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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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)
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
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

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/

Lower rates are better for this measure
State Median = 24.4
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
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
IHN SDOH Investments in the last Ten Years

- Other Spending: $10,335,996
- SDoH Spending: $18,848,422

- Housing: $2,909,362
- Behavioral Health Supports: $3,809,251
- Health Information Technology: $1,685,774
- Transportation: $1,621,800
- Education: $1,461,767
- SDoH & Dental Integration: $554,900
- Access to Culturally Specific Services: $533,241
- Food Security: $448,529
- Traditional Health Workers: $5,024,599

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
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
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.

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

Ellie Suse, MPH, MSN, RN
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

The Model for Improvement

AIM
What are we trying to accomplish?

MEASURES
How will we know that a change is an improvement?

CHANGES
What changes can we make that will result in improvement?

SMART
Structure, Process, Outcome, Balancing

QI Resources

© 2012 Associates in Process Improvement

Leadership, Advisors, Stakeholders, Patients/Families
## Timeline initiatives and hospital engagement

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<th>Year</th>
<th>Initiative</th>
<th>Teams</th>
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<td>2014</td>
<td>Neonatal Nutrition</td>
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<td></td>
<td>Early Elective Delivery</td>
<td>49</td>
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<td>2015</td>
<td>Golden Hour</td>
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<td>Birth Cert Accuracy</td>
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<td>2016</td>
<td>Maternal Hypertension</td>
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<tr>
<td>2017</td>
<td>Mothers and Newborns affected by Opioids (MNO) – Neonatal</td>
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<tr>
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<td>Mothers and Newborns affected by Opioids (MNO) – Obstetric</td>
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<td>2018</td>
<td>Improving Postpartum Access to Care</td>
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<td>Immediate Postpartum Long Acting Reversible Contraception (LARC)</td>
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<td>2019</td>
<td>Birth Equity</td>
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<td>Babies Antibiotic Stewardship (BASIC)</td>
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<tr>
<td>2020</td>
<td>Promoting Vaginal Birth (PVB)</td>
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<tr>
<td>2021</td>
<td>Tentative Safe Sleep/SUID</td>
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<td>AIM</td>
<td>&gt;80% of cesarean section deliveries among NTSV births that meet ACOG/SMFM criteria for cesarean</td>
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<td>≥70% of participating hospitals will be at or below the Healthy People goal of <strong>23.6% cesarean delivery rate</strong> among NTSV births by December 31, 2022</td>
<td>&gt;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</td>
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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

Provider Education Posters

CMQCC Unblinding Provider Data

Cesarean Decision Checklist

Labor Management E-modules

ILPQC PVB Dashboard

CMQCC California Maternal Quality Care Collaborative

Are you using ACOG/SMFM Guidelines to Safely Reduce Primary Cesarean Delivery?

Failed Induction

- Active Phase Arrest

- Second Stage Arrest

ACOG/SMFM Guidelines Checklist for Labor Dystocia & Arrest

ACOG/SMFM Guidelines

1. Cervical dilation, not effacement
2. Use of oxytocin + misoprostol or misoprostol alone
3. Use of oxytocin + non-opioids
4. Use of oxytocin + epidural
5. Use of oxytocin + anesthesia
6. Use of oxytocin + surgery
7. Use of oxytocin + induction
8. Use of oxytocin + administration
9. Use of oxytocin + management
10. Use of oxytocin + education

ILPQC Promoting Vaginal Birth Initiative

Labor Management Support E-modules
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

Percent of teams working on 6 key structure measures

- % of teams with all 6 key SM in place
- % of teams with at least 4 key SM in place
- % of teams with all 6 SM in place or working on it

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

- Cesarean after Induction
- Labor Dystocia
- Fetal Heart Rate Concerns
- Total NTSV C-Sections

Graph shows the percentage of NTSV C-Sections meeting ACOG/SMFM Guidelines across different quarters from Baseline to Quarter 1 2022.
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

- PQC 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 PQC's
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?”
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
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

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

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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](http://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.

**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

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

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
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
Ana Lòpez – DeFede, PhD
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.
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

Upcoming Meetings

May Monthly Meeting

Dates: 05/11/2022 - 10:30
Location: United States
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.
Improving the diagnosis of arrested labor

“6 is the new 4”

Safe Prevention of the Primary Cesarean Delivery

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 multiparous, 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 indeterminant (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 several examples of interventions that can contribute to the safe induction of the primary cesarean delivery.
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

TO: Providers Indicated

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

Effective 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 South Carolina 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.

SCBOI Launches the Supporting Vaginal Birth Initiative in 2014

South Carolina Birth Outcomes Initiative Presents:
Should We Worry About C-section Rates in South Carolina?

August 26, 2014

CME Credits
For Physicians:
Certificates will be mailed.

For Nurses:
A link will be provided by email to print your certificate.

CME Credits:
Certificates will be emailed.

CNE Credits:
A link will be provided by email to print your certificate.

Questions? Email Lisa Hobbs at lhobbs@scboi.org

South Carolina Birth Outcomes Initiative presents:
An ounce of prevention is worth a pound of cure: Antepartum strategies to prevent primary Cesarean delivery

September 23, 2014

CME Credits
For Physicians:
Certificates will be mailed.

For Nurses:
A link will be provided by email to print your certificate.

CNE Credits:
A link will be provided by email to print your certificate.

Questions? Email Lisa Hobbs at lhobbs@scboi.org

South Carolina Birth Outcomes Initiative presents:
The role of the labor and delivery patient care team in the safe prevention of the primary cesarean delivery

SC Birth Outcomes Initiative

October 14, 2014

Healthy Connections
MOMS & BABIES

Ms. BZ Giese, BSN, RN
Director, SC Birth Outcomes Initiative
"That which is measured improves. That which is measured and reported improves exponentially."
- Karl Pearson
Early Elective Inductions (37-38 weeks) All Payers vs Medicaid
Quarterly trend Q1 2011 to Q4 2014

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.

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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

<table>
<thead>
<tr>
<th>Measure</th>
<th>2018-2020 Trend</th>
</tr>
</thead>
<tbody>
<tr>
<td>Early Elective Deliveries &amp; Inductions (TJC, PC-01)</td>
<td>↓</td>
</tr>
<tr>
<td>Primary C-Section (TJC, PC-02)</td>
<td>↔</td>
</tr>
<tr>
<td>Severe Maternal Morbidity</td>
<td>Mixed result: CA Trend test not significant, but adjusted Chi-square test was. ↓</td>
</tr>
</tbody>
</table>

**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.
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.

Organizations
Community Members

Partners Organizations

Work groups

Structural and Process Elements

Backbone Support
Common Agenda
Shared Measurement
Continuous Communication
Mutually Reinforced Activity
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


- 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
    - 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
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 MACQuality Improvement@mathematica-mpr.com