

Mathematica State Medicaid and CHIP Agencies and Obstetrical Partners Working Together to Reduce Low-Risk Cesarean Deliveries-20220610 1700-1

[Lekisha Daniel-Robinson] Hello everyone. Welcome to today's webinar, State Medicaid and CHIP Agencies and Obstetrical Partners Working Together to Reduce Low-Risk Cesarean Deliveries.

Before we even get to today's session, please note that questions may be submitted via the Q&A function to the right of your screen. You may also reference the instructions that will be available in the chat. Given that we have a very full agenda today, we hope to answer as many questions as possible. But if, by chance, we don't get to your question, you may submit them to the mailbox, which will be available at the end of the presentation. Next slide, please.

The objectives for today are to provide an overview of CMS's Maternal and Infant Health Initiative, describe the improving maternal health by reducing low-risk cesarean delivery learning collaborative, to understand Medicaid's role in leading, convening, and/or coaching quality improvement partnerships, focused on improving maternal and infant health by reducing LRCDs. And finally, to learn about state programs and policy initiatives to LRCD.

As I mentioned, our agenda is packed for today, but we will begin with Kristen Zycherman who will provide an overview of the initiative, and then we will move to four state presentations: Oregon, Illinois, New Jersey, and South Carolina. We will ask for questions following those, but throughout the presentation, feel free to enter them into the Q&A feature, and then we will address them during that period before closing out. Next slide, please.

I'd like to now turn it over to Kristen Zycherman from CMS.

[Kristen Zycherman] Thank you so much, and on behalf of CMS, just want to welcome everybody and thank you for joining this presentation. Next slide, please.

As many of you know, the Maternal and Infant Health Initiative was launched in 2014. But in 2019 and 2020, we reconvened an expert workgroup to develop new recommendations. The three current MIHI focus areas are increasing the use and quality of postpartum care visits, increasing the use and quality of infant well-child visits, and this focus, reducing the rate of low-risk cesarean delivery in order to improve maternal outcomes. Next slide, please.

This is the second webinar in our three-webinar series, so encourage you all to join back with us for webinar three, as well as any states that are interested in a more action-oriented affinity group to join the informational webinar for that process. Next slide, please.

The Low-Risk Cesarean Delivery Affinity Group is, as I said, more action-oriented with our quality improvement team, doing one-on-one coaching, as well as group coaching, to help states and their care partners improve their rates of low-risk cesarean delivery through quality improvement projects. The expressions of interest are due July 15th, and if you have any questions, you can reach out and, additionally, more information is available at this website. Additionally, this is the process that will be explained in the informational webinar that will be happening later this month. Next slide, please.

And with that, I will hand it back to Lekisha, I believe.

[Lekisha Daniel-Robinson] Thank you, Kristen. So, as you can see, there is wide variation in the number of low-risk cesarean delivery rates; however, there is certainly opportunities for improvement, and today, we'll hear from our speakers, who will share some of the strategies that they have been using.

On the next slide, I would like to introduce our first set of speakers, Melissa Isavoran, as well as Alicia Bublitz. Melissa is from the Medicaid Operations at Samaritan Health Plans, and Alicia, Traditional Health Worker Liaison at Samaritan Health Plans. I'll turn it over to you. Thank you.

[Melissa Isavoran] Thank you. So this is Melissa Isavoran. And Intercommunity Health Network is a part of the Samaritan Health Plan, but Intercommunity Network is a Medicaid managed care plan that serves around 80,000 members in a tri-county region in Oregon. Go to the next slide.

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Intercommunity Health Network provides a full scope of health-care benefits and wrap-around services, but we also have a really strong commitment in improving population health and health equity, and to support this commitment, we invest in social determinants of health and transformative initiatives that serve our population. And that includes services that aren't typically integrated into the traditional health-care delivery model. The community doula program that we'll be talking about today is one of those initiatives that Intercommunity Health Network has supported, and it's shown great success, and specifically in the area of reducing low-risk cesarean deliveries.

On the next slide we're just highlighting our investments in transformative projects and initiatives, which is equated to about \$30 million over the past ten year, and 20 percent of that, in the bottom right corner, has been attributed to work related to traditional health workers that truly are our supports for preventative care and wrap-around services, and that's the bucket in which IHN, Intercommunity Health networks, has funded the Community Doula Program (CDP). So I am going to defer to Alicia Bublitz, our resident expert in doula work, who will provide you with some key details about Community Doula Program and its successful outcomes.

[Alicia Bublitz] Thank you, Melissa. Again, I am Alicia Bublitz. I am the Traditional Health Worker Liaison at IHN-CCO. But until about two weeks ago, I was one of the teams who developed the Community Doula Program, so I had experience on both sides of this project, so to speak. And I wanted to start with quick background into Oregon THW Doula Program. Since 2013, birth doulas in Oregon have been able to be independent Medicaid billing providers as traditional health workers, and while they provide many of the same services as a private health doula, as traditional health workers, they are really focused on addressing social determinants of health barriers that we see, and, in fact, the Community Doula Program has had a particularly high percentage of high-need clients as communities just looking for any supports that they can give individuals. And we've had to develop a lot of ways to work extensively with child welfare, domestic violence advocates, et cetera. Next slide.

This is the part where I say that the THW doula model is not the candles and whale songs model that you may think of when you hear doula. Doulas in Oregon Traditional Health Worker Registry have received expanded training, both on an approved foundational doula course, through the Oregon Health Authority, and also trained in cultural competency, trauma-informed care, interprofessional collaboration, et cetera.

I also really want to mention that regarding the background checks here that the Oregon Health Authority has established THW-specific guidelines, specifically to support people with lived experience of homelessness, substance abuse, mental and behavioral health diagnoses, so that we're not precluding people with those backgrounds from doing traditional health-care work.

The CDP provides all these trainings free of charge and work to reduce additional barriers to attendance, like coordinating childcare, transportation, et cetera. I will say that one thing we didn't initially realize was the need for dedicated support for the certification and credentialing process. Honestly, we were all learning on the fly, but it did become clear very early that technical and administrative support to navigate Medicaid provider requirements is going to be essential in building the workforce. Next slide.

There are a number of studies on the benefits of doula care and physiologic birth, so I'm not going to go into those. But I do want to highlight these few benefits that we've heard about at the CDP, and had our providers bringing back to us, that client supported early labor, whether physically at their home or, through communication with the doula, arrived at the hospital with a more established labor pattern. The next two points being that what we hear from hospital staff is that doctors and midwives and nurses feel more able to support physiologic births when they know a laboring person has ongoing support.

And one of the biggest benefits of our program is that through the partnerships that we've built within our health system, oftentimes, our doulas, through the CDP are known to the staff, and so the staff is able to feel really confident that families have what they need. Continuity of care has a variety of established benefits, particularly for clients with high barriers to care, whether it's language access, cultural, et cetera, that can be a real stabilizing force for pregnancy and birth.

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A great example of this was a young homeless client we had, who had been raped and was planning a relinquishment. And her doula was a huge stabilizing force for her at the hospital, was someone who could make sure people coming in the room were up to the speed on the situation, mom didn't have to keep explaining things over and over and so forth. And, of course, we know that there are huge benefits to language and cultural matching, not just for the birthing person but for the entire family, particularly with families that are not used to navigating the American health-care system. Next slide.

The Community Doula Program, here's a little more information, was developed specifically to provide socially, culturally, and linguistically matched care to Medicaid eligible families in our region. And to do that, we had to build a THW workforce. And I just wanted to share this picture, because the doula in this picture is the absolute essence of a Community Doula. She heard about the program through the WIC office after the birth of her first child, trained as a doula, bicultural, bilingual, serves a huge number of families in our program, and just had a doula herself from our program for her second birth. And she was the best person for care at the hospital, because all the labor and delivery nurses knew her and loved her and was so excited to be there for her. Next slide.

Well, there are pros and cons to working with community-based organizations versus hospital or clinic-based doula programs. We did find in this partnership with IHN-CCO that the benefit in this case really was a small organization can be very nimble and can see a really great return on investment into direct member services. In our first three years of Community Doula Program, you can see that 80 percent of the funding went right back into the community. Next slide.

Highlighting a few of the goals of our program here, workforce development in particular was very successful, with 126 doulas trained, with 40 of them getting onto the state Traditional Health Worker Registry, which is about 25 percent of the current list in the State of Oregon. And we had a very high percentage of bilingual and BIPOC doulas in our area training. So, these numbers really highlight the need for partnerships in investments in workforce development, and we found that people really wanted to do the work but needed support to access training and get through these processes.

I also don't have a lot of time here to talk about the scholarly evaluation work, but the Community Doula Program did also partner with a research lab at Oregon State University to develop qualitative and quantitative research around that programming. Next slide.

Pardon me. As I come to the end of our time here, this is time for the 'but does it all work slide'? And the short answer is yes. The CDP has thus far seen really outstanding outcomes when compared with local and national data. Most relevant to our time here, you can see our cesarean rate in our program is 15 percent versus the expected 23 percent. And when you look at primary or unplanned cesareans, the CDP rate is between 12 and 13 percent. Preterm birthrates down, et cetera. And keeping in mind that the CDP is serving very high-risk social determinants of health clients, these numbers are very promising. There are also the hidden cost savings, lowering costs through reduction and utilization of high-cost cares like these NICU stays.

One of the examples I love to give was a very high-risk mom, actually in a rural community who was scheduled for a cesarean at a larger hospital several hours away. The plan for when she went into labor - or if she went into labor before her scheduled date was to call Life Flight. Her doula was the one who worked with her to make sure she had transportation, including a gas card to get to the other city, arranged her a place to stay so she could be there a few days early to settle in, et cetera. And when she did go into labor two days early, she was onsite, and not only was the cost of air ambulance avoided, but so was all the stress and worry for her family what could have been a very scary situation. And last slide.

All that is really good news. I do want to highlight a few of the barriers to integration and utilization, particularly because I remember at the end of the previous webinar, there was a mention of low utilization in states that have had Medicaid reimbursement for doulas. Our experience has highlighted a few of these barriers here, including low reimbursement. Although just yesterday, it was announced that Oregon is seeking to raise the reimbursement rate to much more in line with what other states are paying

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nationally. The administrative burden that I mentioned and the ways in which doulas are not yet currently integrated into our health system, and I would like to pass it back to Melissa here for her final thoughts on this partnership.

[Melissa Isavoran] Thank you. And just in closing, to mitigate some of these barriers, we really have a desire to support sustainability and address these things, and so IHN, Intercommunity Health Network, is really focusing on reimbursement strategies and value-based contracting to support doulas, and, also, bringing technology solutions for case management and referrals, not only to doulas but all traditional health workers in the community. And, really, the most important thing is how do we capture outcomes in a way that translates to hard data that resonates in the medical community. So those are some of the things we're looking forward to tackling in greater extent, and we're really excited to continue supporting the integration of doulas in member care. We thank you for your time today.

[Lekisha Daniel-Robinson] Thank you so much for the presentation. And, again, remember, participants, that you may submit your questions via the Q&A. We'll now move to Ellie Suse, who is the project coordinator of the Illinois Perinatal Quality Collaborative's Promoting Vaginal Birth Initiative. Ellie, I'll turn it to you.

[Ellie Suse] Thank you so much. So I'm going to be talking about the Illinois Perinatal Quality Collaborative, or ILPQC, and opportunities to engage statewide quality improvement. Next slide, please.

So, I'll be talking about the role of perinatal quality collaboratives and our approach here in Illinois, our promoting vaginal birth initiative, as well as opportunities for collaboration with Medicaid. Next slide.

So, Illinois is a statewide network of hospital teams, perinatal clinicians, patients, public health leaders, and policymakers, committed to improving obstetric and neonatal care to reduce disparities in maternal and infant morbidity and mortality and improve outcomes for all mothers and other birthing persons, and newborns across Illinois, through collaboratively identified and developed quality improvement initiatives.

ILPQC started in 2012, after the State Prematurity Task Force recommended forming perinatal quality collaborative. And since then, we have completed ten quality improvement initiatives to date, and we have three currently in progress, and over 95 percent of birthing hospitals and NICU's participate in our initiatives throughout the state. You can see here where they're spread out all over the state. Next slide.

So, ILPQC uses quality improvement science to build hospital capacity to drive systems and culture change. So, in addition to supporting team development, as described in the previous slide, we provide opportunities for collaborative learning across hospitals through in-person events, currently virtual, but we're hoping to move back to in-person events twice a year, monthly web-based meetings, and creating a rapid response data system that allows teams to track and compare their data on progress for the aims, using structure, process, outcomes, and balancing measures. We maintain regular communication via newsletters and our updated website with all the hospital teams, and we provide QI support to the teams through resources such as our online tool kit, regional network meetings, and one-on-one QI coaching calls with the teams. Next slide.

So, ILPQC has a data system that facilitates teams' ability to collect user data to drive quality improvement, so hospital teams collect monthly data on this paper data form, and report it via a secure web-based REDCap data form, in the top right, to our ILPQC data system, and then web-based rapid response support, such as seen here, our data dashboard for promoting vaginal birth initiative allows teams to see their progress towards initiative aims, and these are immediately available for teams as soon as their data is entered. And these reports are actively used to inform the team's quality improvement work. Next slide.

So, ILPQC started with a kickoff conference here at Northwestern in the fall of 2013, and since then, we have completed ten initiatives and have these three currently in process. You can see here the Promoting Vaginal Birth Initiative highlighted in pink, and we're also currently working on a Birth Equity Initiative and our Babies Antibiotic Stewardship Initiative. Next slide.

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So, to focus more on our Promoting Vaginal Birth Initiative. The aim of our PVB Initiative is to have greater than 70 percent of participating hospitals at or below the healthy people 2030 goal of 23.6 NTSV cesarean delivery rate by December 31st of 2022, so these are the low-risk births, nulliparous, singleton, vertex deliveries. And our process and outcome measures include greater than or equal to 80 percent of NTSV C-sections meeting ACOG and SMFM criteria for cesarean. As well as greater than or equal to 80 percent of physicians, midwives, and nurses in Illinois educated on ACOG/SMFM criteria, labor management support strategies, and facilitating decision huddles and debriefs. Next slide.

So, these are our key strategies for creating clinical culture change. We have developed these throughout the initiative. You know, things have adapted and grown, so these strategies include first using a cesarean decision checklist and performing cesarean decision huddles with provider, nurse, and patient; supporting nursing care, making sure nurses and providers are educated on effective strategies for labor management support for patients; bringing patients into the decision-making process through shared decision-making and making sure that patients are educated and setting realistic expectations; sharing unblinded provider-level and NTSV c-section rates so that providers know where they stand in relation to their colleagues, and then finally, reviewing and debriefing NTSV section rates that do not meet ACOG/SMFM guidelines using the PVB dashboard.

So, we have developed and gathered some really great resources for our PVB teams to do this work. These are just a few of our many, many resources in our PVB tool kit. So, first, we have our PVB dashboard, which allows teams to see which C-sections performed that month did not meet ACOG/SMFM criteria and have a discussion about what could have been done differently, you know, how improvements could have been made, how the patients could have been managed differently. We created provider education posters that were sent out to all Illinois hospitals, to be hung on their Labor and Delivery units, to educate providers on ACOG-/SMFM guidelines, and key strategies for PVB.

We shared the unbinding provider data protocol from the California maternal collaborative for teams to start that process. They've created a really great step-by-step guide for teams of how to get to un-binded provider data. We also created a cesarean decision checklist that will be used before cesarean decision to ensure that all criteria are met and a checklist for nurse, physician, or midwife, and patient to review and see whether it's time to make that decision. And finally, we worked with a midwife in Florida, Jessica Brumley, to hold two live virtual labor management support courses with over 400 attendees across the state, and then we recorded these sessions, broke them down into e-Modules, and those are available on YouTube for our teams for anyone who wasn't able to attend the live courses.

So, I'll just go into a little bit of the data that we collect. So this graph shows our NTSV section rates for all of Illinois, as well as the percent of teams achieving the goal of 23.6. So throughout 2021, we were making some really great progress, and reducing our NTSV section rate down from 25.6 percent to 23 percent, as well as increasing the percent of teams that are meeting that goal. With the winter COVID surge and subsequent staffing shortages, we definitely struggled to maintain that progress over the past six months, but we hope to see some more improvements in the coming months. We are also working with hospital teams to collect this data by race and ethnicity and insurance status so that we can determine and address any inequities.

We've also made really great progress on the percent of teams that are working on many of our six key strategies and structure measures, so, as of March 2022, 27 percent of teams have all the six key structure measures in place, 59 percent have at least four of these structure measures in place, and 80 are either working on or have these key structure measures in place. So, this is really how you create that culture change, is by implementing all these structure measures and strategies.

This graph shows the percent of NTSV sections throughout Illinois that are meeting ACOG and SMFM guidelines, so we have three different categories: cesarean after induction, labor dystocia, and fetal heart rate concerns. So you can see here that our goal is 80 percent, and overall throughout the initiative, we have seen an improvement from 60 percent to 66 percent of all NTSV c-sections meeting those criteria.

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And then a little bit about examples of PQC-Medicaid collaborations. So, state Medicaid and Medicaid health plan associations often serve on PQC leadership teams, stakeholder groups, and advisor workgroups, which creates many opportunities for collaboration, and we are lucky to get to work with some people from Medicaid that have been really great on our PQC Leadership Team, and then due to our close relationship with hospitals, we're constantly in touch with all the hospitals doing one-on-one call. In Illinois, we have the opportunity to facilitate initiatives that support implementation of Medicaid policy changes and provide feedback on the barriers to implementation of those changes. And finally, state Medicaid also provides incentives to hospital teams for participation in PQCs in certain states.

[Lekisha Daniel-Robinson] So Suse, if you don't mind, I'm going to interrupt you here, and perhaps we can get to your last couple of slides during the Q&A.

[Ellie Suse] Okay.

[Lekisha Daniel-Robinson] Thank you so much. So, with that, and thank you for your presentation. I'd like to move to our next set of panelists, Shin-Yi Lin the Policy Officer of New Jersey State Medicaid Agency, where she works on recent implementation of the community doula benefits, and Michele Samuels, who is the quality assurance specialist with the agency and administers the implementation of the doula services benefit. I'll turn it to you. Thank you.

[Shin-Yi Lin] Yes, thank you. Let's get started. So, thank you for having us. Before we get started on the benefit itself, I wanted to frame that our community doula benefit was built in the context of wider range of maternal health improvement efforts that are tied to a statewide Nurture New Jersey Initiative. This was started by our First Lady, Tammy Murphy, in light of our 's poor statistics regarding maternal and infant health, just with an explicit focus on reducing racial health disparities impacting our black birthing people and their babies. And so this context is important to know that our benefit was not designed exclusively as a lever to reduce cesarean rates, although that's certainly an area of focus that we have, but more connected to specifically addressing our racial health disparities and to broadly improve the experience of care throughout the perinatal period. And with that framing, let me turn it over to the next slide, to my colleague, Michele, to talk about the design and features of our New Jersey Benefit.

[Michele Samuels] Good afternoon. So, why community doulas? In the beginning, New Jersey Medicaid was aware of the benefits of doula care, and you can see the March of Dimes statement regarding doula care on the slide to the right. And so much like other states, we began implementing a doula benefit within our Medicaid system. Rather than a labor doula support model, New Jersey opted to go with a community doula approach.

So, there are a couple of key features that went into New Jersey's decision for the community-based doula model. One came about as a result of our work with our doula stakeholder group, in which we gained a better understanding of the community-based doula model specifically and how it can serve the needs of our Medicaid members in a culturally competent and responsive way. And this is due large in part to the fact that the doulas themselves are reflective of those community that is they actually serve in.

An additional key feature of New Jersey's community doula model is that the doulas have knowledge of those community resources to provide both that local and New Jersey-specific social services that are available to those birthing individuals and their babies. And this knowledge could really directly affect those outcomes by their ability to address those social aspects, such as food insecurity and refer for psychosocial support, or even encourage preventative care by providing support during the prenatal and postpartum support. Next slide.

So, as I mentioned, the decision of the community doula model was largely derived from our stakeholder group. We focused on stakeholder work with doulas that participated in a doula pilot program that was funded in partnership with our New Jersey Department of Health and maternal health nonprofits based throughout New Jersey. So, these doulas were trained with New Jersey-based trainings that follow or were built from community training such as Uzazi Village and Health Connect One. So this focus, from the stakeholder perspective, is reflected in this specific set of doula training programs that we decided to

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accept as qualifications to become a New Jersey Medicaid doula provider. So our stakeholder group was comprised of not only the doulas from the doula pilot program, but also additional partners that I had mentioned earlier, our New Jersey Department of Health, those nonprofits, and it also included our Medicaid MCOs, or managed care organizations.

So, our meetings began pre-pandemic in 2019, and at that time, they were in person. And we began building those relationships with the doulas and the other partners, and that was through direct input from the doulas. They began sharing their day-to-day, highlighting the needs of those they serve and time spent on visits and case study sharing. So, their input really facilitated the design of our benefit, and in January of 2021, our doula benefit went live. And, of course, at this point, we're not in person anymore. We were virtual for those stakeholder meetings. So, after go live, our enrolled doulas were added to our stakeholder group, and then later, our DLC was added, or the Doula Learning Collaborative, and Shin-Yi will discuss a little bit more in-depth about the DLC a bit later. So next slide.

So, I'm going to discuss some of the key features of New Jersey's doula benefit. As I discussed earlier, we had extensive guidance from our stakeholder group in shaping New Jersey's doula benefit. And in the blue box, there's a link to more specific slides about the input that the doulas had in shaping our benefit.

So, the benefit, as I've mentioned, is available throughout pregnancy and into the postpartum period. And earlier I noted in a slide that there was some shared decision-making. And this is an example of one of those areas where the doula can support a member in various locations, such as a home, community, or even attend a clinical visit with a member, where the doula can help to advocate for the member or assist the member in advocating for themselves.

So, our benefit offers a couple of different models. So the first is our standard model, which is eight visits, and that's inclusive of one initial visit, and that one initial visit is allotted for a longer period of time, plus the attendance at birth. There's also an enhanced model of care for our younger members who are 19 years of age and younger, and they receive up to 12 visits. This also inclusive of that longer initial visit, plus the labor attendants. There's also a value-based incentive for the doula when a member completes the clinical postpartum visit. So the doula completes their postpartum visit, and then once the member sees their OB, midwife, or PCP, the doula is able to get that value-added incentive.

So, reimbursement with the incentive for the standard model is just under \$1,000, and for enhanced doula care for those younger members that I mentioned, it's just under about \$1,200. And based on our preventative services SPA, a clinical recommendation is needed for doula services. But the doulas are providing services, not under that direct clinical supervision. So, our doulas can enroll as Medicaid providers and have a choice to enroll and practice independently. They may also enroll as part of a doula-only organization, or with a clinical group. And also, wherever possible, we've try to eliminate those administrative fees that are attached to enrollment, enrollment application fees, those background check fees, we've eliminated those. So now I'm going to pass it back off to Shin-Yi to talk a little bit about enrollment support on the next slide.

[Shin-Yi Lin] So thanks, Michele. So we have found that in New Jersey engaging in the workforce development work is really critical, particularly if you are choosing to lean on a community-based doula workforce for your benefit, as we have. The kind of support that we and our key partners have been providing is really wide ranging. Some of it is under our direct control as a Medicaid program, in terms of documentation and training. Some of which you can see on our website. We also created a Medicaid staff position that are called doula guides for doulas wanting to enroll in Medicaid. We found that it's important to have that one-on-one support where a doula is not calling a general provider line, that that is critical for getting doulas from the "hey, I'm interested", phase to, "yes, I'm willing to sign on and become in the enrolled provider" stage.

We're also a managed care state in New Jersey, and we kept close oversight over our five managed care organizations to ensure that they also have dedicated named staff that know about our benefits so that doulas can help navigate paperwork that was really originally designed for clinical providers and for providers that have billing and administrative staff.

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Outside of Medicaid, we've been working with our Department of Health funded Doula Learning Collaborative, which is built to be a source of peer-based doula workforce support. So, in addition to engaging the stakeholder work that we mentioned before, they provide support for each other on Medicaid processes, and also with respect to supervision. The DLC is also helpful for people who want to become a community doula. They're offering no cost subsidized training to help create the next cohort of community doulas eligible to become a Medicaid provider.

And so if you move onto our next slide, I think this slide is really meant to share our big picture, which is the work that we've described around workforce development and shown on the right can sometimes feel like it's outside of the normal lanes of day-to-day Medicaid policy work. We're really used to the technical work, designing a benefit, securing federal authority, setting rates, these pieces were ones that we knew would be needed. But now, a year-and-a half into the launch of the benefit, I think a major lesson we can share is to be prepared to do that work, that technical work, is only the tip of the iceberg, that work needs to be done around our benefit. And, yet, we have to stay committed to the systemic efforts, where Medicaid is maybe just one member at the seat of the table, because these efforts are needed to really ensure that a doula benefit grows into a true successful one, where we can ensure that members are able to equitably access doula care throughout the state so that doula care can be successful as an intervention to really improve the birth experience and reduce adverse outcomes. And with that, let me pass it back to Lekisha.

[Lekisha Daniel-Robinson] [Technical Difficulties].

[Doris Lotz] It looks like we have some audio issues with Lekisha, so let me step in and ask South Carolina to begin, Dr. Crockett and Dr. Lopez-DeFede, if you would begin your presentation, please.

[Amy Crockett] I'm here and ready. Let's move on to the next slide. So, I'm going to talk just a little bit about the background of the South Carolina Birth Outcomes Initiative, and Dr. Defede is going to share some of the outcomes from our own NTSV initiative, and I'm going to spend just a minute talking about how we got there and how we engaged partners around the state in that work. Next slide.

Our PQC was founded in 2011. We're a little bit different than a lot of other states, in that our main backbone supporting agency is actually our state Medicaid agency, which has been just lovely to have them at the table and highly engaged. We also have very strong support and participation from the South Carolina Hospital Association, our Department of Public Health, and a number of state partners, including all of the academic medical institutions around the state and the hospital systems.

We're also a little bit different in that everybody's in. It's all in in South Carolina. We have about 40 birthing hospitals, and we push data out to all of them, and all of our educational work is aimed at everybody. We definitely have stronger participation historically from some hospitals compared to others. But, really, when we look at our outcomes, we want to touch everybody across the state. Next slide.

In 2011, when we started the BOI (Birth Outcomes Initiative), the real first initiative for us was NTSV, and that was based on this data that came out just a few years before, looking at rates of cesarean delivery across hospital systems. And when you looked at hospitals that have rates of 15 and 20 percent, and other hospitals having rates of 65 to 70 percent, you can see that there are cultural things happening at the hospital level that are driving some of these rates that are beyond actual medical quality care decisions, and that if we can do some education to sort of level out the culture, maybe we can work to bring this rate down. And so the first thing that we really tackled was early elective deliveries. Next slide.

And we had some really great support from the ACOG and SMFM that also came out right about the same time, giving us really good data-driven support for making that recommendation. Additionally, it was sharing a lot of the information about labor management, which tends to be a really cultural thing on a lot of labor and delivery units. And so there's a picture on this slide of our Sim coach. This is organized by the University of South Carolina, in Columbia, and it's a mobile simulation center.

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So, we take this to all of the birthing hospitals in the state at least once a year, and we can run simulations and deliver education. So, this goes out to all the nurses and all the physicians. We get a handful of anesthesiologists. A handful of ER doctors show up. But the first year that we rolled out with this Sim coach, we really focused on the NTSV numbers, and I think we did a shoulder drill that year and talked about why it's important to wait to call your C-section coach, so labor is really arrested.

We've also had the opportunity, obviously with this, to do a lot of other really great simulations related to other aim initiatives, like hemorrhage bundles and hypertension bundles. But it got its start, really, with NTSV. Next slide.

We supported the NTSV and early election induction initiative with Medicaid bulletin. So we got to pull the payment levers around this as well, which I think there were some great examples of how doulas can also be encouraged using payment levers. And we were the first state in the country to use non-payment for cesarean deliveries that didn't have a medical indication. And we did that in partnership with physicians across the state through ACOG and the State Medical Society that had a lot of good buy in on this when it rolled out. And then next slide.

Really, through the year of 2014, we not only were on the Sim coach talking about cesarean delivery rates, but we also had a series of webinars and shared the data and the outcomes back with all of our hospitals, which also had been a really powerful tool for encouraging change. So I'll let Dr. DeFede talk a little bit about that on the next slide.

[Ana Lopez-DeFede] Thank you very much, Amy. So, what one of the quotes that we love is sort of the Pearson model, "That which is measured improves. That which is measured and reported improves exponentially." And so as part of the work, there was very early on work with dissemination of hospital-level data. We are one of the few states that has an all-payer data system, so we can report all the payers in terms of the maternal and child health outcome, and there is a portal, which is interactive, that allows all of the hospitals, as well as statewide to look at the measures where we stand and accept that it addresses issues of health equity, urban, rural, and some of the key social determinants of health. Let's move on to the next slide, please.

So, this is a very quick sort of trend, and as you can see, it does make a difference when we split between Medicaid and all payers. Our public and private payers have been at the table. You can see that between the time period of quarter one, 2011, to quarter four, 2014, this is critical. Because we had the change from ICD-9 to ICD-10 codes, which made a tremendous difference in terms of the way that we capture that information. But you see during those early years, we saw an all-payers reduction of 64 percent, and in Medicaid we saw a 58 percent reduction. Let's move on to the next slide, please.

When we look at the period between 2014 to 2016, there was a relative decrease across all track six section measures across South Carolina, and those range from 3.5 to total C-sections, to a drop of 8.6 percent as we look at elective primary C-sections at 39 to 40. But for us in South Carolina, we felt that that strong collaboration that framed the establishment of the South Carolina birth outcomes was critical to the success of achieving these goals. Let's move on to the next slide, please.

Now, when we get into 2018 to 2020, of course we're looking at the impact of Covid. We're also looking at the full transition into ICD-10 codes. So when we looked at early elective deliveries and induction, PC-01, we see that there is a relative change, and these are across fields, and we know that that is statistically significant. We need to further examine, like all states, the impact of the pandemic on elective procedures and the implications of hospitals mixed and designations in terms of high-risk pregnancy.

What we saw between 2018 and 2020, which is why I started out with that Pearson model quote, we placed less emphasis on the primary C-section, which sort of gives a takeaway for us that we need to begin to reexamine the level of emphasis that we place on supporting vaginal births, as we move forward. And we are an Aim state, and so we track many of these measures. These are only one of the ones that are in the portal for folks to look at their data across hospital systems and other stakeholders supporting the quality initiatives in hospitals.

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So, when you look at the severe maternal morbidity, the rate of severe maternal morbidity in calendar year '20 is 1.67, a decrease from 1.82, which is an eight percent relative improvement. Now this really corresponds with South Carolina's engagement in the Aim program, and when we looked at these trends, they are statistically significant. Next slide, please.

I want to spend a little bit of time, as I have allocated, because, really, for us, what we worked on and the vision to reality is the collective impact model, and that is, very early, on the South Carolina realized and believes strongly as part of the workforce for the Birth Outcomes Initiative, that no single governed entity, policy, or organization can deal with deeply entrenched social problems alone. So when we talked about these monthly meetings, comprised of 100 to 150 stakeholders who are engaged at different intervals, our monthly meetings really do represent all of the key stakeholders and investors in improving the maternal and child health outcomes in our state.

We have structural and process elements. That backbone support is the Medicaid agency. We work to frame a common agenda that works across all of these entities and shared measurements, mutually reinforced activity, and then there's continuous communication, as well as a built-in data group. I'm going to talk about little bit about and just highlight some of our workgroups that come together and these monthly meetings with a structure that is set up as a vision council, comprising all the key stakeholders, as well as all of the leadership structure for each of the groups.

So, our groups are comprised of state safe sleep, equity, access, and care coordination, behavioral health, data workgroup, which I am very pleased and honored to co-lead with the data by president out of the hospital association, as well as Health Department lead on vital records. We have a postpartum learning collaborative, quality and patient safety, newborn care coordination, and all of that is really around data-driven decisions.

As I mentioned earlier, all of the data reported to all the stakeholders allows them to slice and dice, save and print. But more importantly, it allows for that landscape between rural and urban, race, ethnicity, age groups, and various other factors. And that link between the way that we're polling the data really has been very helpful for the hospitals. We bring in all of the data from the hospital discharge. We have provider in our state that requires all hospitals to provide that data to a central unit within the Department of Administration in our state. That allows us to link it to vital statistics records, so old birth certificate data, and then it allows us to link to Medicaid eligibility .

Dr. Amy Crockett has been the medical director for the Birth Outcome Initiative since its inception, and we are incredibly pleased with that collective impact model, because it makes everyone equal partners in solving these issues, as well as creating structure where there is input across all the various interest areas, and we don't duplicate. We enhance and we support. So, thank you very much for the opportunity to share South Carolina's Birth Outcome Initiative, and particularly, our work around this area.

[Lekisha Daniel-Robinson] Thank you so much as well, and to all of the panelists, in fact. I think we've packed in quite a bit over the last hour, but wanted to move to some question and answers. The first one on the list is about the slide presentation. They will be available within two weeks on the Medicaid.gov website. So what you've seen today will be available in about two weeks. I'd like to then move to another question, which is for Illinois. Can you talk a little bit more about the initiatives Illinois Medicaid did to promote the PQC initiative. For example, were there any incentives that were offered?

[Ellie Suse] Yeah, that's a good question. I don't know if I'm going to be able to answer it very well, but I can definitely connect whoever asked that with Patty, our project director. One thing that I didn't get to touch on during my presentation, but was just CMS's new maternal morbidity structural measures, so there's two parts of that, one of which includes participation in a PQC and implementing patient safety practices or bundles to address complications of maternal morbidity, so that is definitely one thing. But in terms of specific partnerships, I can definitely connect you with Patty, who might be able to answer that question better.

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[Lekisha Daniel-Robinson] Okay. Thank you. Let's move to our next question, which is for New Jersey. Can you say a little bit more about the governor's interest in doula care. Like how did that -- well, I guess the governor's wife, how that effort really got started. Can you say a little bit more about that?

[Shin-Yi Lin] Yeah. I would definitely refer the questioner to the Nurture New Jersey website. I think if you just Google Nurture New Jersey, and there is a strategic plan that puts the doula work in context. I mean, I think when the first lady first became aware of the statistics and how poor they were, particularly with our racial health disparities, a lot of the genesis came when the Department of Health did these targeted focus groups as part of what was called the "Healthy Women Healthy Family Initiative" to figure out, like, what are the best ways to get at this crisis and doula care was one of the things that came out of that, and so that also was the genesis of the Department of Health's pilots that Michele was talking about. Michele, do you have anything else to add?

[Lekisha Daniel-Robinson] Maybe we can go to a question for Oregon. You mentioned the cost of the doula program at \$260,000 per year. Do you have numbers about the number of Medicaid beneficiaries served?

[Alicia Bublitz] Absolutely. So, this is Alicia, and those costs were our initial startup costs, so they included all the training and the other things that I mentioned. The Community Doula Program currently has contact with approximately 300 to 400 beneficiaries per year. We have about 100 to 150 who complete a full course of care, which in Oregon is two prenatal births, and birth support, and to postpartum visits, so it kind of waivers. The program is in its fourth year of accepting clients, so it has been building definitely over the last few years. And, again, it's a three-county region. It's not a statewide program.

[Lekisha Daniel-Robinson] Great. Thank you. I think we only have time for one more question, and one I'm seeing in our chat has to do with how do you get Medicaid to -- or what are your recommendations for collaboration with Medicaid? So, I'll open up to South Carolina, how do we get Medicaid involved?

[Ana Lopez-DeFede] So very early on, Medicaid in the state of South Carolina pays for approximately 60 percent of all births, it pays for a little over 80 percent of all teenage pregnancies, and it pays for a very large percentage within, 60 percent of high-risk pregnancies. Because of that, it became really imperative for the Medicaid program, in its examination of enhancing prevention activities, to look at ways to come together with other stakeholders. And as Dr. Crockett mentioned, it started, really, with a discussion between the physician community, the hospital association, and Blue Cross/Blue Shield in our state, as well as our Health Department and March of Dimes, who all had big footprints in terms of turning around and improving health-care outcomes.

When, as a state, you are paying for and are responsible for 60 percent of all deliveries, the engagement of the Medicaid agency, for all intents and purposes, was very natural. And when the Hospital Association supported, as well as other key stakeholders, the non-payment policy, that has remained the backbone for the South Carolina Birth Outcomes Initiative remains in the Medicaid agency. We started out slow. It was all built with data, and we did the very first, our unit at the University of South Carolina, did the very first internal cost benefit analysis, which looked at some cost neutrality/cost savings, which then initiated the support for other programs, whether that was Dr. Crockett and the incredible job that has been done on centering pregnancy in our state.

So, it really saw that not only were we improving birth outcomes and maternal overall health status, but we were also able, through the Medicaid program and the way that they approached this, to enhance other activities with some of those cost-savings dollars. And to this day, some of those activities are still being funded by Medicaid. For example, there's funding for the Sim coach and some of these other efforts, and so it's a win-win situation. And having all the stakeholders at the table, sharing a common vision, was also incredibly helpful in terms of framing that collaboration and supporting that collaboration through monthly interactions, webinars, and the framing of this group structure that was created subgroups, in support of those overall arching goals.

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There are overarching goals that are set, and then the vision, council or committee that meets on a monthly basis to drive some of the dialogue around areas for improvement, new areas for consideration, joint efforts and activities, and I believe that that's a fairly good statement, but glad to answer more questions as appropriate. Amy, is there anything else that you would like to add?

[Amy Crockett] No.

[Lekisha Daniel-Robinson] Thank you so much, yeah. Sorry. Kate?

[Kate] All right, today's webinar recording and slides will be available on Medicaid.gov at the link listed on the screen in about two weeks. We invite you to join us for the upcoming webinar on using data to plan and assess quality improvement strategies to reduce LRCD and Medicaid and CHIP, which will take place Friday, June 24th, at 1:00 p.m. Eastern Time, as well as the information session on the Overview and Process for Expression of Interest for the Improving Maternal Health by Reducing Low-Risk Cesarean Delivery Affinity Group, which will take place on Wednesday June 29th, at 2:00 p.m. Eastern Time. You will receive an e-mail reminder with the registration link in the coming weeks. Please note that the expression of interest to join the Affinity Group is due on July 15th. More information on this is available at the Medicaid.gov website. Next slide, please.

We greatly appreciate your attendance and participation in today's webinar. As you exit the WebEx meeting, you will be prompted to complete an evaluation. We would very much appreciate your thoughts on today's webinar. If you have any questions or we didn't have time to answer your question during today's webinar, please e-mail MACQualityimprovement@mathematica-mpr.com. That concludes today's webinar. Thank you all again for your participation.