Using Data To Plan and Assess Quality Improvement Strategies to Reduce Low-Risk Cesarean Delivery in Medicaid and CHIP

[Lekisha Daniel-Robinson] Welcome to the session, Using Data to Plan and Assess Quality Improvement Strategies to Reduce Low-Risk Cesarean Delivery in Medicaid and CHIP. Before we dive into the presentation, I want to mention that you may use the Q&A function located on the right side of your screen to submit questions. Next slide. Thank you. Click the Q&A window and select "All Panelists" in the "Ask" window. Type your questions and don't forget to send. Questions will be addressed at the end of the presentations.

The objectives of today's webinar is to provide an overview of the CMS Maternal and Infant Health Initiative, describe the Reducing Low-risk Cesarean Delivery Learning Collaborative, and learn how a couple of states have used data to establish baselines and monitor progress related to LRCD.

I am Lekisha Daniel-Robinson of Mathematica Policy Research. And on our agenda today, you will hear from Kristen Zycherman from CMS, Chrissy Fiorentini from Mathematica, colleagues from state agencies, and organizations, Dr. Sappenfield from Florida, and Dr. Zerzan-Thul in Washington. And then we will follow the presentations with questions. Next please.

To kick us off, I'll turn to Kristen Zycherman.

[Kristen Zycherman] Thanks, Lekisha. And on behalf of CMS, I just want to welcome you all today, and thank you for joining, and we're very excited to kick off this third webinar, the last in our series for the Improving Maternal Health by Reducing Low-risk Cesarean and Delivery Learning Collaborative. Next slide, please.

A little background on the Maternal and Infant Health Initiative for any of you that don't know, that the initiative was initially launched to improve access and quality of care to pregnant and postpartum persons and their infants. Then, five years into the initiative, in 2019 and 2020, CMS reconvened an MIH expert workgroup to provide updated recommendations about where Medicaid and CHIP can influence change in maternal and infant health.

Resulting from those meetings, three MIHI focus areas emerged. Those are to increase the use and quality of postpartum care visits, to increase the use and quality of infant well-child visits, and to improve maternal health through reducing the rate of low-risk cesarean delivery. These focus areas align with measures in the Medicaid Core Sets, which provide a view of the quality of care and health outcomes for Medicaid and CHIP beneficiaries. Next slide, please.

As I said, this is the third webinar in our series, and the first webinar is available currently on Medicaid.gov. The second webinar will be ready very soon on Medicaid.gov, just going through the posting process. And webinar three will be available in about two weeks. The informational webinar about the Affinity Group following the webinar series will be occurring next week, and there will be more information on that later the session. Next slide, please.

As I mentioned, the Affinity Group is action oriented, and our QI team supports Medicaid and CHIP programs and their care partners in implementing and developing evidence-based change ideas in a quality improvement project. This is an opportunity for states to expand their knowledge in policy programs, as well as the PDSA process, and to use that opportunity to reduce LRCD rates and advance their knowledge of skills in quality improvement, as well as address inequities. As a reminder, the expressions of interest for the Affinity Group are due July 15th, at 8:00 p.m., and more information can be found on the website noted. Next slide, please.

And now I think I'll turn it back to Lekisha to introduce the speakers.

[Lekisha Daniel-Robinson] Sure. Thank you, Kristen. So, we'll now hear from my colleague, Chrissy Fiorentini, a researcher at Mathematica Policy Research. She will provide a focused discussion of the low-risk cesarean measure in the CMS Core Set and its relationship to other measures. Chrissy.

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[Chrissy Fiorentini] Thank you, Lekisha. Next slide. So here you can see some information about the Low-Risk Cesarean Delivery Measure that is in the Medicaid and CHIP Core Set, which is referred to as LRCD. This measure assesses the percentage of first-time term singleton births in a cephalic presentation delivered by cesarean during the measurement year. The measure steward is the National Center for Health Statistics, NCHS, and the data collection method is state vital records submitted to NCHS's National Vital Statistics System.

To reduce state burden and streamline reporting, CMS calculates the measure for states using state natality data obtained though the Centers for Disease Control and Prevention Wide ranging Online Data for Epidemiologic Research or CDC WONDER, and this slide contains links to both the CDC WONDER Data tool and the Core Set. Next slide.

So, now I'm going to go through some performance data on the LRCD measure from calendar year 2020. All data on this slide and the next couple of slides include only births from Medicaid, as listed as the principal payer on the birth certificate. The first dark blue bar represents the National Low-Risk Cesarean delivery rate. This rate includes births to residents of the 50 U.S. states and D.C., and the lighter blue bars represent national LRCD rates stratified by maternal race and ethnicity. At the national level, non-Hispanic Black women have the highest LRCD rate, and American Indian and Alaska Native have the lowest LRCD rates. Next slide.

This slide shows the national LRCD rate again, along with rates stratified by type of geography. There are not large differences at the national level, but nationally, the LRCD rate is highest for women living in non-metropolitan or rural areas, but this varies by state. Within some states, the LRCD rates are lowest in rural areas, and highest for urban areas. The size of the gap between rural and urban areas also varies by state. Next slide.

This slide shows LRCD rates by state, the state shaded according to their rate in 2020. The states in yellow have the highest LRCD rates in 2020, ranging from 26.3 to 30.2 births per 100 deliveries. The states in dark blue had the lowest LRCD rates, ranging from 16.5 to 21.7 births per 100 deliveries. Next slide.

This slide compares the LRCD measure, which is currently in the Core Set, to another quality measure that many of you may be familiar with, PC-02 cesarean birth. The LRCD measure and NCAS measure and will specify for population-level reporting, while the PC-02 measure is a Joint Commission measure and is specified for hospital-level reporting. The denominator definitions for the two measures are very similar, with one difference being that LRCD restricts the denominator to births in the cephalic presentation, while the PC-02 measure restricts the births in the vertex position.

There are also some small differences in terms of the excluded population. But the most notable difference between the measures is the data sources. LRCD is calculated using state vital records, while PC-02 is calculated using Medicaid administrative data and medical record review. At the national level, the two measures produce very similar performance rates. In 2018, the performance was 25.9 percent on LRCD and 25.5 percent on PC-02. Next slide.

Here, we list some potential data sources for identifying low-risk cesarean deliveries. First is Medicaid claims and enrollment data. These data do not contain all the data elements necessary to identify a low-risk cesarean births, but you could use them to identify births to Medicaid beneficiaries, if linked with one of the sources listed below.

Next are vital records. You could use these to identify low-risk cesarean deliveries using the LRCD measure specifications. However, your ability to access these data and the length of the data lag in your state may vary. And next is medical record reviews. You can use this method to identify low-risk cesarean deliveries using the PC-02 measure specifications. However, you may need to link back to Medicaid data to identify births to Medicaid beneficiaries.

And last is hospital discharge data. The availability and content of a state-level database with hospital discharge data will vary by state. If this is available in your state, the database may contain some or all of the data elements needed to identify low-risk cesarean deliveries. Next slide.

Now I'm going to turn it back to Lekisha.

[Lekisha Daniel-Robinson] Thank you. I'd now like to introduce Dr. William Sappenfield, who is the director of the Florida Perinatal Quality Collaborative, as well as director of the Child Center at the University of South Florida, and professor at College of Public Health there as well. Dr. Sappenfield.

[William Sappenfield] Thank you, and glad to be with you today. Medicaid is such an essential partner to try and reduce these unnecessary cesareans. Next slide, please.

I direct the Florida Perinatal Quality Collaborative. We've been working for 12 years in the state on multiple quality issues to improve the health for all moms and babies through respectful, ethical, high-quality evidence-based care, and we're volunteering, we're data-driven and population based. Next slide.

We have multiple partners. Medicaid was one of the key partners that actually participated and decided that we needed to even have a stable collaborative to improve care, and they have been an active partner in all of our quality efforts from the start. Next slide.

We've been working on our PROVIDE Initiative, (Promoting Primary Vaginal Births) and reducing unnecessary cesarean deliveries since 2017, started out with 46 hospitals. We finished our initiative just recently with 76 hospitals. Next slide.

We work very, very closely with Medicaid in what we call our AHCA or Agency Health Care Administration agency, reducing primary cesarean with one of their three targeted Medicaid birth outcome goals, where they actually contracted with their plans to have definitive improvement in their rates. We consult with the Medicaid agency and with the Department of Health now annually to give cesarean awards to those hospitals that have reached the Healthy People 2030 goal.

We confidentially share our hospital cesarean data with our Medicaid agency using both birth certificate and a link hospital birth certificate data so that they can compare our data to what they're able to get through their own data system. We have advised for Medicaid and health plans on strategies to reducing primary cesareans. They actually participate in our initiative advisory group in developing, implementing, and the initiatives as well as participate in our statewide meeting with our hospitals. And we've actually worked together to jointly advise some of our hospitals on their cesarean rates. Next slide.

We, just as was described, do use nulliparous term singleton vertex birth. First time, 37 weeks, not twins or triplets, head is down. The reason we do this is because over 60 percent of the increase in the cesarean rates nationally were related to increases in NTSV, and the analysis that's been done in the past, about 60 percent of the variation in hospitals can be explained by a hospital's NTSV level. Next slide.

Now, the initial national quality form measure is very, very simple. Again, we just heard how the Joint Commission added a little bit of difference on vertex, but also added some additional clarifications on age, length of stay, and multiple gestations. Just so you're aware, there is a third measure, that's even more complicated, that's being used and is proposed by the Society of Maternal Fetal Medicine. It includes those multiple gestations. But it also gets into maternal factors: pre-term, stillbirth, and other conditions that may lead to higher rates of cesarean. We do that because hospitals claim they're a high-risk institution, they need to be accounted for. And I'll share some data on that. The challenge with this is as you go down and need more data, is the timeliness strictly on the data, the complexity of the data increases. Next slide.

In Florida, we use our birth certificate data. We do birth certificate reports. We have a Joint Commission measure that we use a link file, and we also have the Society of Maternal Fetal Medicine that uses a

linked file. We get our birth data here in Florida, and I encourage you to talk to your Health Department, we get it within two weeks at the end of the month. We actually use this to report NTSV rates at hospital, state level, and can also do it by Medicaid so that we can be very, very current. We get 99 percent of our births within that time period. If we need the linked file, to do the more complicated Joint Commission MFM (maternal fetal medicine), we're now waiting 15 to 18 months before you get it, so it's great for tracking. It doesn't work as well in quality improvement because the delay is a little long. Next slide.

When we started this in 2017, working on a variety of issues. We use national data. We started out with the highest rate in 2020. We are now tied for fifth. We had a 7.4 percent decline compared to the U.S., who has had about a 1.5. So we've been actively working with all the partners and hospitals to reduce the rates. Next slide.

However, in this last year, with Covid and decreases in nursing staffing in hospitals, we've had more of a problem. These are tracking measures that we use with our hospitals, we use with our state. We can actually look at it by race. You can look at it by Medicaid and non-Medicaid. The black line is actually the state's NTSV cesarean rate on a quarterly basis. The nice thing about this graph is that red shaded area is the rates where the highest hospitals are. The dark green is the lowest quartiles of the state, and the other in the middle, so you can always track where each of the different groups are doing and how you're comparing. This data can be very, very useful. This is going through the first quarter of 2022. Next slide.

We really like it, because we could also break it down readily and look at it by different pieces. This is our same rates for the state, but now we break it down by payer source. Again, these are for the 76 hospitals in our cesarean initiative. Our Medicaid agency was thrilled to see that they now have their lowest NTSV cesarean rate that they've had, especially after several quarters of increasing rates related to COVID and staff changing. So this was a very positive finding. Actually, we're having less of an impact in our private insurance sources. So we track this so state hospitals at their own level can look at this. Next slide.

We also can look at it by race/ethnic group, this is very helpful. We are very excited that it looks like, it's too early with just one quarter, that we're having a closing in our gap on the racial disparity. And we hope that continues. And our increase that we've been experiencing over time with Hispanic is actually stopped and may start to be decreasing. We need to keep our eyes on this. The data is available. The birth certificate, for us, is very usable. Again, the national data is there, but we're talking 2020 and we're 2022, so I encourage you to talk to your Health Department about the ability to use preliminary data. Next slide.

Although I showed you, and I showed you in the diagram by quartile, in 2021 we still have a wide variety of rates across the state, with some meeting the Healthy People 2030 goal, and some that are higher than Joint Commission of 30. I do want to let you know, the whole intent with California and their successful program is you're not really hoping to bring those reds down to the greens right away. What you're hoping to do is, all the reds and oranges will each be working to reduce their rates from where they are. But being able to track them not only at the state level but by your institution, the people you're paying, is another way to help dig more granularly to focus your efforts. Next slide.

At a hospital level, I wanted to show you very positive examples. This is one of our hospitals, so you can see in quarter two, it was in the second highest quartile of hospitals in the state. They did implement our change packages. They quickly were able to be [inaudible] down in the second quartile and now reached the first quartile and have one of the lowest rates, and they're one of the largest hospitals in the state. So, it clearly shows that you can make a difference. However, I went to a hospital that has one of the highest rates in the state, and the first comments were from the OB providers was, well, "Our complication rates are low and our mothers are happy, why do we need to do anything?" This is a provider-driven issue, and so your role in Medicaid is important. Next slide.

It is not only important that hospitals and providers feel the need to improve, but there needs to be multiple pressure points trying to promote and improve that quality so those providers know not only medically that there are reasons why they should be reducing that cesarean rate but also there are forces and incentives within the system that are encouraging better outcomes, because the outcomes we're

talking about are evidence-based, and sometimes it takes a little bit of a push to get people to recognize the change that needs to happen. Next slide.

I'll give you another example. Here's one of our hospitals that's looking over time. They, too, actually made it down to that first quarter. As you notice, over time, their rates are going back and increasing up. I show you this because even through your own Medicaid agency, once you bring your rate down, this is a dynamic issue. You have turnover in your providers, you have new providers coming out, and the forces that caused the cesarean rates to go up frequently have not gone away, and they will increase.

The other reason I bring this slide up is if you look in that right corner, you see a flag, and what you see is there's some data quality issues for this hospital. We always put out data quality issues. You need to know your data quality, even within your own state Health Department, so that you know that you're really dealing with the most accurate data, and we do that, and we actually work on improving reporting. We actually do training twice a year for birth certificate clerks to make sure the data is accurate. Next slide.

We always are thrown out, our providers say, "Well, you're just not taking out our high risk". So when you use birth certificates, the data is not accurate, which we show them that it is; and then two, that you have high-risk conditions you're not taking into account. So we actually provide our hospitals with the birth certificate measure, the Joint Commission measure, and the Society of Maternal Fetal Medicine measure.

And I'll just point this graph out here to show you they frequently do not matter. At most, they will decrease a hospital's rates two to four percent. But for some, it will actually increase their rate. If you look at this hospital, in 2020, data is delayed, the Joint Commission rate is actually higher than what birth certificates say, and their MFM rates are at the same level, and so what this is saying is, those that identify as high risk actually have the same or higher risk of NTSV than those that don't. So, again, you'll get a lot of complaints and a lot of reasons, and having the data and being able to break it down like this is very helpful in trying to get people on board. Next slide.

We've even, because of our vital records people, have been able to now break it down to obstetrical provider level. They have cleaned up the data on birth certificates for 72 of our 76 hospitals, so we can not only look at what their rates vary by provider, but we can also look at it within a hospital. The benefit of this is not only, as you can say, target high-rate hospitals, but you can target high-rate providers. In fact, some of our plans here in the state of Florida were actually talking with some of the providers and suggesting that they were going to be dropped from the plan because their rates as providers were too high and making too much of a risk for their patient load. So, again, this data is useful at multiple levels, even by a Medicaid agency. Next slide.

We do do clinical measures in our quality initiative. It is important that you connect with your quality collaborative if you have one. Some of them are working on cesareans. But here you can see we analyze on a monthly basis -- this is reported quarterly -- on those that are actually meeting ACOG's definition for delivery, and the ones that are not, we'll show by the graph, they're dilated. For example, many of them being done by cesarean are less than six centimeters, which is the definition for active labor. So we're intervening way early for many moms in our state. We do this by key driver diagram. I'm just showing you some of them. There's no way to show all. But I wanted to bring up the point of clinical data. Next slide.

But, also look at are they using one of our key strategies for success in several hospitals -- the one that you saw that had the large decrease was they actually focused in on a pre-cesarean checklist, where the nurse and the doctors communicate together to actively decide. This is not about justifying cesarean, it's about actively making better decisions, so it's more of a quality effort. They also focused on their high-risk cesarean providers to try and reduce their rates. Next slide.

We also look at the change factors. Are they making changes and structural measures and pieces that can do that? So the benefit of the clinical piece is, we can work together with Medicaid. They can help us in promoting our key drivers, and we can help advise them and assist them and help them monitor their key changes. Next slide.

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There may be questions, and I forward to our question period at the end of the time.

[Lekisha Daniel-Robinson] Thank you so much. And as a reminder, please submit your questions in the chat, and we'll get to them after Dr. Zerzan-Thul's presentation. So, Judy Zerzan-Thul is the chief medical officer of the Washington State Health Care Authority. Dr. Zerzan-Thul.

[Judy Zerzan-Thul] Thank you. That was a great presentation. I am super excited about data at the individual level, and my presentation is going to be sort of the next layer up from the state perspective. So, here at the Washington State Health Authority, we cover 2.7 million lives. The bulk of those, about over two million are Medicaid, but the rest are public employees, school employees, and retirees. And so we sort of have a nice both Medicaid and commercial view of this issue, and I'm excited to share with you today some of the work we've been doing. Next slide, please.

So, first, I wanted to talk about why we care about this. And I know I'm preaching to the choir; that all of you know that we spend more than any other country on maternity care, and, yet our outcomes are stinky. In Washington, our overall, so the whole population, our C-section rate all cause is 27.9 percent, and that is lower than many other states, but, still, plenty high. We also have a regularly meeting, Maternal Mortality Review Panel. And in Washington State, as I'm sure in most of your states, about 60 percent of maternal deaths are preventable. Most of those are related to behavioral health needs and access. But, also, there are racial and ethnic differences, particularly among our tribes, and that is a gap we are working hard to address. Next.

So, this slide is a little wonky, but I wanted to show you, we have at our agencies, as many do, a quarterly target review of number of both operational and quality measures for organizations that we look at and have discussions. And so this slide is from that presentation that happened a month-and-a-half ago.

So, first, I'm going to orient to the sort of graph. So, the dotted line that's black, that's sort of flat, is overall all Washington hospitals, and you can see that that rate hasn't changed a ton. The blue dotted line that goes up and down and then up again is our uniform medical plan, so that is our state employee teachers' plan, not everyone but the bulk of them, and so you can see that that has gone up fair a bit. And then the solid blue line at the bottom is for Medicaid, and similarly, Medicaid has lower cesarean rates than commercial populations, and that is shown here.

We do have an overall goal that is from our Governor's Office of 14.7 percent primary C-section rate that we had met, but now our UMP (Washington's Uniform Medical Plan), plan is going up, and as the last presentation shows, if we dive into the data further, there is still a ton of variation across hospitals, and we are trying to figure out sort of how to do that.

Also, we have seen in 2020, an increase with COVID, and sort of wondering what's going on, and so we are continuing to sort of dig into this data and continuing to work on this is as an issue. I think as the last presenter shared, for sure, if you take your eye off this ball, it pops back up. So, we're working on a number of things. Next slide.

I also wanted to show you, because we recently started looking at our race/ethnicity data, and not surprising, there is variation, and our results are similar to what CMS showed from the national rates, and that African Americans have the highest rates of C-sections. I will say that the top table is for Medicaid, and then the bottom table is the non-Medicaid lives. And so you can see that there is a lot of variation, and some of those rates are quite high, particularly Pacific Islanders, which we have a number of, and people of Asian descent, which is, I know, is a giant bucket. But looking at these over time, I think is going to help us target some interventions to work on this. Next slide.

And so this is from our state-wide database, so this is all lives Medicaid, our UMP plan, but also every other pregnant person in Washington, and so there's a little bit more data. Much of this comes from the birth certificate data that our Department of Health does. And so you can also see that there are differences in terms of race/ethnicity. While some of them are somewhat stable, some of these have been

going up. So I think looking at equity and thinking about options, particularly we're thinking about doulas is a really important piece of how to work on the C-section rates. Next slide.

So, this talks about all those things we are doing to work on maternal care in general. As this webinar series is part of maternal infant health in general, we have a broader strategy, not just looking at C-sections. And so we are currently working, and what I'd like to chat with you about, is value-based purchasing. We have had a value-based purchasing roadmap in Washington state for a while now, I think since 2017, before I came here. And our most recent places that we're looking at how to bring value-based payment to maternity care. And how we're doing that is built on a number of different initiatives.

Here in Washington State, we have a Bree collaborative, which is a group of Washington-based providers, some advocates, and they put out sort of evidence-based standards of care for Washington to follow, and they finished, last year, a maternity episode of care that, if you're interested in, I highly recommend looking up.

We, as did a handful of other states in our last legislative session, have now extended our postpartum coverage of Medicaid from 2 months to 12 months for pregnant people, which I think will make a big difference. We have also implemented, in our commercial side of our house, a maternity episode of care, and then we have been participating in a learning collaborative on increasing access to midwifery-led care. We think that that is a piece that will really help the C-section rates. And then we've also been able to hire a couple of FTE that are specifically focused on maternity care, which has definitely been a game changer, and those staff are fantastic. Next slide.

So, the goals of our VBP work in maternity care are overall to incentivize high-quality/high-value care that improves perinatal health outcomes and addresses racial and ethnic disparities. And some of our specific targets are about the use of prenatal and postpartum care, increasing the screening, and then coordination and services for people with mental health and/or substance use disorders. Ideally, the care is dyadic, so we're thinking about the birth parent to the infant and services are coordinated and linked. That has proved harder to do than I wish it was. And then increase team-based care, including doulas and expanding the appropriate use of midwives.

One thing I wanted to point here, is that we have explicitly decided that controlling costs is a secondary consideration. Medicaid rates are always low. People always want more money. But we really feel strongly that this is not a place that we want to say we're saving money, but we want to change where the money goes, and we want to change what we're doing with the money, but not necessarily save money. So that's sort of a secondary consideration for us. Next slide.

We have done with our contractors that are helping us with this bundle, NORC, has done an environment scan for us to look at what other VBP models in other states exist and what that looks like, and we really wanted to make ours go through a year. But we found that most are episode-based, and they go through 60-days postpartum, and that most are also focused on cost containment and saving money. And North Carolina is the only state that offers a statewide maternity medical home. That is a model that we're very interested and might be a way that we shift our payments for this.

And then we've also learned, through this environmental scan, that thinking about that parent/infant dyadic care, there's really not a lot out there in terms of episode-based care, and it is difficult to get OB providers and pediatricians to communicate well with each other and work on that, and so we are thinking about the medical home opportunity or other ways that we can improve care coordination for these folks. Next slide.

So, I wanted to walk you through a couple of decision points that we are currently struggling with, and I'll say "struggling" in the hopes that this might help you. And we are happy to talk to people offline. So, the first one is thinking about, "what does this VBP model look like". The accountable provider is, of course, the OB or the delivery provider, which is, in some cases a family practice stuff or a midwife. And we are thinking that the amount might differ, based on the beneficiary risk category. So people with SUD or that need additional services would get a higher reimbursement than those that don't. And then this is, I think,

a really interesting place we're trying to sort out, "where is the best place to start". I think there's been a lot of VBP models in other types of care, but this is still relatively new for maternity care, and so how other VBP models have passed is that they've started with pay-for-reporting, which might be where we start, that we have people give us their data and give us our data that we currently have, that I showed you, is all claims' data, so thinking about how do we get additional data.

We have also thought about case pay-for-performance, so that you get more money when you do better on our measures that we're looking at. And then we're probably not going to do this, but this is certainly where some of the broader VBP conversation is moving nationally, is thinking about shared savings and thinking about downside risk, and so how might with move into that overtime if that is appropriate. Next slide.

So, the next one that we are struggling with and trying to figure out is what the measures are that we use for a VBP model, and so the Bree collaborative reports list some. You'll see some of this is screening and kind of risk assessment. The second category is birth outcomes and vaginal births versus C-sections is definitely on our list, and then care coordination. Next slide.

So, we are still building out the components of this project and figuring out both our current payment, which it turns out is not as simple as you think it might be, and continuing to have these discussions as I share these two issues about how to make this model that providers will want and how to create the right measurement tools that are easier to look at, to track progress. And we look forward to talking with all of you and continuing to evolve this, so thank you very much.

[Lekisha Daniel-Robinson] All right. Well, thank you both for excellent presentations that provide perspective on the clinical side, as well as the state perspective on addressing low-risk cesarean delivery.

We'd like to now turn it to questions. We have a number in the queue already. But if you have a question, please enter in the chat. Hopefully we will have time to get to it. I think the first question is for Dr. Sappenfield in Florida. Could you talk about how Florida established the data exchange for birth certificate data to go to the PQC?

[William Sappenfield] Yes, we do. We have data use agreement with the Florida Department of Health, and they have an online system, where they automate and can provide data routinely out to a variety of people, including Medicare and Social Security, and a variety of groups on the list. Once we have their data use agreement, we routinely have their data being dropped in a secure portal that we can retrieve and use the birth certificate data immediately.

[Lekisha Daniel-Robinson] Okay. Thank you. And let me give you one more as well. So you talked about some of the gains. How are the facilities able to retain some of those gains once lower rates are achieved?

[William Sappenfield] That is the biggest question. Part of it gets to be is you want to try to make sure the changes you build are built into the environment and into the system. For example, if you're using that pre-cesarean checklist, you want to continue to use that checklist over time. Many hospitals have a culture that promotes cesareans, so you want to try to do those environmental changes that will help.

So, the key is to figure out those key pivot points that led to those changes and trying to continue those. And it may be necessary to do what we call a refresher, where you have to go back after a period of time and reinforce some of the changes you made previously. And evidence shows that if you do that, you actually show that you not only regain it, but you actually go further. The challenge is being able to launch that second one and do it again. But again, you cannot lose your focus or let others lose their focus or move to something else. And the tracking systems, like provider rights and other things, need to be consistent so the quality is maintained. I hope that helps.

[Lekisha Daniel-Robinson] Okay. Thank you. Let me turn to a question for Dr. Zerzan-Thul. Can you talk more about your partnership for the obstetric home development.

[Judy Zerzan-Thul] Yes. This is something that we've just started to explore after NORC found this model. And so thinking about that, currently, we've just been talking internally about how might we do this and what would that look like. In our ideal state, we would like coordinated care to happen for the birth parents and the infant all through the first year of life. And we totally recognize our system is not set up for that right now. You know, it's typically an OB or a midwife that takes care of the birth parents. They pass off care, you know, to the pediatrician. There are areas of overlap, but the pediatrics or the family medicine docs do, as many states, do reimburse for maternal depression screening, and so that often happens at the infant's visit.

But, really figuring out, I think there's pieces that happen at the maternity provider visit, and there are pieces that happen at the infant visit, and sort of how can we put that together in a full picture is something that we're really trying to figure out. And it's made much more complicated by fact that all of this is related to payment, and those are very different payments, and there's not a way, really, for money to flow between practices unless you're in a big system, and so we're thinking about how to do that differently, and how to encourage that care coordination for the family unit.

[Lekisha Daniel-Robinson] That's great. Thank you. Next question is for Chrissy. Can you talk a little bit more about the CMS measure. Can an individual state get their own data on LRCD? Where are the specifications located?

[Chrissy Fiorentini] So, the specifications are located on the Core Set website, which is linked to in my slide. We have a resource mail that come out every year that has the specifications. CMS does calculate it on state's behalf, and I believe there's a plan to preview the data with the states at some point. I don't know if anyone else from Mathematica can speak more to that.

[Margo Rosenbach] This is Margo. I can speak to that. And, yes, there is a plan to preview the data, at some point, with states, so we'll be showing the LRCD measure as well as the low-birthrate measure, also, looking at stratification by states. So, more to come on that, and we're really excited to be able to make this progress.

[Lekisha Daniel-Robinson] Hopefully that was helpful. Another question, how are you addressing behavioral health and SUD for pregnant people in Washington?

[Judy Zerzan-Thul] So, we have a number of programs working on this. And, actually, one that I am most excited about getting off the ground is one that keeps the birth parents and baby together in the hospital for about five to seven days after birth, while the infant goes through opioid withdrawal. And so that dyadic care, I think, is really something that helps parents with addiction, and we have a hospital that started doing that, and they have some fantastic outcomes. So we're very excited about that piece.

We also have sort of an awful name, but it's called the "CUPP" program, Chemically Using Pregnant Persons, and that is a benefit specifically for pregnant people with addiction that provides addiction services and sort of intensive case management and things like that. One of the gaps that we realized as we really started to dig into substance use more deeply is that we don't really have a good program for pregnant people that are identified at birth. So, many people with addiction don't seek prenatal care, and they show up at the hospital in labor, and we don't have -- all of our programs that we have set up right now are really based on diagnosing or starting to provide those services pre-labor. And so we're just now starting to try and figure out how do we get those folks into a program, and what does the substance use benefit look like.

I'm very hopeful and I'm very excited that now we have a year of coverage postpartum that we'll be able to really develop some nice services that can help people who are struggling with addiction.

[Lekisha Daniel-Robinson] Thank you. Just a reminder that you can enter your question via the chat. We do have a few more minutes for those. But for our next question, it's Dr. Sappenfield again. Can you talk about the activities that you're focused on specifically to close the racial gap.

Using Data To Plan and Assess Quality Improvement Strategies to Reduce Low-Risk Cesarean Delivery in Medicaid and CHIP

[William Sappenfield] I'm embarrassed to say that I think we are far short of what we need to do to try to address that, and I think we're only learning how to do that better. Right now, what we try to do is work towards standardizations, because a lot the disparity that we have, especially in terms of medical procedures, relates to offering the same standard procedures that are taking place. So that's where the pre-cesarean checklist gets to be important. That's where we have been working on.

We spend a lot of time training on non-medical or non-pharmacologic ways to support labor. So many of the nurses are coming out now and don't know how to do the evidence-based strategies on positions and peanut balls and other things that can actually help. So, a lot of our focus right now has been much more on standardizing that care. We have tried to work on some of the communication messages and other pieces to try to promote diversity, but we have not had a very clear strategy, because part of that is part of that racial disparity is within the hospital, but some of that also depends on which hospitals that they're going to. I wish I had a better answer.

[Lekisha Daniel-Robinson] Well, understandable. But you talked about the checklist. Is that something that's publicly available?

[William Sappenfield] The nice thing about the Florida Prenatal Collaborative, everything that we have and everything we've talked about is literally on our web. If you go to FPQC.org, you can go to our PROVIDE Initiative. Literally, all the tools, everything we have is immediately available for those participating and not participating. One of the things we did recently is, California just published an article on effectively reducing their state's rate by the work that they're collaborative's have done. We actually developed a checklist of what Florida and what hospitals would need to do to have California's experience. We do a variety of tools. If you're interested to, if you reach out to us, we'll be happy to help walk you through some of that if that would be of help.

[Lekisha Daniel-Robinson] Great. Thank you. If we can, we'll try to see if we can drop it in the chat before we end. All right. So --

[William Sappenfield] One of the last things, I can bring up something.

[Lekisha Daniel-Robinson] Yes.

[William Sappenfield] Our Medicaid agency approached us, estimating NTSV cesarean rates using just their Medicaid claims data only. We've done a very nice analysis here in Florida that we're hoping to publish, that basically shows that claims data grossly underestimates what the NTSV cesarean rates are. It cuts a little bit less than half. But the other problem we discovered is that the random variation of coding by hospitals is such that it's distorts the perspective so they are not a close representation in our Medicaid agency, after reviewing our information, backed off of that idea.

[Lekisha Daniel-Robinson] Okay. Thank you. Thank you for sharing that. So, I think I want to thank both of our presenters at this point. Hopefully all that are participating have received a good flavor of activity that is underway within states to address low-risk cesarean deliveries. Uh-oh, it looks like -- okay, I thought there was another question in the chat. So, we appreciate your time and the discussion today. Hopefully this gives some additional thought about whether or not you'd like to participate in the CMS Affinity Group. Just as a reminder, the expressions of interest are due on July 15th, at 8:00 p.m., and I think we've dropped the link in the chat, where it will appear, or where you will find expression of interest.

But at this time, I think we will move to our next slide. I'll turn it over to my colleague, Kate now.

[Kate] Next slide, please. 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 final webinar in our series 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 next Wednesday, June 29th, at 2:00 p.m. Eastern time. You will receive an e-mail reminder with the registration link early next week. Please note

that the expression of interest to join the Affinity Group is due on July 15th, at 8:00 p.m. 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 email MACQualityImprovement@mathematica-mpr.com. That concludes today's webinar. Thank you all again for your participation.