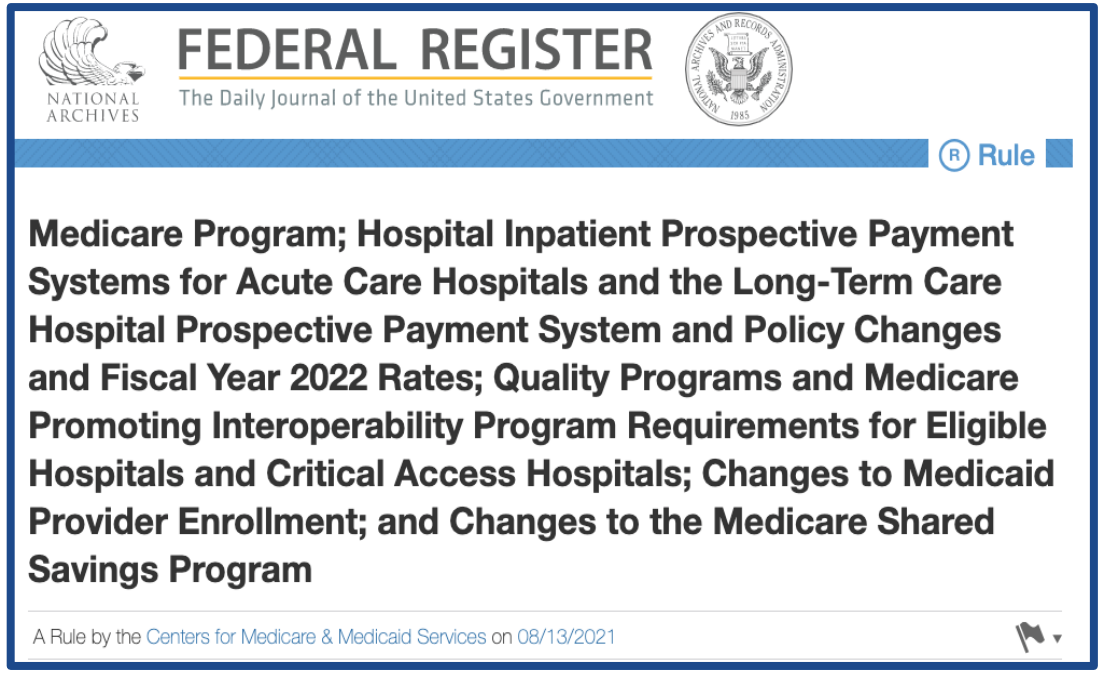


Examples of PQC-Medicaid Collaborations

- State Medicaid and Medicaid Health Plan associations serve on PQC leadership teams, stakeholder groups, or advisor workgroups creating opportunities for collaboration
- PQCs facilitate initiatives that support hospital implementation of Medicaid policy changes and provide feedback on barriers to implementation
- State Medicaid provides incentives to hospital teams for participation in PQCs

CMS's New Maternal Morbidity Structural Measure

"Does your hospital or health system **participate in a Statewide and/or National Perinatal Quality Improvement Collaborative** Program aimed at improving maternal outcomes during inpatient labor, delivery and post-partum care, and has it **implemented patient safety practices or bundles related to maternal morbidity** to address complications, including, but not limited to, hemorrhage, severe hypertension/preeclampsia or sepsis?"


NATIONAL ARCHIVES

FEDERAL REGISTER

The Daily Journal of the United States Government

Rule

Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Policy Changes and Fiscal Year 2022 Rates; Quality Programs and Medicare Promoting Interoperability Program Requirements for Eligible Hospitals and Critical Access Hospitals; Changes to Medicaid Provider Enrollment; and Changes to the Medicare Shared Savings Program

A Rule by the Centers for Medicare & Medicaid Services on 08/13/2021

For more information and collaboration opportunities

- Review online initiative PVB toolkit at https://ilpqc.org/initiatives/promoting-vaginal-birth-initiative/
- Connect with your state PQC https://www.cdc.gov/reproductivehealth/maternalinfanthealth/pqc-states.html
- Reach out to us with questions at info@ilpqc.org

IL PQC
Illinois Perinatal Quality Collaborative

Thanks to our Funders

IDHS Illinois Department of Human Services

IDPH Illinois Department of Public Health

AIM Alliance for Innovation on Maternal Health

I PROMOTE-IL

CDC Centers for Disease Control and Prevention

Thanks

In kind support:

NorthShore University HealthSystem

Northwestern Medicine Northwestern University Feinberg School of Medicine

Ann & Robert H. Lurie Children's Hospital of Chicago

Saint Louis University

NEW JERSEY
DEPARTMENT
OF HUMAN SERVICES

Low-Risk Cesarean Delivery Learning Collaborative: June 10, 2022

State Medicaid and CHIP Agencies and Obstetrical Partners: Working Together to Reduce Low-Risk Cesarean Deliveries

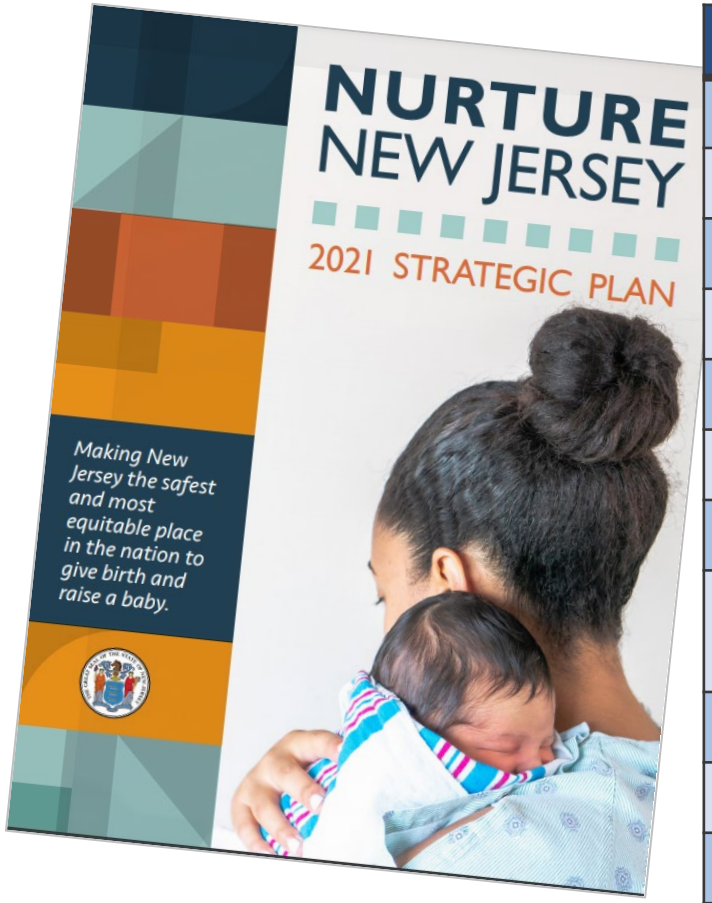
New Jersey Medicaid's
Community Doula Benefit

Presented by:
Shin-Yi Lin
Michele Samuels

New Jersey's Community Doula benefit…in context

Nurture New Jersey is a statewide effort to make New Jersey the safest and most equitable place in the nation to give birth and raise a baby.

- Launched by First Lady Tammy Murphy in 2019
- Acknowledges New Jersey's poor statistics in maternal and infant mortality and maternity-related racial health disparities



Aligned Initiatives in NJ Medicaid
10/01/19: PlanFirst family planning coverage
12/31/19: CenteringPregnancy benefit
01/01/21: Mandated use of Perinatal Risk Assessment Form
01/01/21: Non-payment for Early Elective Deliveries
01/01/21: **Community doula services benefit**
04/05/21: Expanded breastfeeding equipment benefit
04/01/22: Quality-driven Perinatal Episode of Care pilot
04/01/22: Expanded prenatal + contraceptive coverage for women ineligible for Medicaid due to immigration status
05/01/22: Expanded access to midwives (CM, CPM)
2022: Postpartum coverage from 60 to 365 days
2022–2023: Lactation Consultant and Counselor support
2023: Postpartum Home Visiting (Targeted and Universal)

Why **Community** Doulas?

Doulas are non-clinical professionals who provide physical, emotional, and informational support before, during, and after birth.

Community doulas are also equipped to meet particular needs of Medicaid populations and under-served communities.

- *Culturally-competent care:* Black, Indigenous, and people of color (BIPOC) workforce, culturally and linguistically competent
- *Community-based care:* Trauma-informed, aware of the local social services available in NJ

March of Dimes
July 2018 Position Statement

Studies suggest that increased access to doula care, especially in under-resourced communities, can improve a range of health outcomes for mothers and babies, lower healthcare costs, reduce c-sections (cesarean sections), decrease maternal anxiety and depression, and help improve communication between low-income, racially/ethnically diverse pregnant women and their health care providers.

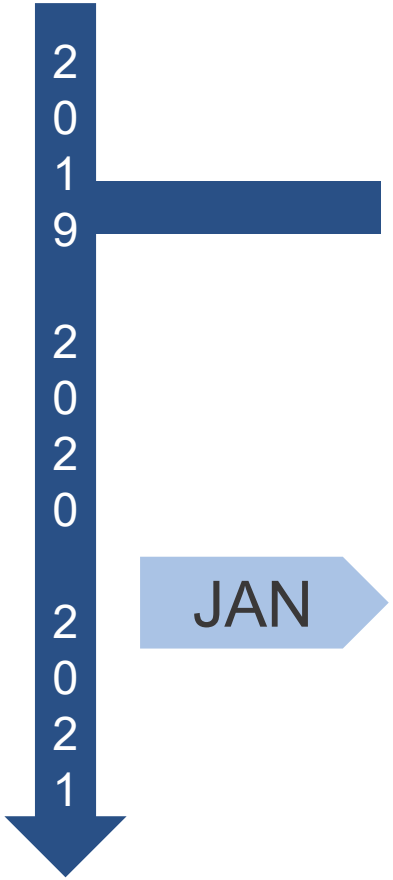
March of Dimes supports increased access to doula care as one tool to help improve birth outcomes and reduce the higher rates of maternal morbidity and mortality among women of color in the United States.

March of Dimes advocates for all payers to provide coverage for doula services.

March of Dimes recognizes the importance of increased training, support and capacity development for doulas, including doulas from racially, ethnically, socioeconomically and culturally diverse communities

www.marchofdimes.org

New Jersey's **path** to benefit design and launch



Proactive Multi-stakeholder group with NJ's community-based doulas

Key partners: First Lady's Office, Department of Health, Doulas, Non-profits, Medicaid Managed Care

- *Accepted training* must reflect "community doula" expertise.
- *Shared decision making* means the doula and their client to decide how many visits make sense for them.
- *Doulas* need not practice under direct clinical supervision.

JAN

01/01/2021 Doula Benefit Live

Ongoing Multi-stakeholder discussions

New partners: Our enrolled doula providers, Doula Learning Collaborative

Key **features** of New Jersey's Medicaid benefit

The focus

- Community-based doula BIPOC workforce

For details about the impact of the stakeholder input, see https://www.nj.gov/humanservices/dmahs/info/2021-10-19_DOH_DMAHS_Community_Doula_Stakeholder.pdf

The benefit

- Available throughout pregnancy, labor, and postpartum
- Our benefit goes beyond labor support
  - Visits can start early in the prenatal period and go up to six months postpartum
  - Visits can be in the home, in the community, and/or involve going with client to a clinical visit
- Provides a value-based incentive to community doula if client has clinical postpartum visit
- More visits are available for clients 19 years or younger

The providers

- Community doulas have the choice to practice independently, as part of doula-only organizations, or with clinical groups
- Wherever possible, administrative fees have been removed around provider enrollment

Key **workforce support** for New Jersey's community doulas

- Support via documentation and trainings
  - Medicaid's Community Doula Benefit website https://www.nj.gov/humanservices/dmahs/info/doula.html
- One-on-one support via identified points of contact
  - **DMAHS-to-doula** support: Doula Guides
  - **MCO-to-doula** support: MCO points of contacts for doula contracting and claims submission
  - **Doula-to-doula** support: Doula Learning Collaborative (see below)
- Regulatory support of doula support in hospitals
  - NJ-Department of Health's Executive Directive: doulas are an essential part of the care team during labor and delivery

What next? Technical vs **Adaptive Challenge**

Technical Challenge

- **Authorities** apply existing expertise, procedures, and technology
  - *Stakeholder dialogue, policy decisions*
  - *Benefit design, systems, documentation, claims*

Adaptive Challenge

- **People** learn new ways
  - *Experiments, discoveries, difficult conversations*
  - *Requires adjustments from numerous places*

From Heifetz and Linsky, *Leadership on the Line: Staying Alive through the Dangers of Leading*

- Leverage our benefit and our community doula providers within the broader **universe of New Jersey Medicaid's maternity initiatives and benefits** to lead to synergistic improvement in New Jersey's maternity-related outcomes and a reduction in racial health disparities
- Publicize and increase awareness among **Medicaid members** of their access to and the benefits of community doula care
- Gain **clinical champions and partners** in women's health practices, hospitals, and managed-care care management teams, to ensure doulas are treated as part of the care team for pregnant individuals
- Build the **community doula workforce** supported by NJ-Department of Health and NJ-non-profit grant dollars
  - Continue to invite and join community doulas at the table for discussions
  - Encourage doulas to engage with health care payers like Medicaid
  - Create professional support for these non-clinical providers through the **Doula Learning Collaborative** (http://www.njdlc.org)

SC Birth Outcomes Initiative

Improving Maternal Health by Reducing Low-Risk Cesarean Delivery

June 10, 2022

Center for Medicaid and CHIP Services Low-Risk Cesarean Deliveries Webinar Series

Amy Crockett, MD, MSPH

PRISMA HEALTH

Ana Lòpez – DeFede, PhD

Celebrating 30 Years
Institute for Families in Society
Improving Policy. Advancing Practice. Strengthening Communities and Family Well Being. Since 1992.

Presentation Objectives

- Describe the elements framing the creation of the SC Birth Outcomes Initiative
- Share data results measuring low-risk-cesarean deliveries
- Describe the model framing working relations across partner organizations driving the effort to reduce the number of low-risk cesarean deliveries.

SOUTH CAROLINA
Healthy Connections MEDICAID

South Carolina
BIRTH OUTCOMES INITIATIVE

Report Fraud

HOME | UPCOMING MEETINGS | WORKGROUPS | ABOUT | RESOURCES

Welcome!

The South Carolina Birth Outcomes Initiative was established in 2011. It is a collaborative of the South Carolina Department of Health and Human Services (SCDHHS), the South Carolina Department of Health and Environmental Control (DHEC), South Carolina Hospital Association, March of Dimes, BlueCross BlueShield of South Carolina (BCBSSC) and more than 100 stakeholders. SCBOI's overall goals are to improve health outcomes in both moms and babies throughout SC. SCBOI leverages the collective impact model to identify a common agenda and provide for continuous communication.

Resources

Article of Interest: HealthyPeople.gov

Please follow link for article: Health Literacy

Upcoming Meetings

May Monthly Meeting

Dates: 05/11/2022 - 10:30
Location: United States
READ MORE

SC HealthViz
South Carolina eHealth Medicaid Statistics

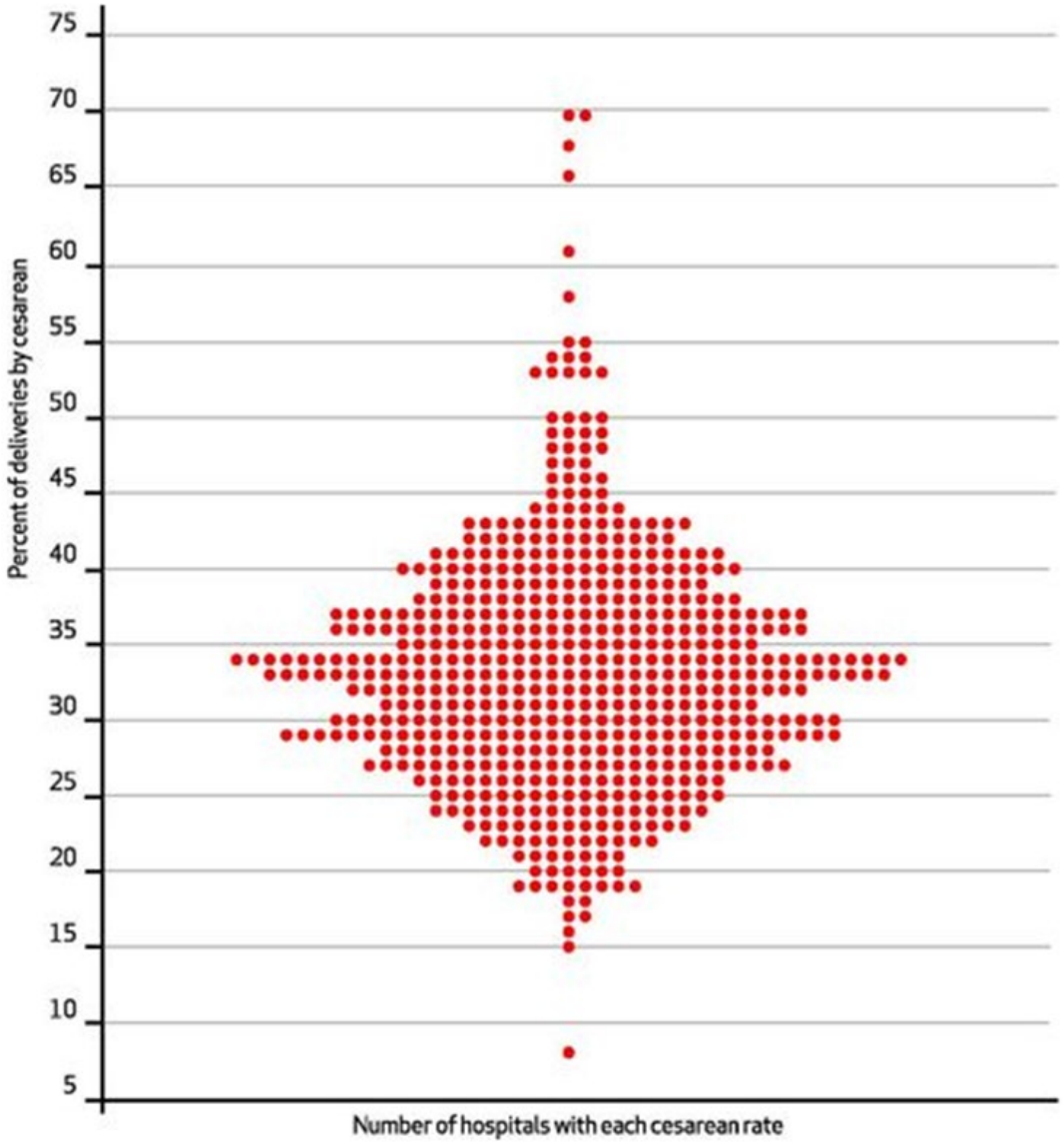
QUALITY OF CARE

By Katy Backes Kozhimannil, Michael R. Law, and Beth A. Virnig

Cesarean Delivery Rates Vary Tenfold Among US Hospitals; Reducing Variation May Address Quality And Cost Issues

ABSTRACT Cesarean delivery is the most commonly performed surgical procedure in the United States, and cesarean rates are increasing. Working with 2009 data from 593 US hospitals nationwide, we found that cesarean rates varied tenfold across hospitals, from 7.1 percent to 69.9 percent. Even for women with lower-risk pregnancies, in which more limited variation might be expected, cesarean rates varied fifteenfold, from 2.4 percent to 36.5 percent. Thus, vast differences in practice patterns are likely to be driving the costly overuse of cesarean delivery in many US hospitals. Because Medicaid pays for nearly half of US births, government efforts to decrease variation are warranted. We focus on four promising directions for reducing these variations, including better coordinating maternity care, collecting and measuring more data, tying Medicaid payment to quality improvement, and enhancing patient-centered decision making through public reporting.

Exhibit 1 Distribution Of Cesarean Rates In US Hospitals, 2009



Improving the diagnosis of arrested labor

"6 is the new 4"

The American College of Obstetricians and Gynecologists
WOMEN'S HEALTH CARE PHYSICIANS

Society for Maternal-Fetal Medicine

OBSTETRIC CARE CONSENSUS

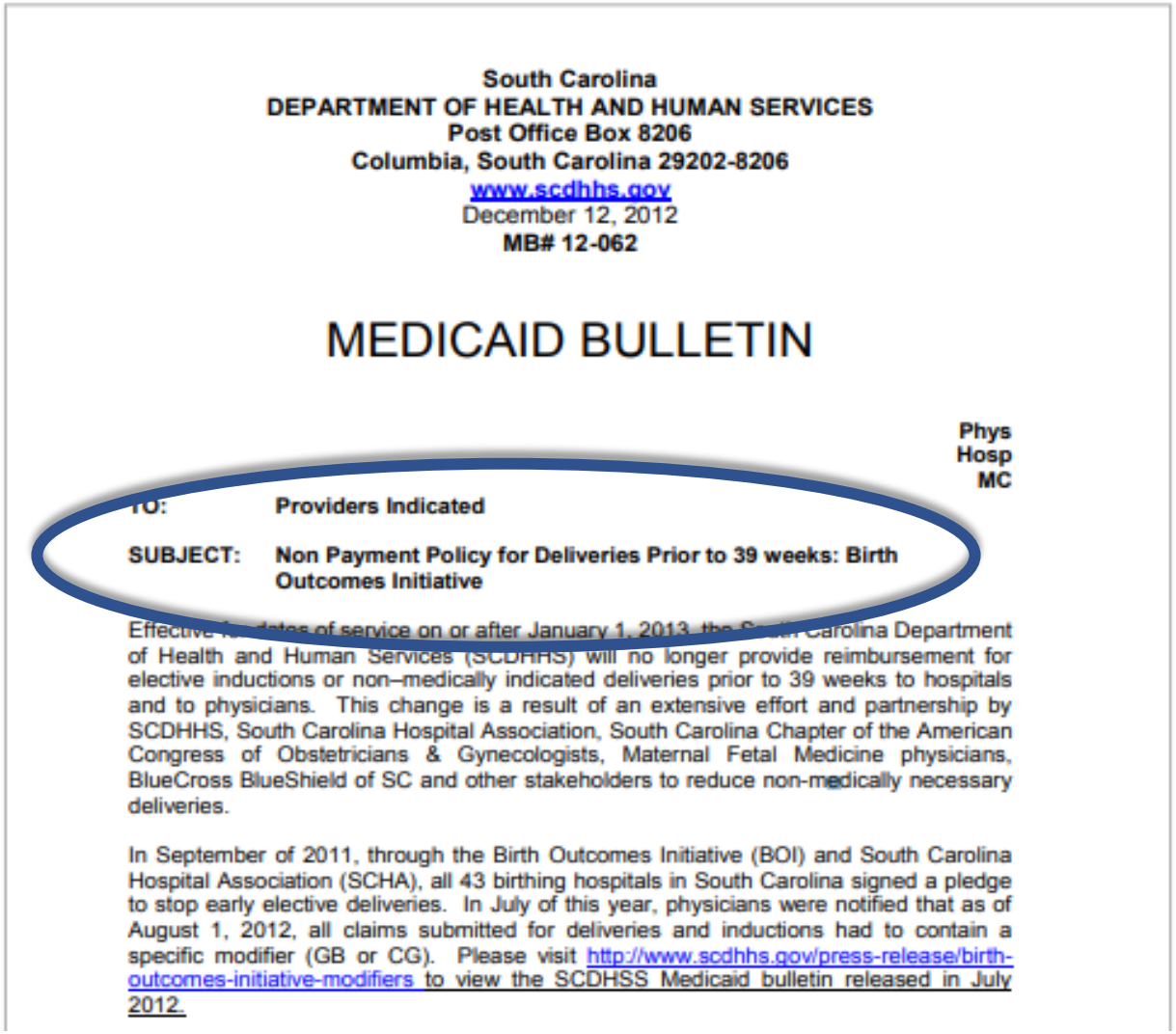
Number 1 • March 2014
(Reaffirmed 2016)

Safe Prevention of the Primary Cesarean Delivery

This document was developed jointly by the American College of Obstetricians and Gynecologists (the College) and the Society for Maternal-Fetal Medicine with the assistance of Aaron B. Caughey, MD, PhD; Alison G. Cahill, MD, MSCI; Jeanne-Marie Guise, MD, MPH; and Dwight J. Rouse, MD, MSPH. The information reflects emerging clinical and scientific advances as of the date issued, is subject to change, and should not be construed as dictating an exclusive course of treatment or procedure. Variations in practice

Abstract: In 2011, one in three women who gave birth in the United States did so by cesarean delivery. Cesarean birth can be life-saving for the fetus, the mother, or both in certain cases. However, the rapid increase in cesarean birth rates from 1996 to 2011 without clear evidence of concomitant decreases in maternal or neonatal morbidity or mortality raises significant concern that cesarean delivery is overused. Variation in the rates of nulliparous, term, singleton, vertex cesarean births also indicates that clinical practice patterns affect the number of cesarean births performed. The most common indications for primary cesarean delivery include, in order of frequency, labor dystocia, abnormal or indeterminate (formerly, nonreassuring) fetal heart rate tracing, fetal malpresentation, multiple gestation, and suspected fetal macrosomia. Safe reduction of the rate of primary cesarean deliveries will require different approaches for each of these, as well as other, indications. For example, it may be necessary to revisit the definition of labor dystocia because recent data show that contemporary labor progresses at a rate substantially slower than what was historically taught. Additionally, improved and standardized fetal heart rate interpretation and management may have an effect. Increasing women's access to nonmedical interventions during labor, such as continuous labor and delivery support, also has been shown to reduce cesarean birth rates. External cephalic version for breech presentation and a trial of labor for women with twin gestations when the first twin is in cephalic presentation are other of several examples of interventions that can contribute to the safe lowering of the primary

Avoiding early elective induction



South Carolina
DEPARTMENT OF HEALTH AND HUMAN SERVICES
Post Office Box 8206
Columbia, South Carolina 29202-8206
www.scdhhs.gov
December 12, 2012
MB# 12-062

MEDICAID BULLETIN

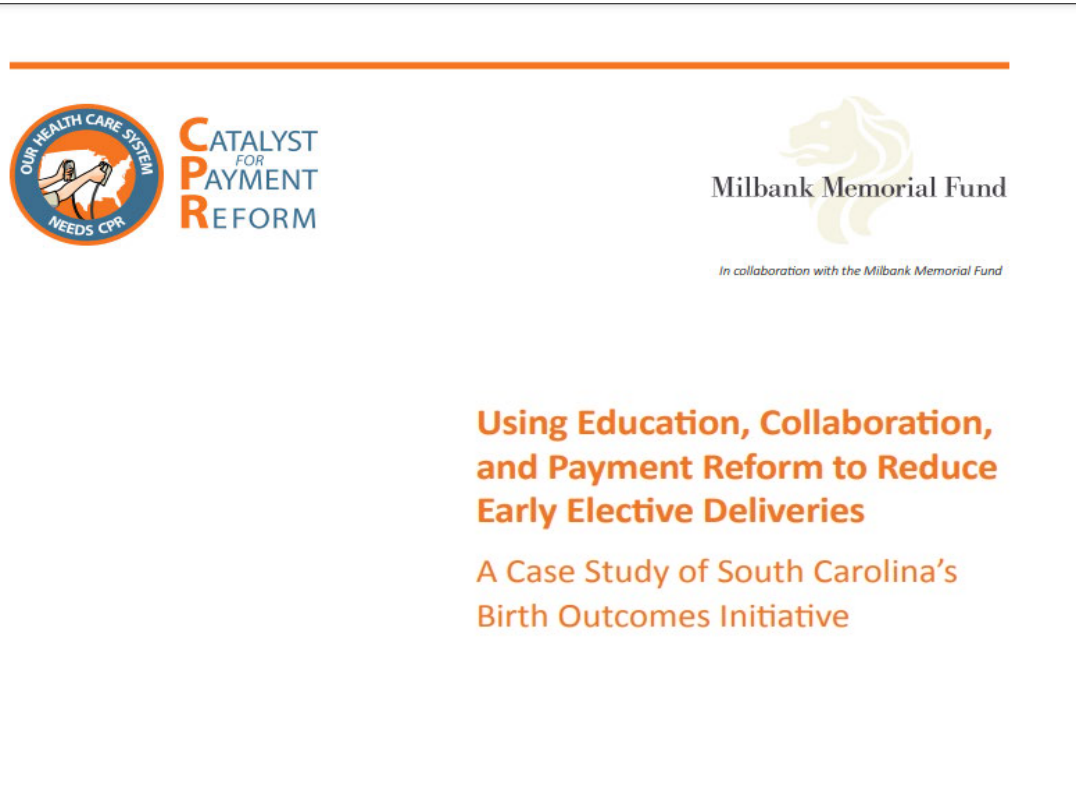
Phys
Hosp
MC

TO: **Providers Indicated**

SUBJECT: **Non Payment Policy for Deliveries Prior to 39 weeks: Birth Outcomes Initiative**

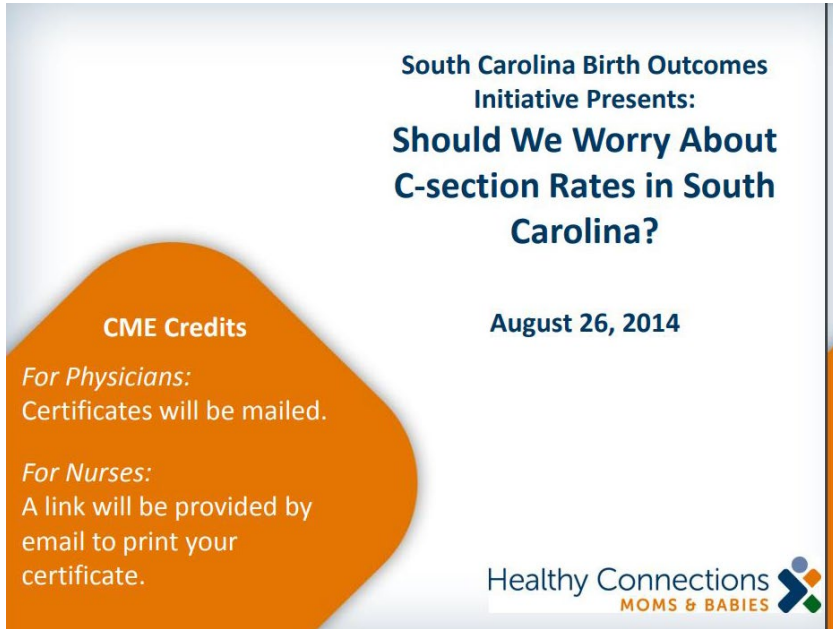
Effective for dates of service on or after January 1, 2013, the South Carolina Department of Health and Human Services (SCDHHS) will no longer provide reimbursement for elective inductions or non–medically indicated deliveries prior to 39 weeks to hospitals and to physicians. This change is a result of an extensive effort and partnership by SCDHHS, South Carolina Hospital Association, South Carolina Chapter of the American Congress of Obstetricians & Gynecologists, Maternal Fetal Medicine physicians, BlueCross BlueShield of SC and other stakeholders to reduce non-medically necessary deliveries.

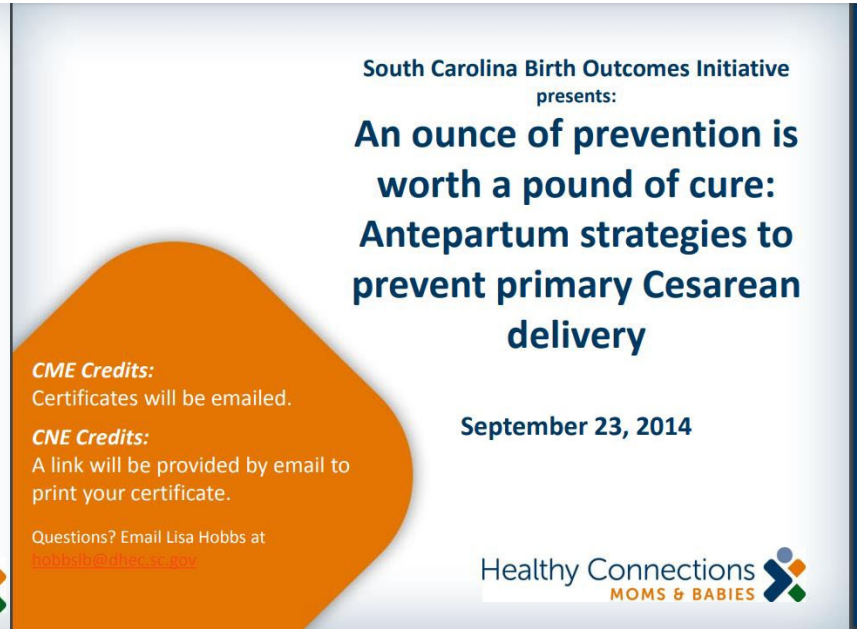
In September of 2011, through the Birth Outcomes Initiative (BOI) and South Carolina Hospital Association (SCHA), all 43 birthing hospitals in South Carolina signed a pledge to stop early elective deliveries. In July of this year, physicians were notified that as of August 1, 2012, all claims submitted for deliveries and inductions had to contain a specific modifier (GB or CG). Please visit http://www.scdhhs.gov/press-release/birth-outcomes-initiative-modifiers to view the SCDHSS Medicaid bulletin released in July 2012.



https://www.catalyze.org/wp-content/uploads/2017/04/2013-Using-Education-Collaboration-and-Payment-Reform-to-Reduce-Early-Elective-Deliveries_SC-Case-Study.pdf

SCBOI Launches the Supporting Vaginal Birth Initiative in 2014





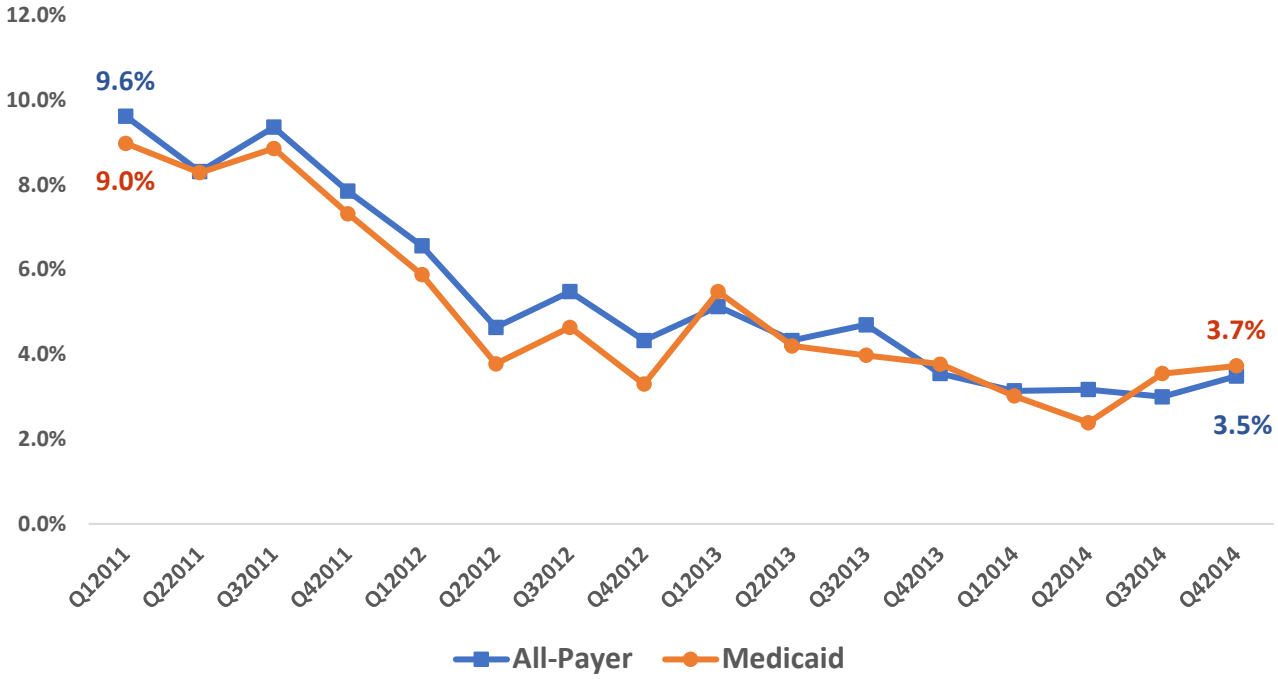
Impact of Policy and Stakeholder Engagement of Outcome Measures

"That which is measured improves. That which is measured and reported improves exponentially."
- Karl Pearson

boi.ifsreports.com

Early Elective Inductions (37-38 weeks) All Payers vs Medicaid

Quarterly trend Q1 2011 to Q4 2014



Early Elective Inductions quarterly trend analysis		
Payer type	**Relative change**	**Trend** (*=p<0.01, Cochran Armitage trend test)
All Payers	↓ 64% reduction	↓* trend
Medicaid	↓ 58% reduction	↓* trend

TAKEAWAYS

Statistically significant decreasing trends and relative reductions of 64% (All Payers) and 58% (Medicaid) were noted for Early Elective Inductions (37-38 weeks) comparing immediately prior to the SCBOI initiative to the end of the last complete ICD-9 year.

Celebrating 30 Years
Institute for Families in Society
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From 2014 (the first year of the Supporting Vaginal Birth Initiative) to 2016 there was a **relative** decrease in all tracked C-Section (CS) measures in South Carolina:

6.1% ⬇ primary CS

6.9% ⬇ elective primary CS

7.5% ⬇ primary CS at 39-40 weeks

8.6% ⬇ elective primary CS at 39-40 weeks

3.5% ⬇ total CS

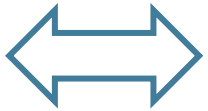
6.2% ⬇ elective total CS

Note:

SC RFA linked data processed as of December 1, 2017 for CYs 2014 to 2016.

Change represents relative improvement between these two years.

Maternal Health Quality Trends

Measure	2018-2020 Trend
Early Elective Deliveries & Inductions (TJC, PC-01)	
Primary C-Section (TJC, PC-02)	
Severe Maternal Morbidity	Mixed result: CA Trend test not significant, but adjusted Chi-square test was. 

Note: 3-year trend analysis was conducted using the Cochran–Armitage and adjusted Chi-square tests.

Arrows that are filled denote statistical significance at P<.05.

TAKEAWAYS

Early elective deliveries were trending down. More data are needed to see whether this reflects the impact of the pandemic which stopped elective procedures.

Renewed focus on supporting vaginal birth may be needed.

The rate of severe maternal morbidity in CY20 was 1.67%, a decrease from 1.82% in CY18 (8% relative improvement). This may correspond with the state's engagement in AIM.

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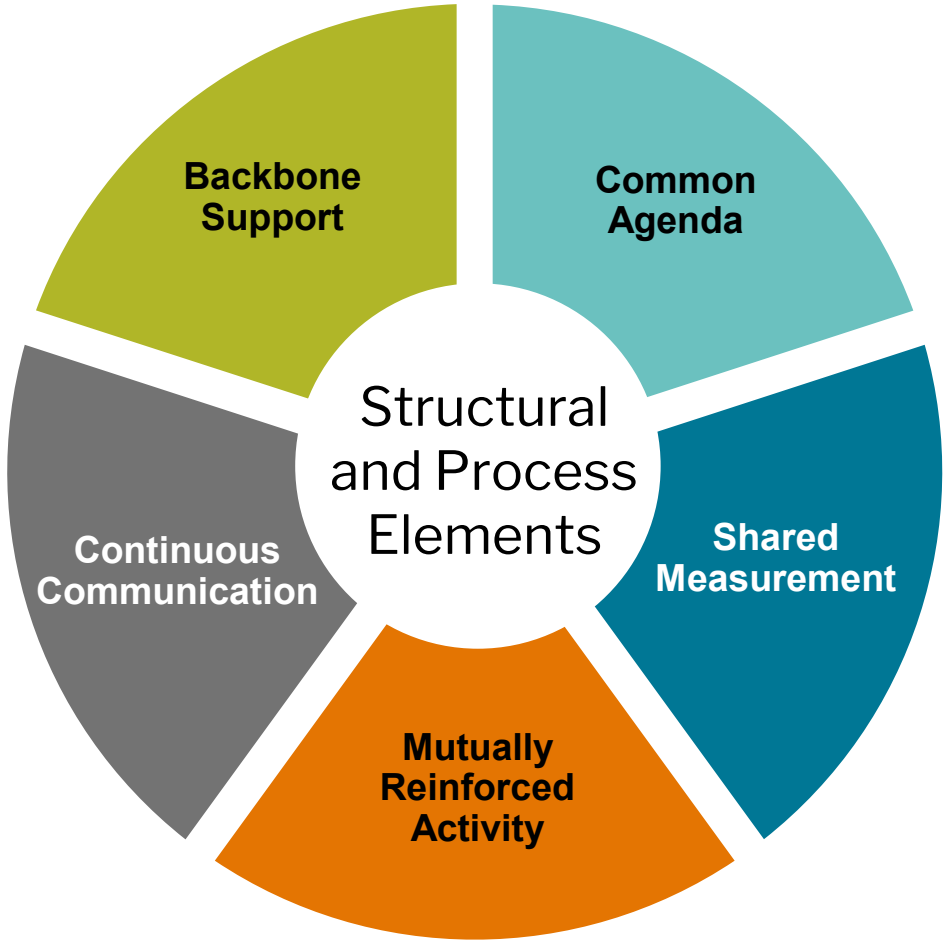
SCBOI Moving from Creating a Vision to Crafting a Reality: Collective Impact Model

The collective impact model **believes that no single government entity policy or organization can deal with deeply entrenched social problems alone.**



Thank You!

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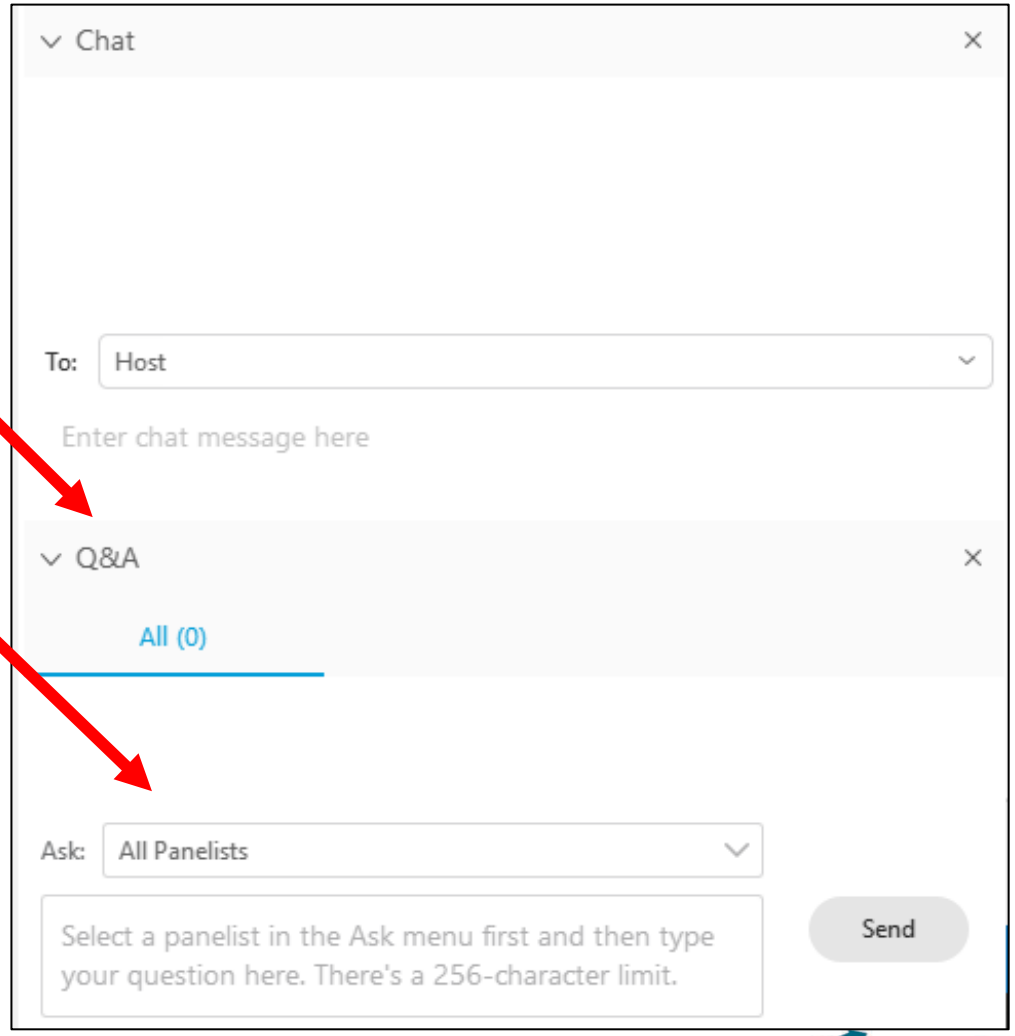
Questions

Lekisha Daniel-Robinson, Mathematica

Reminder: How to Submit a Question

- **Use the Q&A function to submit questions or comments**
  - To submit a question or comment, click the Q&A pod and type in the text box
  - Select “All Panelists” in the “Ask” field before submitting your question or comment
  - Only the presentation team will be able to see your comments



Announcements and Next Steps

Kate Nilles, Mathematica

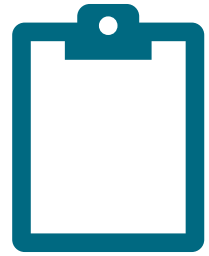
Announcements and Next Steps

- **Webinar recording and slides will be posted on Medicaid.gov at** https://www.medicaid.gov/medicaid/quality-of-care/improvement-initiatives/maternal-infant-health-care-quality/index.html
- **Upcoming webinars**
  - Using Data to Plan and Assess Quality Improvement Strategies to Reduce Low-Risk Cesarean Delivery in Medicaid and CHIP
    - **June 24, 2022, at 1:00-2:00 pm ET**
  - Informational webinar: Improving Maternal Health by Reducing Low-Risk Cesarean Delivery Affinity Group: Overview and Process for Expression of Interest
    - **June 29, 2022, at 2:00-3:00 pm ET**
  - Register for additional webinars at https://mathematica.webex.com/mathematica/onstage/g.php?PRID=b8c2078478d3be51928f2d528cb7a26c
- **LRCD EOI due July 15, 2022 for states interested in technical assistance as they work on reducing LRCDs in their state**

Centers for Medicare & Medicaid Services
Medicaid & CHIP
Maternal & Infant Health Quality Improvement

Thank you

- Please complete the evaluation as you exit the webinar.



- If you have any questions, or we didn't have time to get to your question, please email MACQualityImprovement@mathematica-mpr.com