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

The Role for Medicaid in Reducing Low-Risk Cesarean Delivery

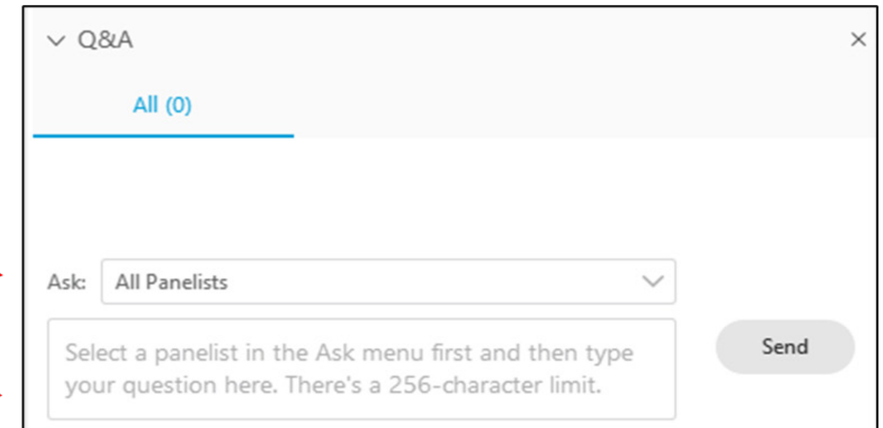
Improving Outcomes and Reducing Disparities

March 31, 2022

Doris Lotz and Kate Nilles, Mathematica
Kristen Zycherman, CMS
Mary Applegate, Ohio Department of Medicaid
Elliot Main, California Maternal Quality Care Collaborative

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"
  - Only the presentation team will be able to see your questions and comments
- **For technical questions, select "Host" in the "Ask" menu**



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

Agenda

Topic	Speaker(s)
Welcome	Doris Lotz, Mathematica
Overview of the Maternal and Infant Health Initiative and Low-Risk Cesarean Delivery (LRCD) Learning Collaborative	Kristen Zycherman, CMS
Why Focus on LRCD?	Doris Lotz, Mathematica
Improving Maternal Health Using Population Health Strategies	Mary Applegate, Ohio Department of Medicaid
California/CMQCC's Initiative to Support Vaginal Births and Reduce Low-Risk Cesarean Deliveries	Elliott Main, California Maternal Quality Care Collaborative, Professor OB/Gyn Stanford University
Questions	Doris Lotz, Mathematica
Announcements and Next Steps	Kate Nilles, Mathematica

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
- Discuss the importance of reducing LRCDs for Medicaid and CHIP beneficiaries to improve maternal and infant health outcomes
- Review the variation and disparities in LRCD in Medicaid and CHIP
- Understand state Medicaid and CHIP program levers to reduce LRCD rates

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

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

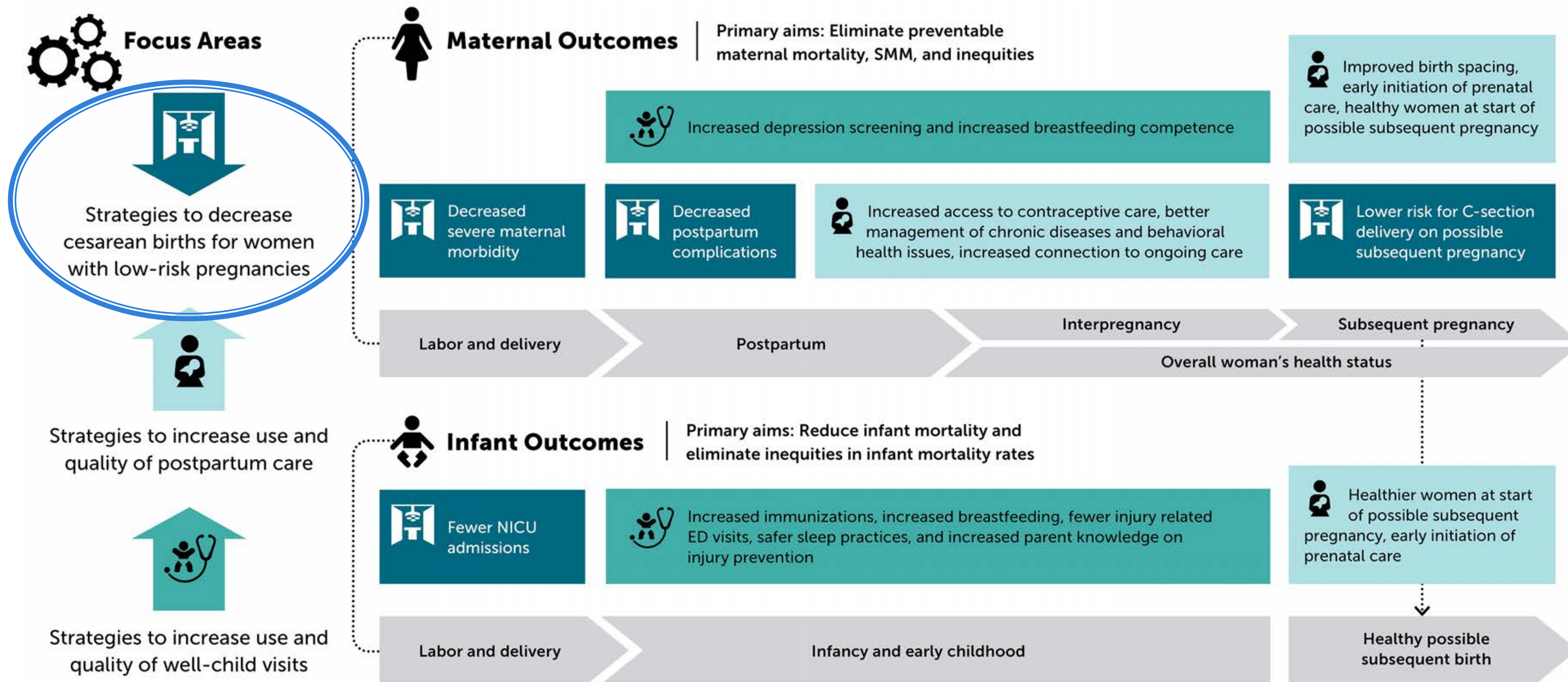
Kristen Zycherman, CMS

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

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)

Focus Areas to Improve Maternal and Infant Health Quality



C-section = cesarean section; ED = emergency department; NICU = neonatal intensive care unit; SMM = severe maternal morbidity

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

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

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

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

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

Why Focus on Low-Risk Cesarean Delivery?

Doris Lotz, Mathematica

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

Reducing Low-Risk Cesarean Delivery (LRCD)

- Cesarean delivery poses greater risk of maternal morbidity and mortality for low-risk pregnancies.
  - Low-risk cesarean delivery is defined as **N**ulliparous (first birth), **T**erm (37 or more weeks), **S**ingleton (one fetus), and **V**ertex/cephalic (head-first) births delivered by cesarean.
- Healthy People 2030 goal for LRCD rate is 23.6%. The 2019 rate for LRCD in the United States was 25.6%.[1]
- LRCD rate disparities between Black and White birthing persons, 30.6% and 24.7%, respectively.[2]
- Medicaid covers 42.0% of all births in the United States.
  - CMS and states have an opportunity to reduce LRCD births in Medicaid and CHIP and improve maternal and infant health outcomes.

1. Healthy People 2030, accessed at https://health.gov/healthypeople/objectives-and-data/browse-objectives/pregnancy-and-childbirth/reduce-cesarean-births-among-low-risk-women-no-prior-births-mich-06
2. Osterman MJK, Hamilton BE, Martin JA, Driscoll AK, Valenzuela CP. Births: Final data for 2020. National Vital Statistics Reports; vol 70 no 17. Hyattsville, MD: National Center for Health Statistics. 2022, available at https://www.cdc.gov/nchs/data/nvsr/nvsr70/nvsr70-17.pdf

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

Low-Risk Cesarean Delivery Rates, U.S. 2010-2020

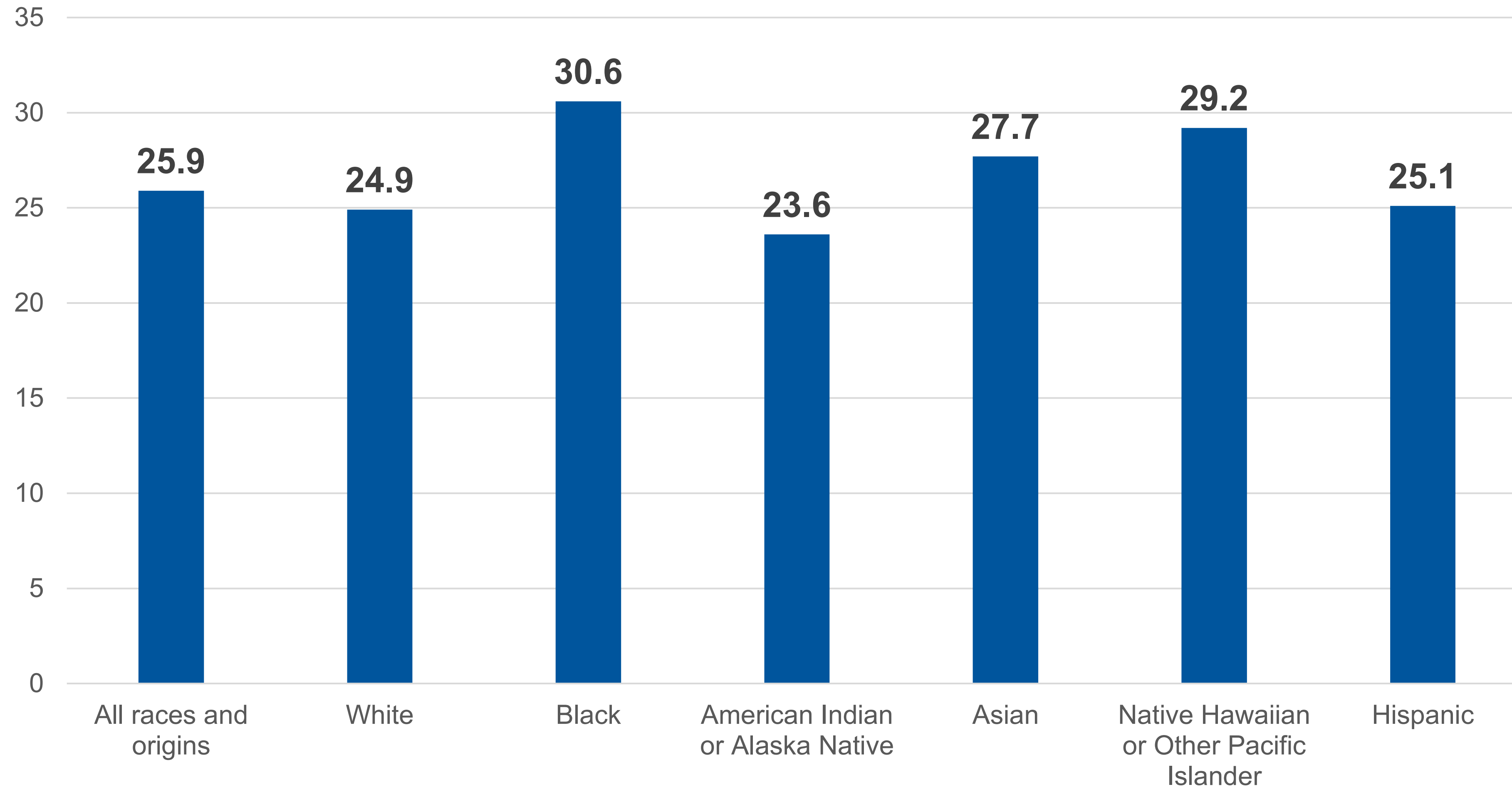
Year	LRCD Rate
2010	27.5
2011	27.2
2012	27.2
2013	26.8
2014	26.0
2015	25.8
2016	25.7
2017	26.0
2018	25.9
2019	25.6
2020	25.9

Y-axis: 22, 23, 24, 25, 26, 27, 28

Legend: LRCD Rate; Healthy People 2030 LRCD Rate Goal

Source: Osterman, M.J.K., Hamilton, B.E., Martin, J.A., et al. "Births: Final Data for 2020." *National Vital Statistics Report*, vol. 70, no. 17, 2022, pp. 2-49
https://www.cdc.gov/nchs/data/nvsr/nvsr70/nvsr70-02-508.pdf

Percentage of Low-Risk Cesarean Delivery by Race, U.S. 2020



Source: Osterman, M.J.K., Hamilton, B.E., Martin, J.A., et al. "Births: Final Data for 2020." *National Vital Statistics Report*, vol. 70, no. 17, 2022, pp. 2-49.
https://www.cdc.gov/nchs/data/nvsr/nvsr70/nvsr70-17.pdf

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

Low-Risk Cesarean Delivery Rate per 100 Deliveries, by State: Births Paid by Medicaid, 2018

Rate range	States
26.6% to 30.5%	MI, NY, CT, MD, DC, KY, AR, TX, LA, MS, AL, FL
24.2% to 26.5%	NV, IA, OH, WV, VA, TN, SC, GA, ME, NH, MA, RI, NJ
21.8% to 24.1%	OR, CA, MT, NE, KS, OK, MN, MO, IL, IN, PA, NC, DE
14.9% to 21.7%	WA, ID, WY, UT, CO, AZ, NM, ND, SD, WI, VT, AK, HI

State Median = 24.1%

Lower rates are better for this measure

Notes:
The low-risk cesarean delivery rate is calculated for singleton, term, cephalic deliveries to women having a first birth. Using this definition, 32% of all births in 2018 were low-risk. There is not a separate option for CHIP on the U.S. standard birth certificate. “Medicaid” may include CHIP beneficiaries. Births with delivery method unknown (<1% of births) are excluded.

Source:
National Center for Health Statistics (NCHS). 2018 Natality Public Use Data on CDC WONDER online database.

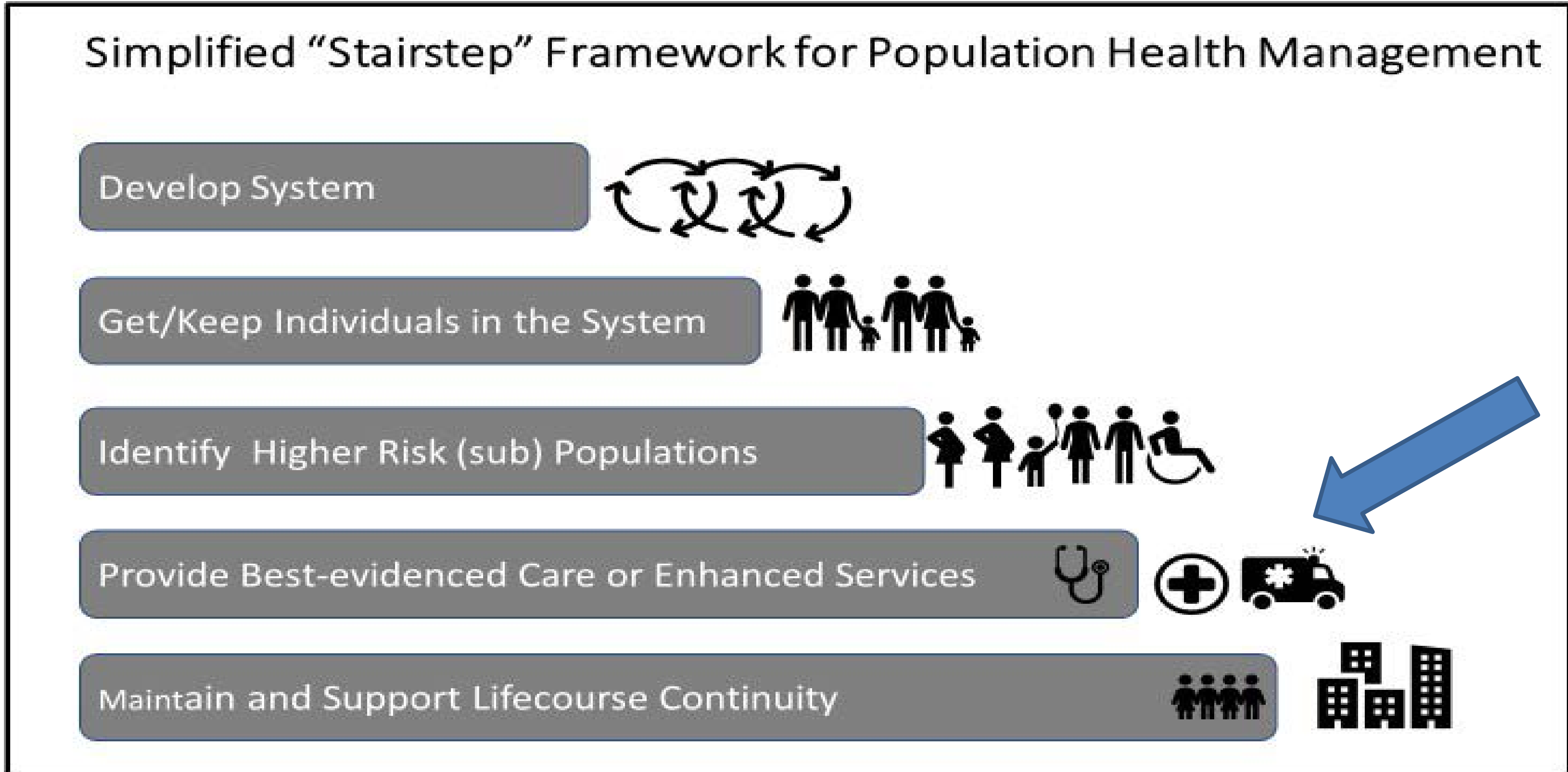
Available at:
https://wonder.cdc.gov/

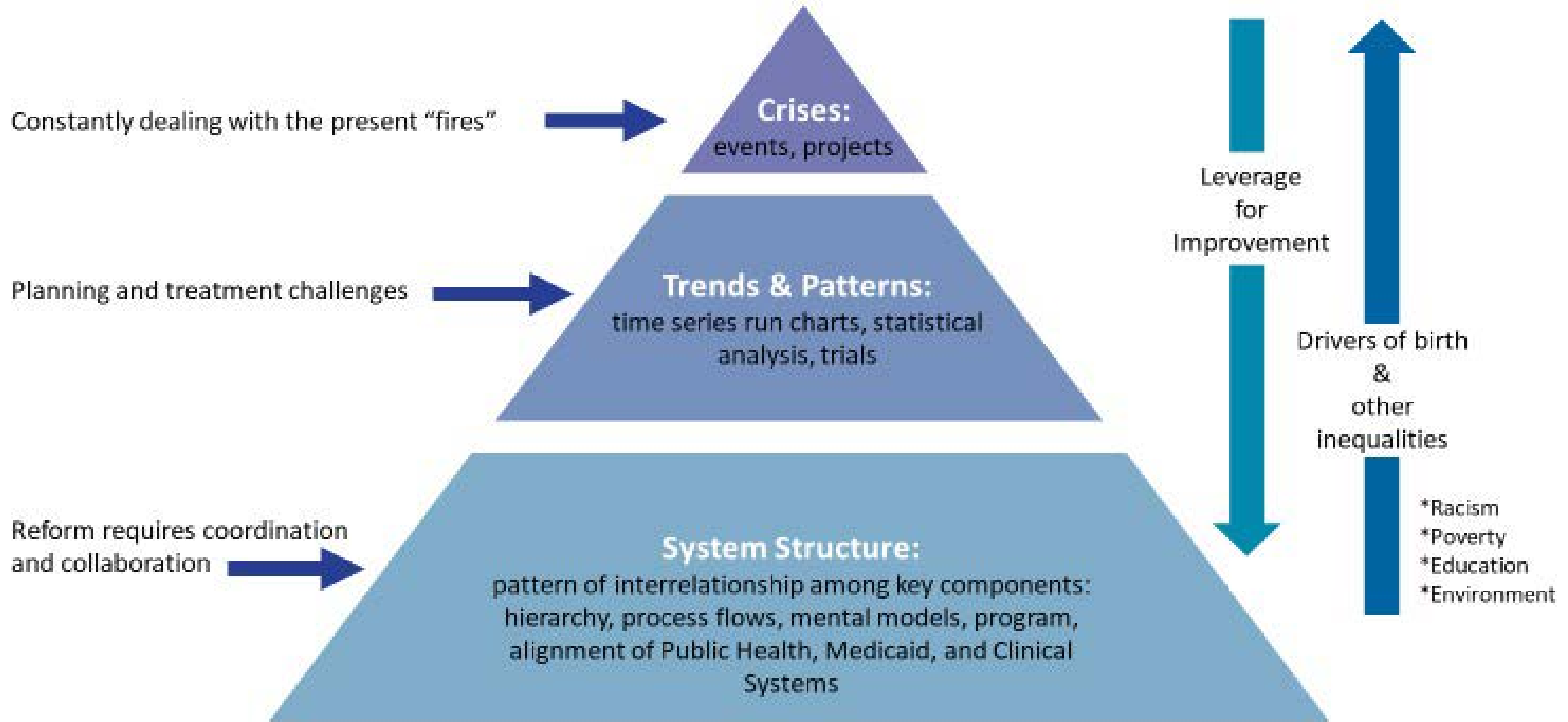
Improving Maternal Health Using Population Health Strategies

Mary Applegate, MD, FAAP, FACP
Medical Director
Ohio Department of Medicaid

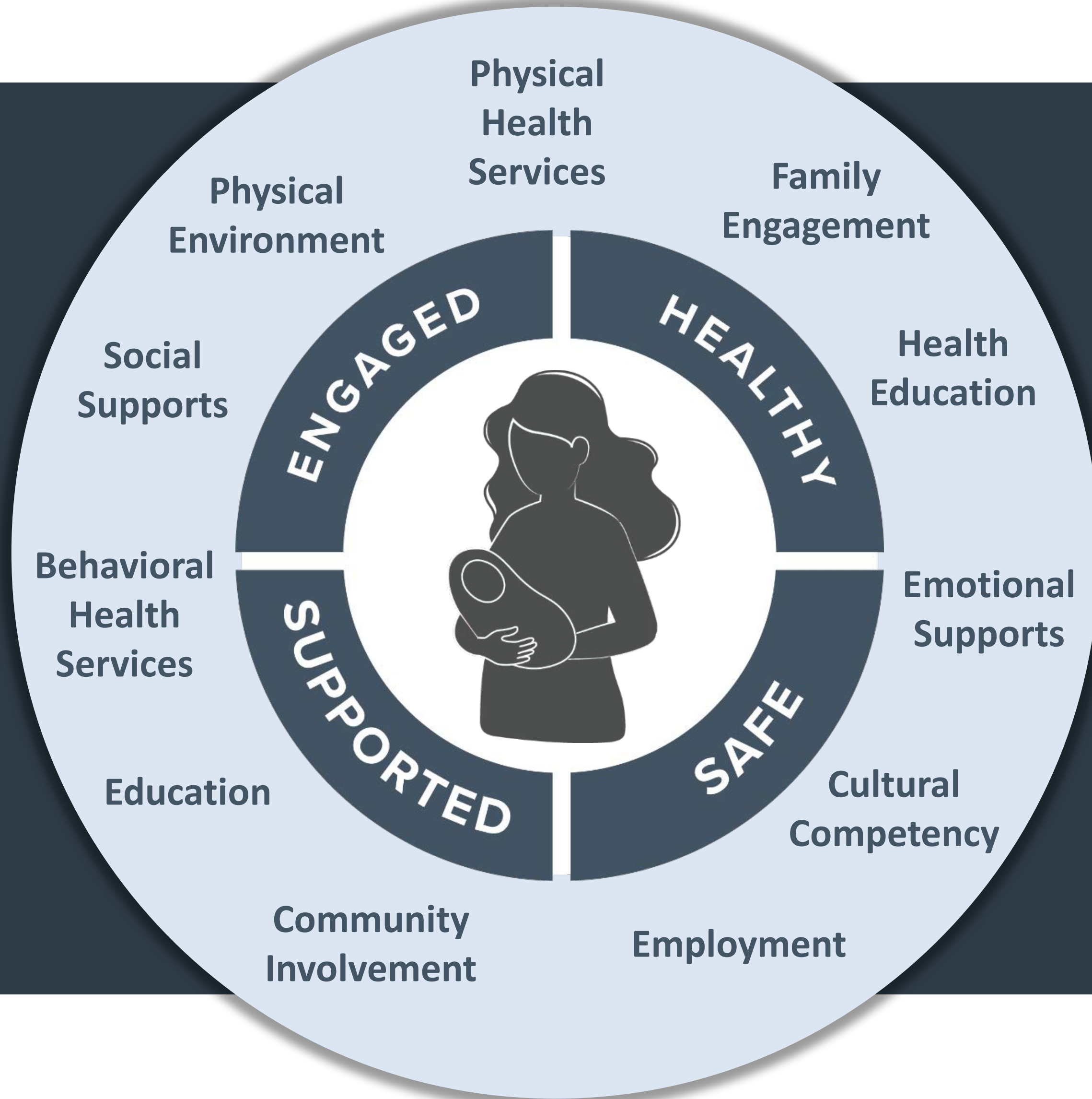
March 31, 2022

The Next Generation of Managed Care: Beyond Payment




Why is Improving Health Outcomes SO Difficult?
Constantly dealing with the present "fires"
Crises:
events, projects
Planning and treatment challenges
Trends & Patterns:
time series run charts, statistical analysis, trials
Reform requires coordination and collaboration
System Structure:
pattern of interrelationship among key components: hierarchy, process flows, mental models, program, alignment of Public Health, Medicaid, and Clinical Systems
Leverage for Improvement
Drivers of birth & other inequalities
*Racism
*Poverty
*Education
*Environment
CHANGE: Organizations need structures, processes, & cultures that support desired outcomes

Ohio's Maternal and Infant Support Program (MISP)



Coordinating Policy, Process and Practice

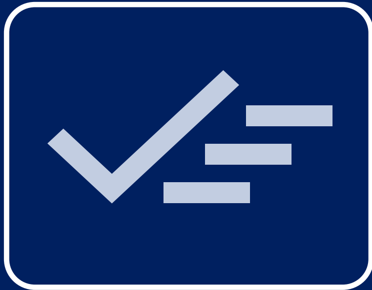
Integrating evidence-based and evidence-informed services within the healthcare system in conjunction with Governor DeWine's Task Force

Key Infant Mortality Community Learnings

In communities with Medicaid-funded CBOs, women have expressed the following key barriers to improved health outcomes:

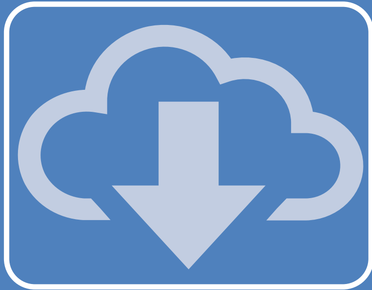
- ✓ Lack of Trust of the Health Care System
- ✓ Lack of Provider Empathy
- ✓ Lack of Effective Communication from Providers
- ✓ Lack of Social Supports
- ✓ Lack of Community Resources
- ✓ Lack of Medicaid Coverage of Alternative Providers and Services

Ohio's Maternal and Infant Support Program (MISP)



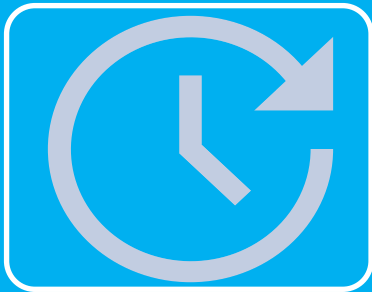
Complete

- Pregnancy Risk Assessment Form/Report of Pregnancy
- Group Pregnancy Education and Group Prenatal Care
- Nurse Home Visiting
- Lactation Consulting and Breastfeeding



In process

- 12 months postpartum eligibility
- **Comprehensive Maternal Care**
- Renewal of Ohio Equity Institute Infant Mortality Grants



This biennium

- Lactation consultants
- Doulas
- Mom and baby dyad
- Welcome Home visits

Comprehensive Maternal Care (CMC) is designed for customized, high-quality, continuous and comprehensive **equitable** care

✓Improved maternal and infant outcomes

✓Improved provider cultural competency

✓Improved patient experience

✓Improved cross-system collaboration

- Give women and their families the clinical and community supports they need to improve outcomes, while helping them build a longitudinal trusting relationship within the health care system
- Deliver person-centered, customizable interventions to women and babies by creating a framework for providers and community partners to work together

Patient Journey

Continuous Eligibility

Patient Identification

"No Wrong Door"

-Notification of Pregnancy or PRAF

-OBs, Hospitals, FQHCs, Emergency Department, PCPs, etc.

Risk Tiering and Attribution

-Completed by Ohio Department of Medicaid

-Algorithm defined by state based on claims, vital stats, PRAF data, etc.

-Determine risk tiering for each woman

-Attribute to provider based on algorithm defined by the state

Planning and Engagement

- Informed Consent

-PRAF completed, if applicable

-Provider identifies MISP options based on patient risk assessment and provides choice to woman

-Linkage to selected partnering entities

-Can be performed at any prenatal appointment

Team-Based Care

- Provider coordinates ongoing health care and community supports

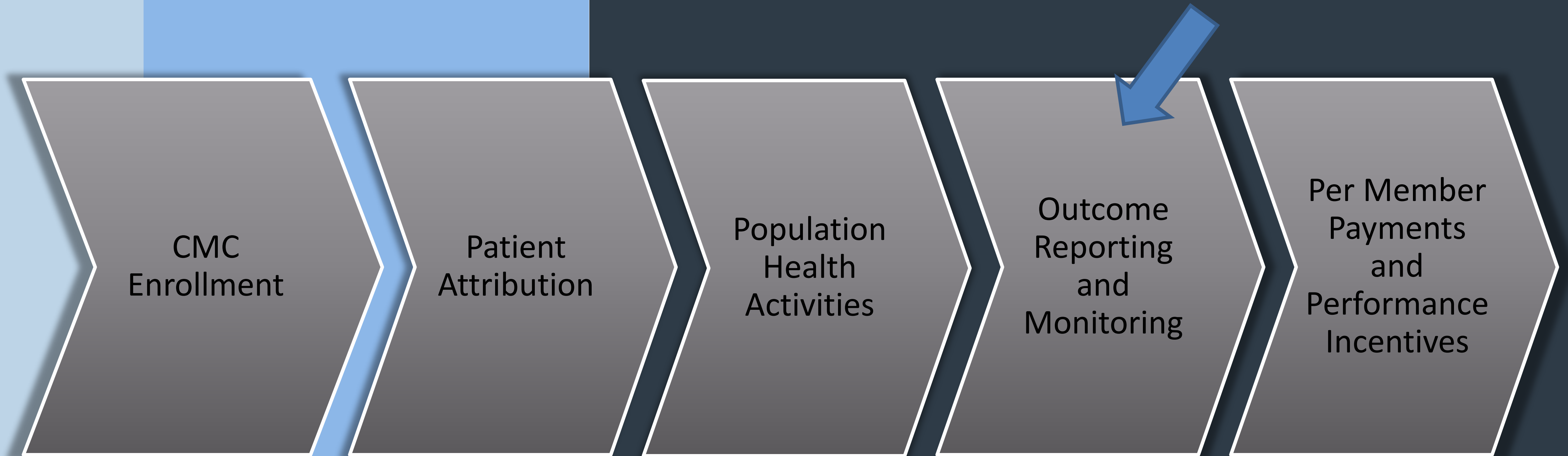
-Uses a family-centered approach to deliver customized interventions to the patient and her family

-Routine, planned multidirectional communication with the team, including the patient, OB, PCP, and pediatrician

Postpartum Care

Routine Source of Primary Care

Components of CMC Model



Proposed Comprehensive Maternity Care Measures

- Postpartum Care
- HIV Screening
- Hepatitis B Screening
- Tdap Vaccination
- Tobacco Cessation
- Primary Care Visits for Mother
- Prenatal Visits by Nine Weeks Gestation
- Breastfeeding
- Preterm Birth
- Percentage of Low Birthweight Births
- **NTSV: Low Risk Cesarean Delivery Rate**
- Dental Visit
- Infant Well Care Visit
- Flu Vaccination
- Maternal Depression Screening
- WIC Enrollment

- Disparities in all of the above

NTSV Cesarean Birth Rate

The percentage of nulliparous, full-term (37-42 weeks), singleton, vertex-presenting deliveries of live births that were cesarean births

- **Anchor Date:** Date of Delivery
- **Payment Status**: Information only for year one
- **Denominator:** Members who were attributed to a CMC provider for at least six months during their pregnancy (need not be continuous), whose pregnancy resulted in a live birth (birth records), and whose pregnancy and delivery meet the following additional criteria:
    - are nulliparous (birth records, using the fields PLBL and PLBD)
    - delivery is between 37 and 42 weeks
    - singleton births (birth records, using the field PLUR)
    - vertex presentation – exclude cases with a non-vertex presentation diagnosis (**Non-Vertex Presentation**)
- **Numerator:** Number of women with a Cesarean section (value set **Cesarean Section**) or with delivery method 'primary cesarean section' according to birth records (using the field DelMethodCD).
- **Data Sources:** Medicaid administrative data linked to Vital Statistics Birth records.
- **Measurement Period:** Rolling 12-month measurement period updated on a quarterly basis, based on the latest accurate data available. The date of delivery must occur in the measurement period for inclusion in this measure.
- **Measure Steward:** CMC-specific measure
- **References**: https://manual.jointcommission.org/releases/TJC2020A1/MIF0167.html (PC-02)

C-section Rates in Perinatal Episodes

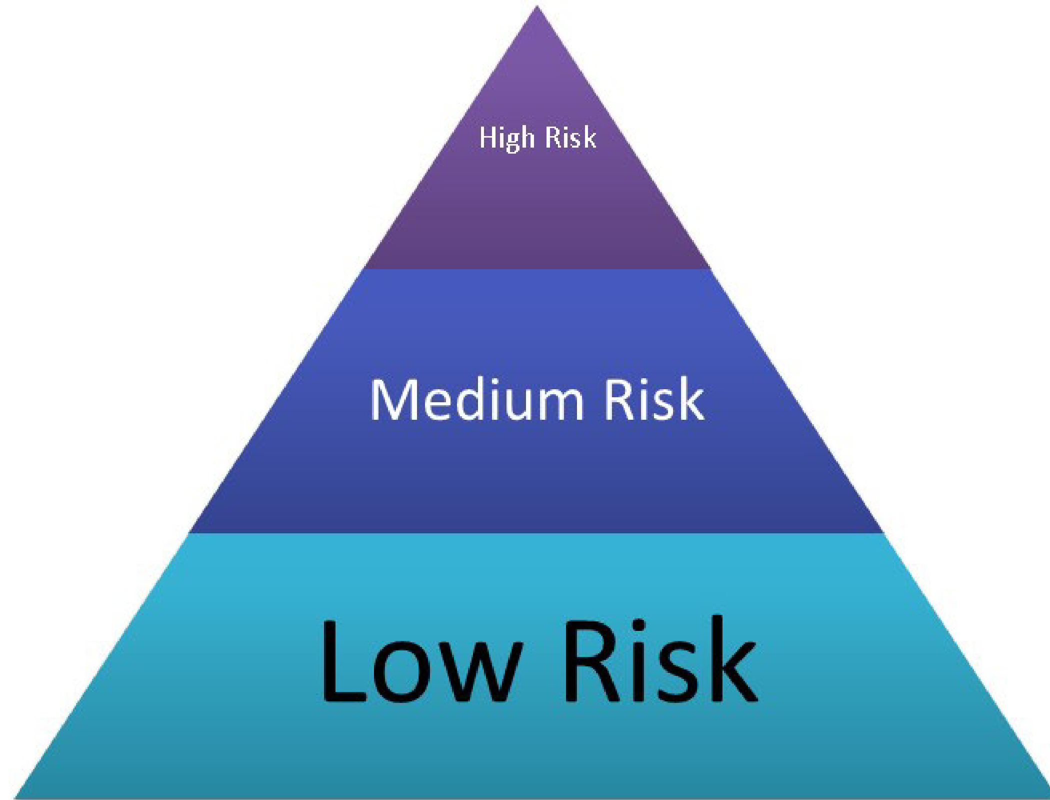
- ~61-70k episodes per calendar year, 2017-2020
- Average c-section rate across all risk groups ~31.5-32.5%

Percent of Total Births

~1%

~8%

~91%



C-Section Percent of Births

~60-63%

~42-46%

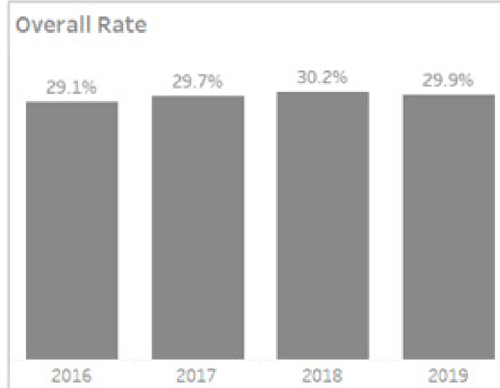
~30-31%

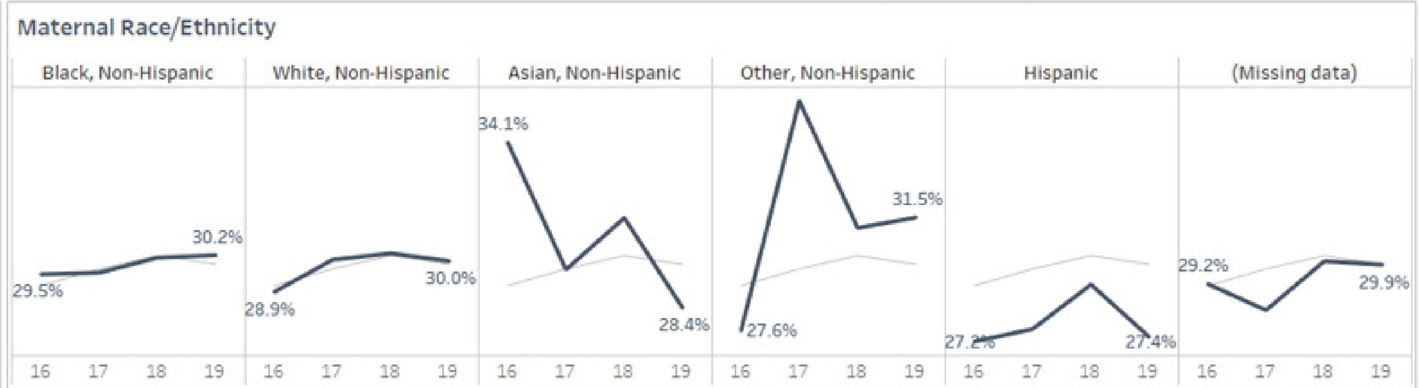
Perinatal Episode

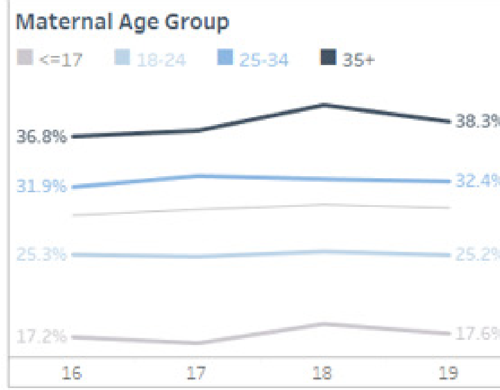
C-Section Details

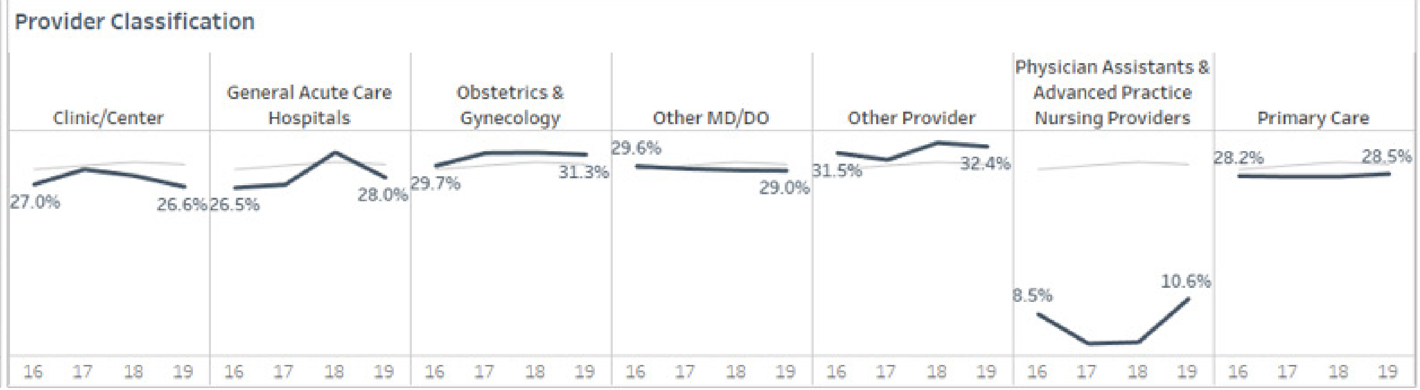
Select Quality Measure
- HIV Screening
- C-Section (selected)
- Follow-up Visit
- Chlamydia Screening

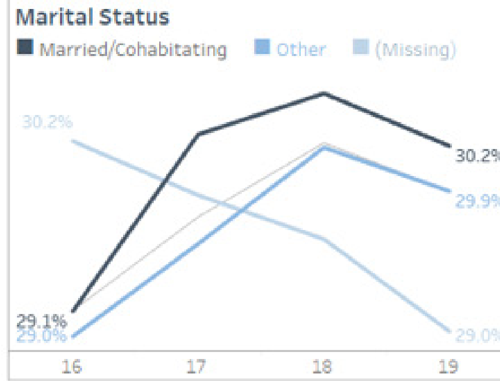
Which Episodes?
- (All)
- Valid (checked)
- Excluded

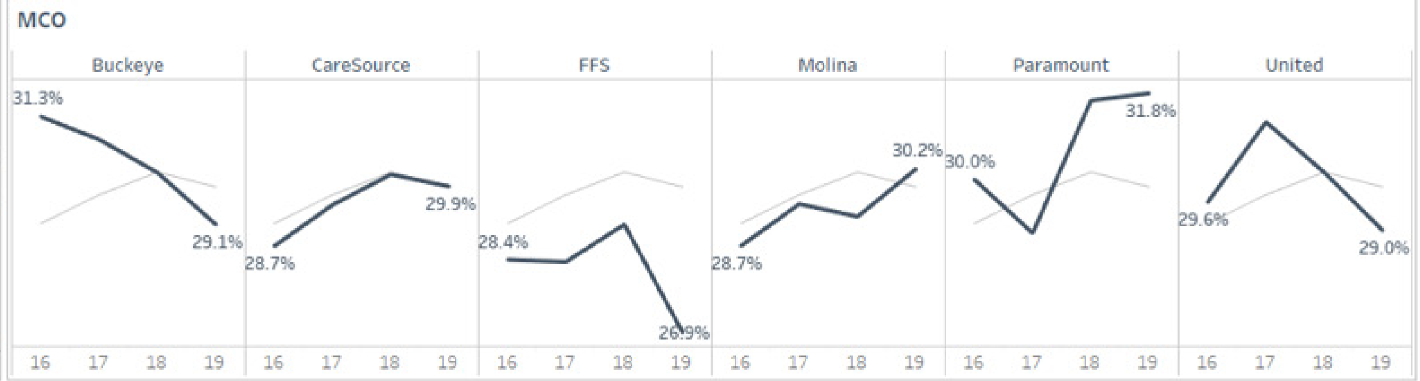












Ohio's Next Generation of Managed Care

- **Low Risk Cesarean Delivery is part of a suite of markers for Quality.**

- **The primary locus of influence is within hospitals.**
  - (hospital associations, perinatal quality collaboratives)

- **Medicaid programs can have some influence through:**
  - Payment (Vaginal=Cesarean delivery rates)
  - Value-based models of care such as CMC; hospital contracting
  - Expanded workforce: more family physicians, midwives, doulas
  - Opportunities related to alternative birthing units that prioritize the birthing experience for mothers from minority communities
  - Support for perinatal quality improvement efforts
    - (PQCs, LCs, PIPs, population health management/equity approaches)

CMQCC
California Maternal
Quality Care Collaborative

California / CMQCC's Initiative to Support Vaginal Births and Reduce Low-Risk Cesarean Deliveries

Elliott K. Main, MD
Medical Director
California Maternal Quality Care Collaborative
Clinical Professor, Department of Ob/Gyn
Stanford University School of Medicine
emain@Stanford.edu

United States Overall (Total) and NTSV Cesarean Rates:1990-2013

- 50% rise in cesarean section (CS) rates over a 10 year period
- Cesarean deliveries account for 1/3 US births and are the most common hospital surgery

Osterman M etal, NVSR vol 63, num 6, Nov 2014

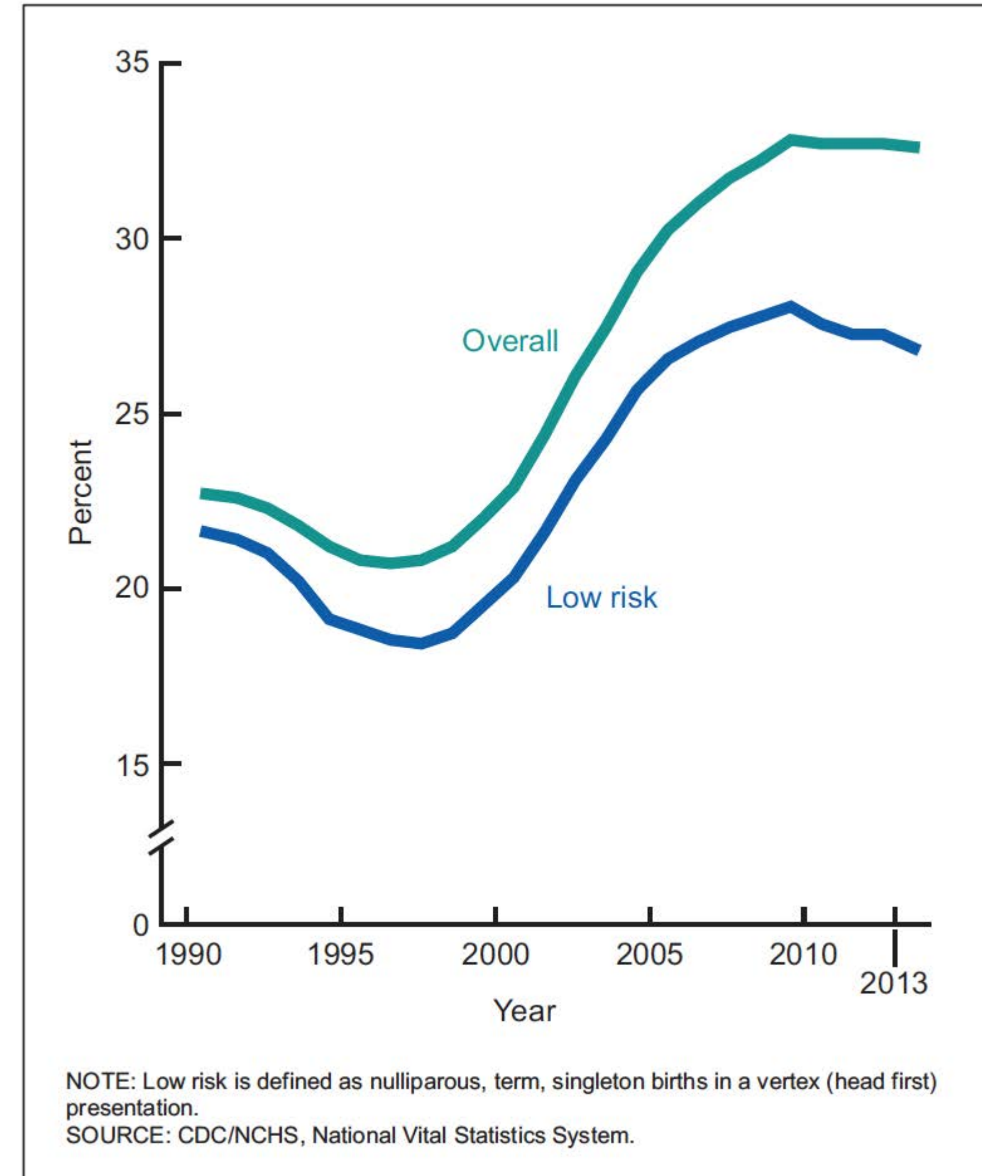


Figure 1. Overall cesarean delivery and low-risk cesarean delivery: United States, final 1990–2012 and preliminary 2013

CMQCC

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

DOI: 10.1377/hlthaff.2012.1030
HEALTH AFFAIRS 32,
NO. 3 (2013): 527-535
©2013 Project HOPE—
The People-to-People Health
Foundation, Inc.

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.

Katy Backes Kozhimannil (kbk@umn.edu) is an assistant professor in the Division of Health Policy and Management, School of Public Health, University of Minnesota, in Minneapolis.

Michael R. Law is an assistant professor in the Centre for Health Services and Policy Research, School of Population and Public Health, at the University of British Columbia, in Vancouver.

Beth A. Virnig is associate dean of research and a professor at the School of Public Health, University of Minnesota.

Major Maternal Complications: Vaginal Births versus Primary Cesareans, Repeat Cesareans, and VBAC

CMQCC

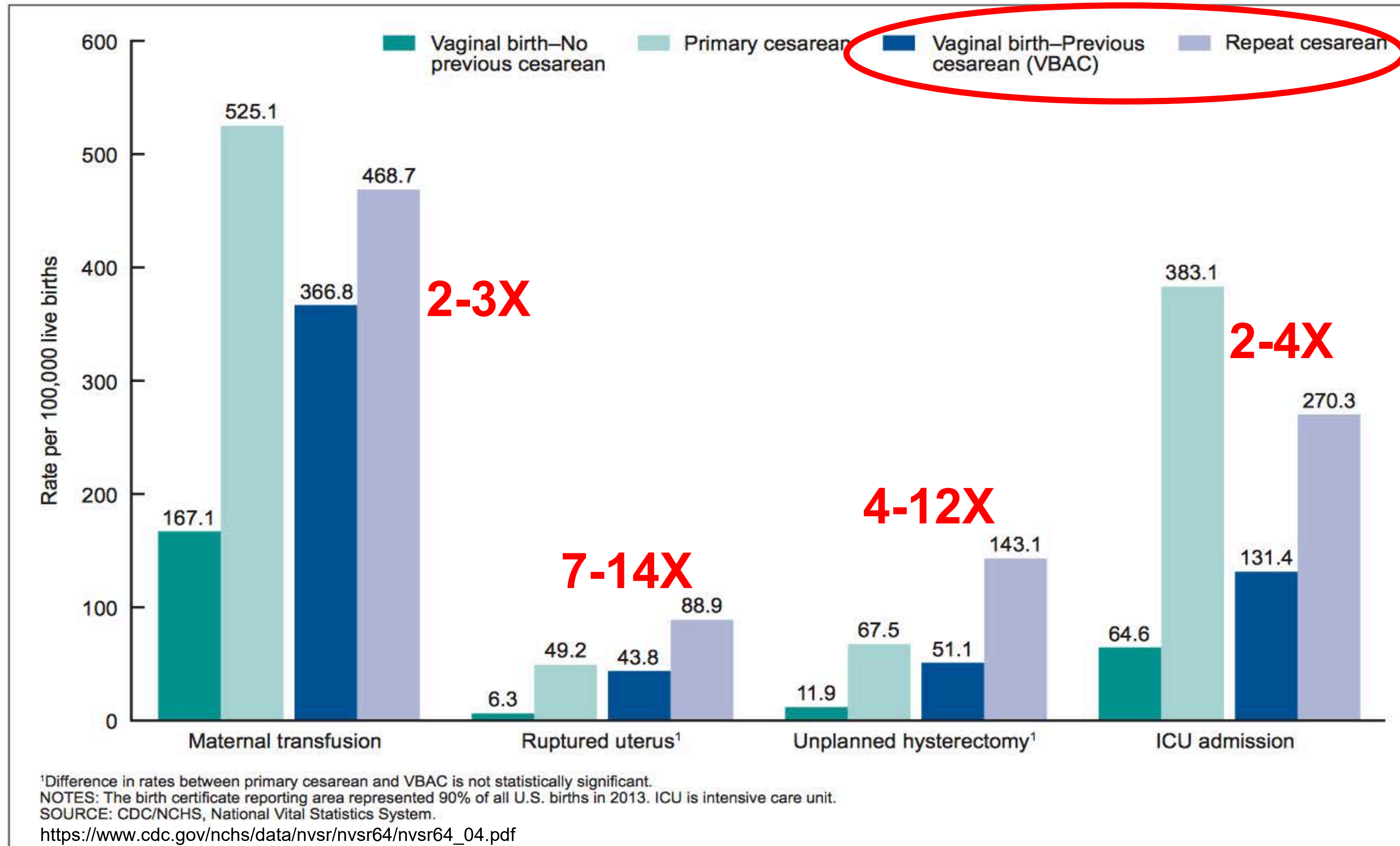


Figure 1. Maternal morbidity, by method of delivery and previous cesarean history: 41-state and District of Columbia reporting area, 2013

Importance of the First Labor and Birth

If a woman has a Cesarean birth in the first labor, over 90% of ALL subsequent births will be Cesarean births

If a woman has a vaginal birth in the first labor, over 90% of ALL subsequent births will be vaginal births

Low-risk Cesarean Delivery Rate
aka Nulliparous, Term, Singleton, Vertex (NTSV)

- Risk Stratified ("standard population")
  - No further risk-adjustment needed
- Widely adopted nationally
  - ACOG: Task Force on Cesarean Section rates (2000)
  - HHS: Healthy People 2010, 2020, 2030 (Low-risk First-birth CS)
  - NQF endorsed, The Joint Commission (TJC) Perinatal Core Measure (PC-02), CMS Child Core Set Measure Set, LeapFrog, US News & World Report
- >20 years experience
- National data and trends available (annual National Center for Health Statistics)
- States can use birth certificate data and come within 0.1-0.2% of TJC PC-02

COUNCIL ON PATIENT SAFETY IN WOMEN'S HEALTH CARE
safe health care for every woman

PATIENT SAFETY BUNDLE

Safe Reduction of Primary Cesarean Births

SAFE REDUCTION OF PRIMARY CESAREAN BIRTHS: SUPPORTING INTENDED VAGINAL BIRTHS

READINESS

Every Patient, Provider and Facility

- Build a provider and maternity unit culture that values, promotes, and supports spontaneous onset and progress of labor and vaginal birth and understands the risks for current and future pregnancies of cesarean birth without medical indication.
- Optimize patient and family engagement in education, informed consent, and shared decision making about normal healthy labor and birth throughout the maternity care cycle.
- Adopt provider education and training techniques that develop knowledge and skills on approaches which maximize the likelihood of vaginal birth, including assessment of labor, methods to promote labor progress, labor support, pain management (both pharmacologic and non-pharmacologic), and shared decision making.

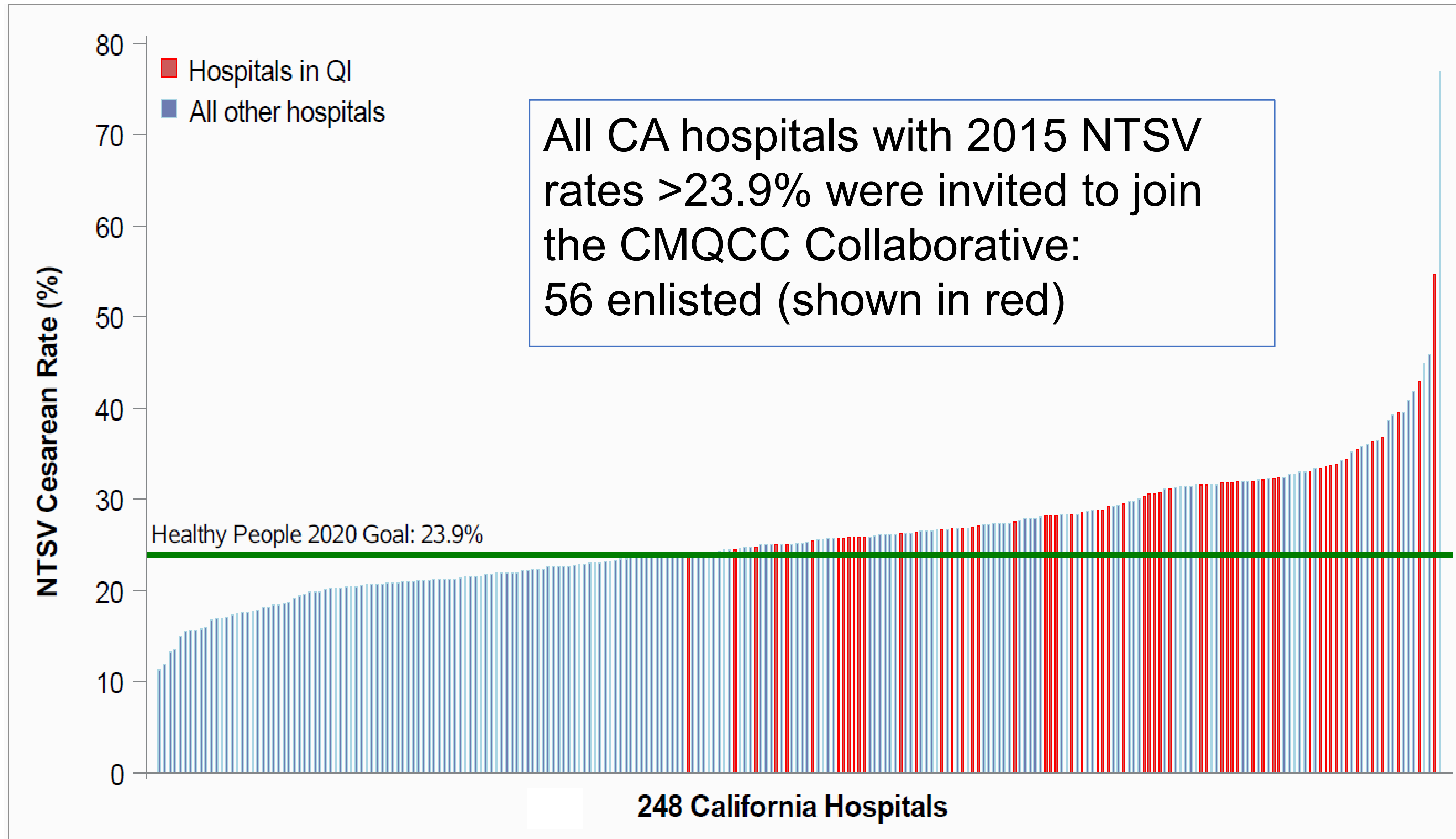
RECOGNITION AND PREVENTION

Every patient

- Implement standardized admission criteria, triage management, education, and support for women presenting in spontaneous labor.
- Offer standardized techniques of pain management and comfort measures that promote labor progress and prevent dysfunctional labor.
- Use standardized methods in the assessment of the fetal heart rate status, including interpretation, documentation using NICHD terminology, and encourage methods that promote freedom of movement.
- Adopt protocols for timely identification of specific problems, such as herpes and breech presentation, for patients who can benefit from proactive intervention before labor to reduce the risk for cesarean birth.

Variation in NTSV Cesarean Rate among CA Hospitals (2015)

CMQCC



KEY RESOURCES:

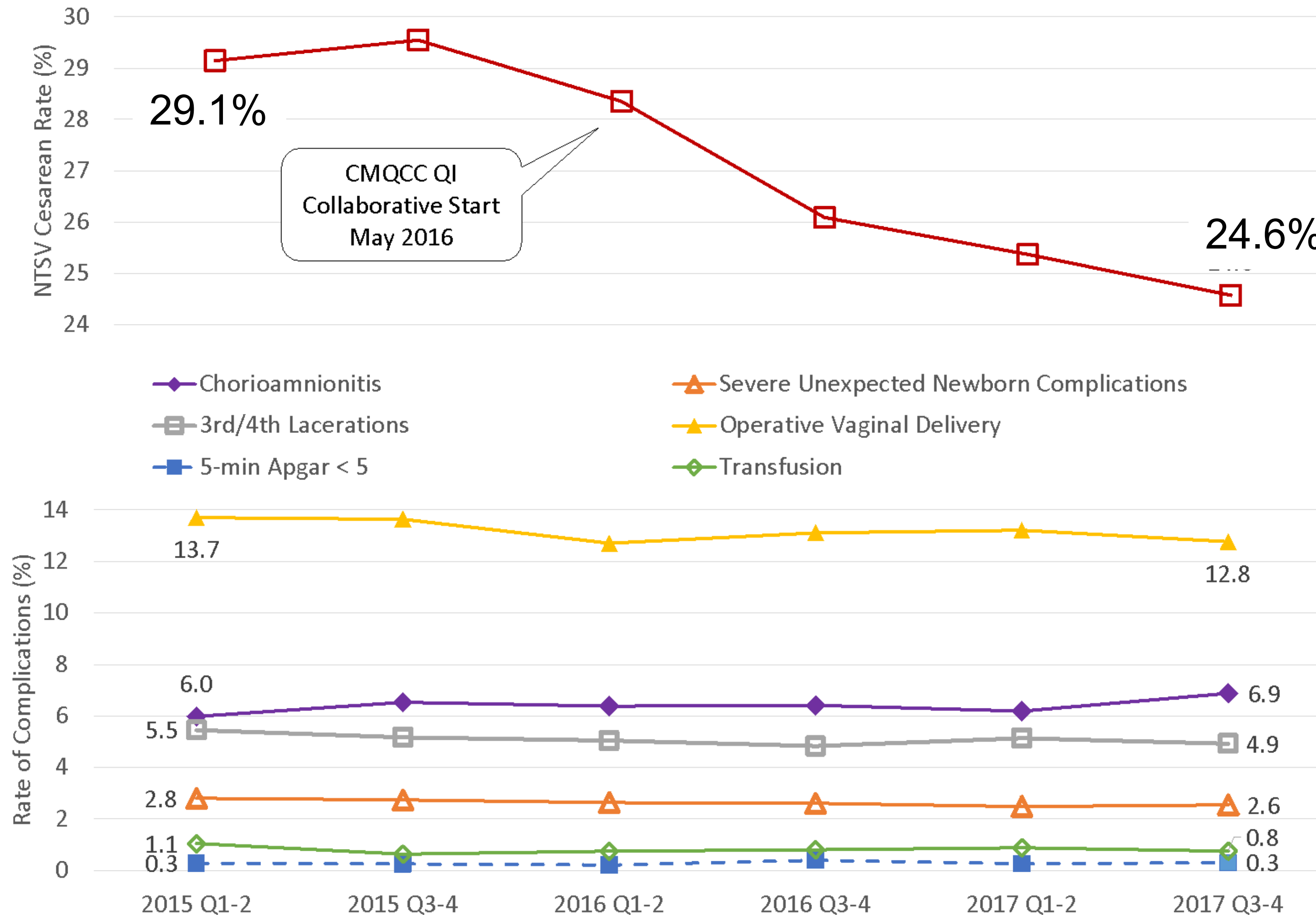
COMMON QI ACTIVITES:

1) Labor support techniques
2) Active phase guidelines
3) CS rate transparency (unit and provider)
4) Latent phase guidelines
5) Induction guidelines
6) Techniques to reduce occiput posterior (face up fetal presentation)
7) Patient engagement
8) Unit culture/teamwork
9) Longer 2nd Stage

(in approximate order of use)

Trendlines for NTSV Cesarean and Safety Measures Rates (6-month blocks)

CMQCC



Early results in these 56 hospitals showed promising reductions and safety!

All balancing (safety) metrics showed no harm from lowering the NTSV cesarean delivery rate

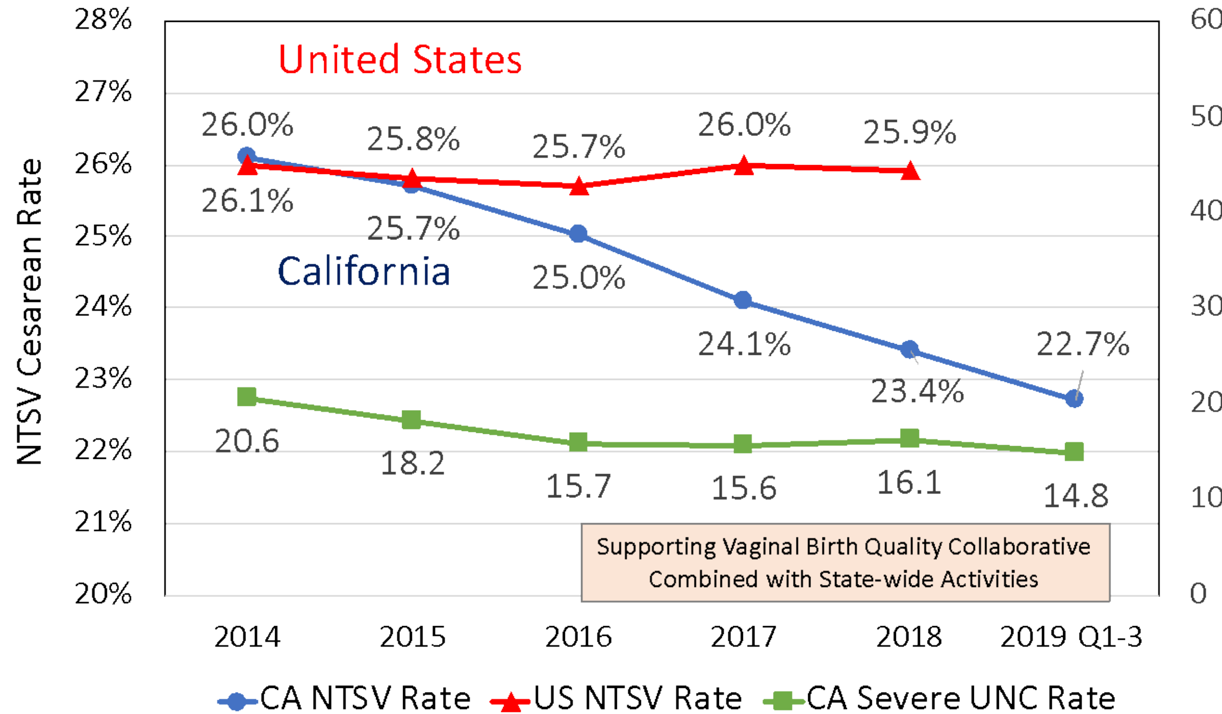
In fact, baby outcomes were better!

Main E. etal. Obstet Gynecol 2019;133:613-23.

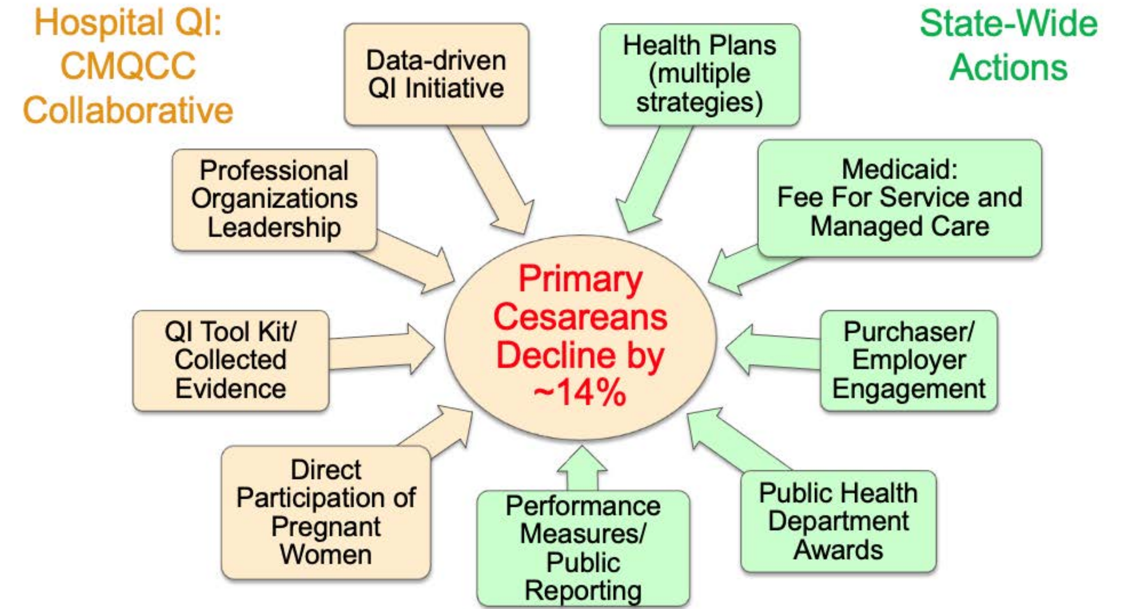
CMQCC Collaborative to Reduce Primary Cesarean Birth

CMQCC

First Birth Low-Risk Cesarean Rate



State-wide Initiative Activities



Collaborative Action : Collective Impact

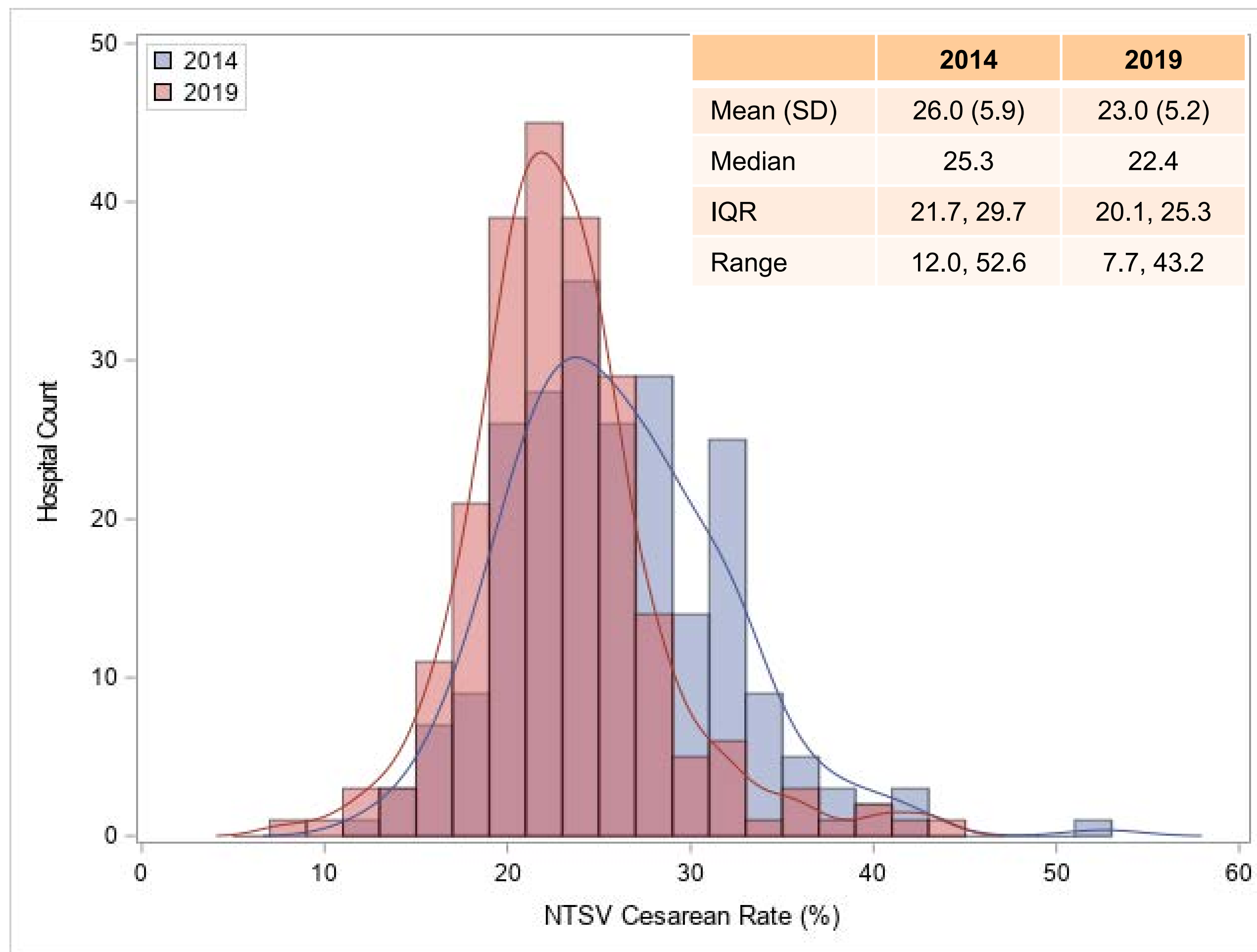
- Hospital level variation is dramatic for all OB metrics
- In 2014, hospital variation was extreme: 14% to 70%
- In 2020, variation still present but much more limited

Rosenstein MG, Chang S-C, Sakowski C, Markow C, Teleki S, Lang L, Logan J, Cape V, Main EK. Hospital Quality Improvement Interventions and Statewide Policy Initiatives and Rates of Nulliparous Term Singleton Vertex Cesarean Deliveries in California. JAMA 2021. Apr 27;325(16):1631-1639.

Distribution of NTSV Cesarean Rate Among California Hospitals

CMQCC

-- Comparison of 2014 to 2019, 226 Hospitals --



	2014	2019
Mean (SD)	26.0 (5.9)	23.0 (5.2)
Median	25.3	22.4
IQR	21.7, 29.7	20.1, 25.3
Range	12.0, 52.6	7.7, 43.2

Parametric Test	Statistics
Paired t-test (equality of means)	$P = 0.03$
Pitman's test (equality of variances)	$P < 0.01$

Non-Parametric Test	Statistics
Difference in medians	2.9, 95% CI: 1.6-4.1
Difference in IQR	2.8, 95% CI: 1.2-4.3

This Project Meets All 3 Goals of a large-scale QI Initiative:

- Significant reduction in mean CS rates
- Significant reduction in variation (narrowing of the distribution curves)
- Reduction of outliers (hospitals with rates >30%)

CMQCC

Recognition

- CalHospitalCompare.org
- Yelp
- Joint Commission Measure
- Yearly Recognition by the CA Secretary of HHS for Hospitals With NTSV CS Rates <23.9%

Mother and Baby

	Current	State Average
C-Section Rate (NTSV)	AVERAGE 25.1% (lower is better)	25.4% (lower is better)
Breastfeeding Rate	SUPERIOR 92.6%	68.5%
Episiotomy Rate	AVERAGE	9.5%
VBAC Routinely Available		
VBAC Rate		

yelp

Find car wash, oil change, auto repair | Near Sausalito, CA | Sign Up

Restaurants | Nightlife | Home Services | Write a Review | Events | Talk | Log In

El Camino Hospital Claimed

320 reviews Details

Write a Review | Add Photo | Share | Bookmark

Hospitals, Emergency Rooms, Obstetricians & Gynecologists

2500 Grant Rd
Mountain View, CA 94040
Get Directions
(650) 940-7000
elcaminohospital.org
Message the business
Send to your Phone

Photo of El Camino Hospital - Mountain View, CA, United States

See all 93

Find a Doctor | View Now

"The staff is also wonderful they always make the patients and relatives feel welcome and make sure the patients are well taken care of." in 10 reviews

"The credit goes to the entire team - a skilled surgeon and the team in the operating room, the nursing staff and all the support staff." in 10 reviews

"This review is for the Women's Hospital Labor & Delivery Unit / NICU I can't say enough positive things about my delivery and postpartum experience at this hospital!" in 4 reviews

Ask the Community

How do I sign up to my records online?

You need to register with your care provider

Maternity Care Data | View More

Based on data from Cal Hospital Compare

C-Section Rate: Average Rate

Breastfeeding Rate: Well Above Average Rate

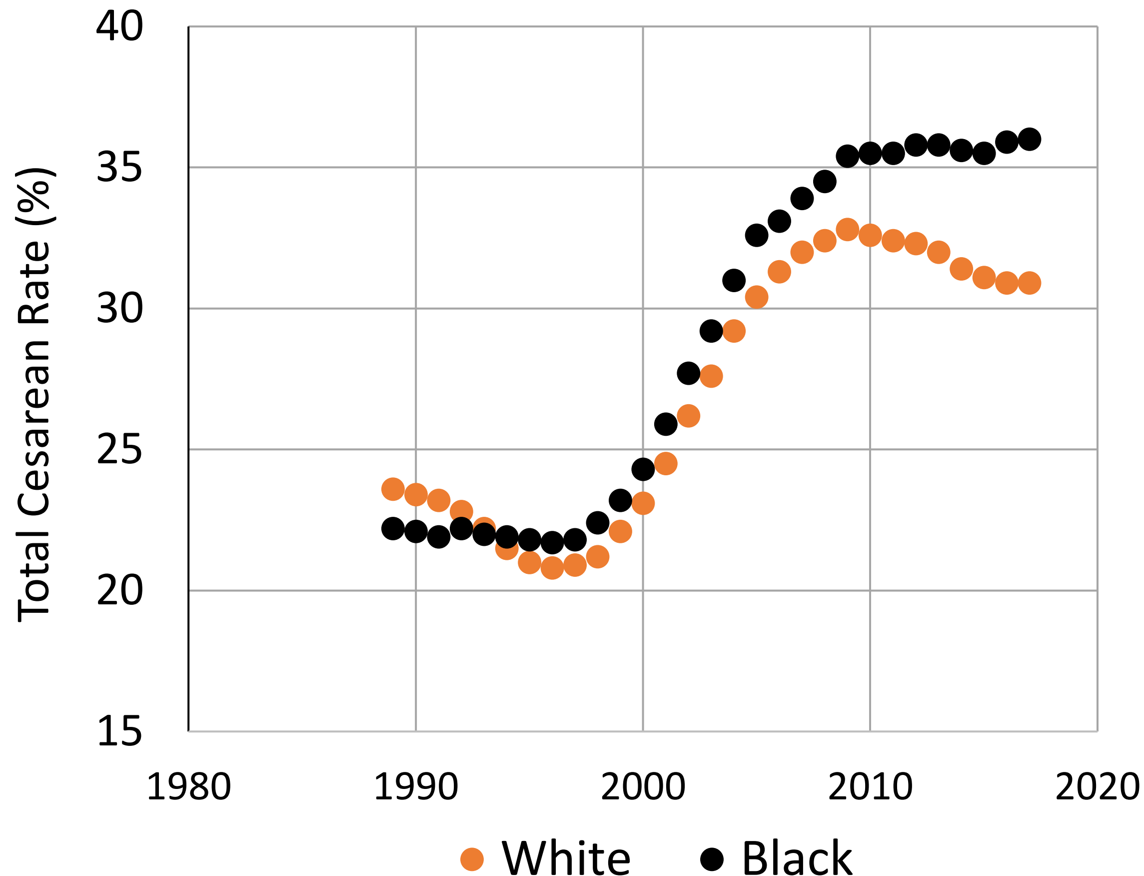
Episiotomy Rate: Average Rate

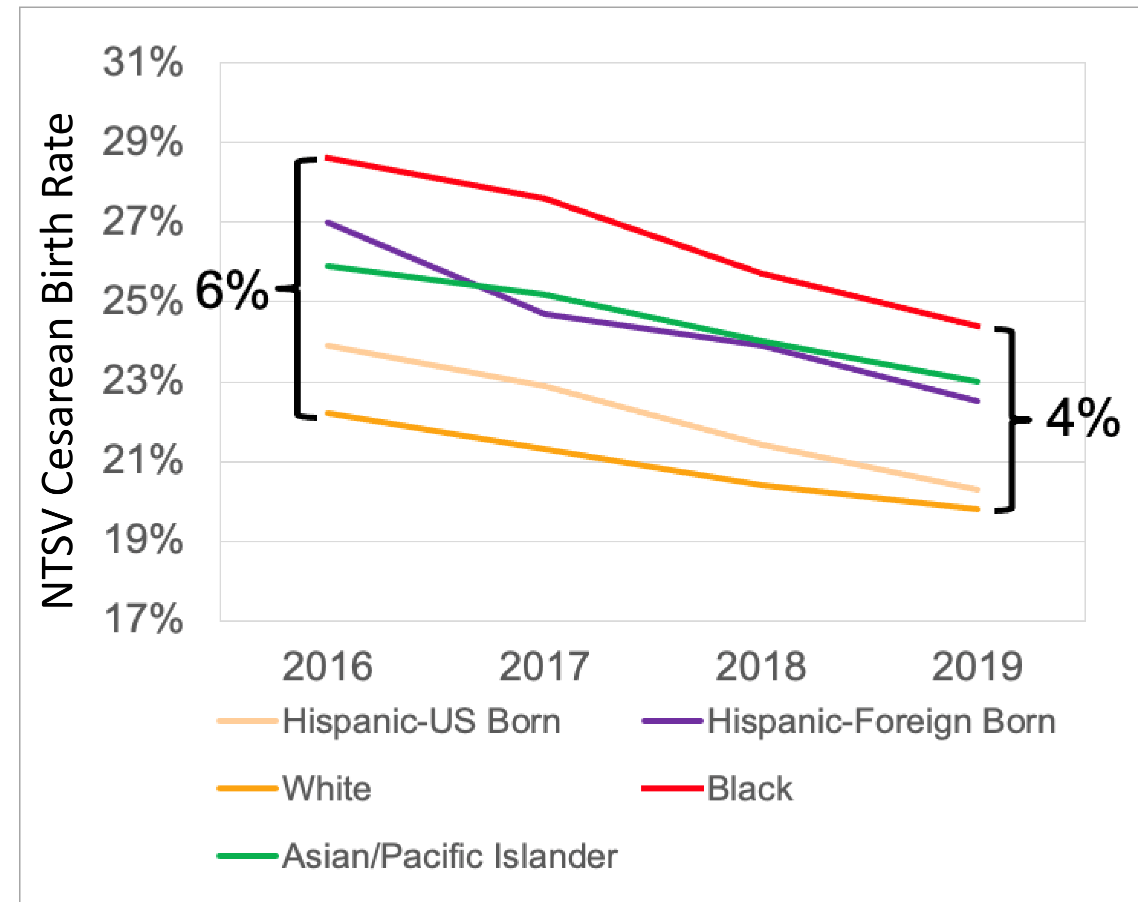
VBAC Routinely Available: Yes

VBAC Rate: Below Average Rate

Health Plan and Purchaser Engagement

- SmartCare California
  - Consortium of purchasers and payers developed engagement strategies
- Covered California (Affordable Care Act purchasing organization)
  - Pushed Health Plans to contract with hospitals meeting target or engaged with collaborative
- Some Commercial and Managed Medicaid Health Plans added NTSV CS to their quality incentive program
- Medicaid (Medi-Cal) structured their CMS 1115 Waiver program to include incentives for safety net hospitals to meet NTSV target
- Beginning in 2022 all California Medicaid MCOs will report their NTSV CS rates



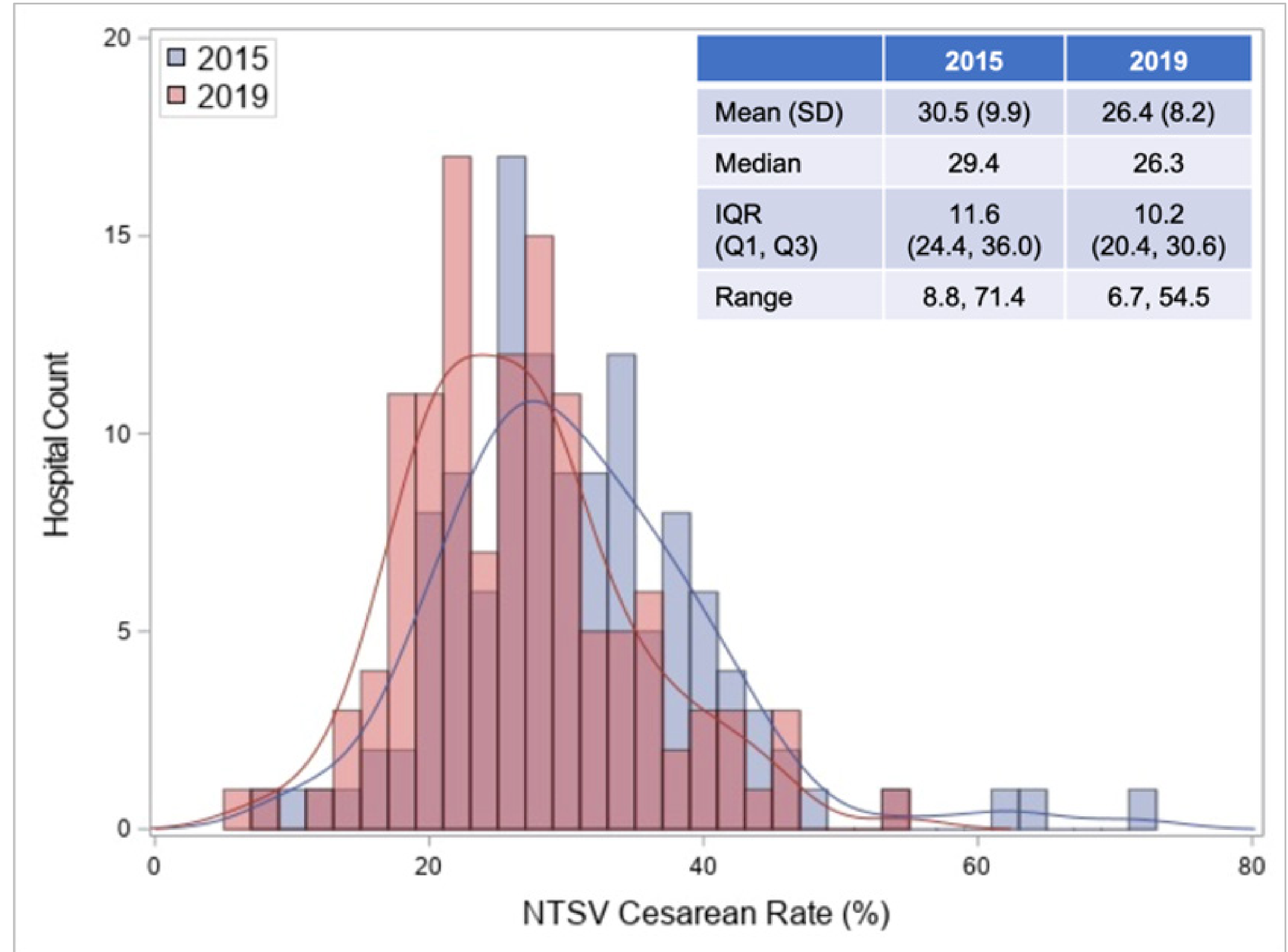


- Until 1995 Black women had lower Cesarean rates than White women
- The Black:White Cesarean rate disparity is actually worsening since 2010

- All races demonstrated significant improvement
- Black mothers decreased more than others, narrowing the difference
- Can standardized care reduce the subjectivity (and bias) in labor decisions?

Hospital NTSV CS Rates for Black Persons

- 123 hospitals with at least 10 Black NTSV births
- Similar shift in distribution from 2015 to 2019
- Note the large number of hospitals that met the HP2020 target for their Black population



	2015	2019
Mean (SD)	30.5 (9.9)	26.4 (8.2)
Median	29.4	26.3
IQR (Q1, Q3)	11.6 (24.4, 36.0)	10.2 (20.4, 30.6)
Range	8.8, 71.4	6.7, 54.5

Reducing Low Risk Cesarean Deliveries Can be Done: 4 Lessons

- “Don’t try this alone”…collect as many partner organizations as possible
- Good and timely data is critical
- Co-lead with an experienced OB QI organization to help lead change (e.g., state perinatal quality collaborative)
- Pull every lever…

Questions

Doris Lotz, Mathematica

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

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

Chat
To: Host
Enter chat message here
Q&A
All (0)
Ask: All Panelists
Select a panelist in the Ask menu first and then type your question here. There's a 256-character limit.
Send

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

Announcements and Next Steps

Kate Nilles, Mathematica

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

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**
  - State Medicaid and CHIP Agencies and Obstetrical Partners: Working Together to Reduce Low-Risk Cesarean Deliveries: **TBD**
  - Using Data to Plan and Assess Quality Improvement Strategies to Reduce Low-Risk Cesarean Delivery in Medicaid and CHIP: **TBD**
  - Informational webinar: Improving Maternal Health by Reducing Low-Risk Cesarean Delivery Affinity Group: Overview and Process for Expression of Interest: **TBD**
- **Register for additional webinars at https://mathematica.webex.com/mathematica/onstage/g.php?PRID=b8c2078478d3be51928f2d528cb7a26c**

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

Resources

- **MIHI Webpage: https://www.medicaid.gov/medicaid/quality-of-care/improvement-initiatives/maternal-infant-health-care-quality/index.html**
- **Maternal and Infant Health Beneficiary Profile: https://www.medicaid.gov/medicaid/quality-of-care/downloads/mih-beneficiary-profile.pdf**
- **Maternal and Infant Health Expert Workgroup Report of Recommendations: https://www.medicaid.gov/medicaid/quality-of-care/downloads/mih-expert-workgroup-recommendations.pdf**
- **Maternity Core Set Information: https://www.medicaid.gov/medicaid/quality-of-care/improvement-initiatives/maternal-infant-health/data-and-measurement/index.html**

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

Thank you for participating!

- 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

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