

# Advancing Value-Based Maternity Care

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September 26th, 2019



# Agenda

*Outcomes-Driven Maternity Care through Value Based Payment report*

Panel presentations:

- Survey of women's childbearing experiences
- Group prenatal care program under the Massachusetts Medicaid ACO
- Building a maternal-infant bundle in Washington State

Q&A session



Established in 2014, the **Health Care Transformation Task Force** is a multi-sector industry consortium comprised of

Providers



Payers



Purchasers



Patients



committed to advancing delivery system transformation.



Our members aspire to have 75% of their respective businesses operating under **value-based payment arrangements** by the end of 2020.





The rate of pregnancy-related deaths in the U.S. has **more than doubled** in the past 20 years, and that rate is **3 to 4 times higher for Black and Native women** than for white women.

**The financial incentives for providers under fee-for-service are misaligned with evidence about effective maternity care.**

The **Expanding Access to Outcomes-Driven Maternity Care through Value Based Payment** report synthesizes research, best practices, and results from existing value-based payment models for maternity care and identifies key policies and strategies to scale outcomes-driven maternity care more broadly.

**Available:** <https://hcttf.org/outcomes-driven-maternity-care-vbp/>



# Outcomes-Driven Maternity Payment

Predominant payment strategies in the transition **away from fee-for-service care** that can be categorized as three outcomes-driven maternity payment levels with **increasing provider accountability for cost and quality**.



## *Perinatal fee schedule changes*

Paying differently for **high-value vs. low-value care**



## *Value-based maternity payments*

Linking reimbursement to **maternal outcomes** and total cost



## *Comprehensive payments for mother and newborn*

Linking reimbursement for **both maternal and infant quality outcomes** and total cost

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## Stakeholders must collaborate to address barriers and promote implementation of value-based maternity models:

- ***Listen to women*** and consider the social and cultural needs of pregnant women in design, implementation, and evaluation.
- ***Align health purchaser demand*** to design multi-payer value-based maternity payment models.
- ***Change public policy*** and the barriers that limit the full integration and consumer choice of using certified nurse midwives, doulas, and birth centers.
- ***Share learning*** to support wider adoption of effective models and continuous improvement.
- ***Conduct additional research*** to assess impact on things that matter to women and performance measures that translate the impact of childbirth on women's lives in a more holistic way.



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# Speakers



**Carol Sakala, PhD**

Director of Childbirth  
Connection Programs



**Rebecca Cunningham, MD**

Associate Medical Director



**Dr. Judy Zerzan, MD, MPH**

Chief Medical Officer



# Listening to Mothers in California



**A population-based survey of  
women's childbearing experiences**

**Carol Sakala, PhD, MSPH  
National Partnership for Women & Families**

Health Care Transformation Task Force  
Advancing Value-Based Maternity Care  
September 26, 2019



YELLOW CHAIR FOUNDATION

# *Listening to Mothers in California: Methods in a Nutshell*

- **Questionnaire adapted** for timely state issues, funder interests, and mobile-first display
- Sample drawn from monthly 2016 birth certificate files, with **oversampling** of:
  - Black women
  - Women with midwifery care
  - Women with vaginal birth after cesarean
- **Exclusions:**
  - Teens under 18
  - Women with multiple and out-of-hospital births
  - Women who could not participate in English or Spanish
  - Women not living with their baby at time of contact
  - Non-residents of California
- **2,539 women completed surveys in 2017** when their index babies were 2-11 months old
  - 2016 statewide birth certificate file used to weight data

*See full survey report appendix and methods overview document for detailed description of methods*

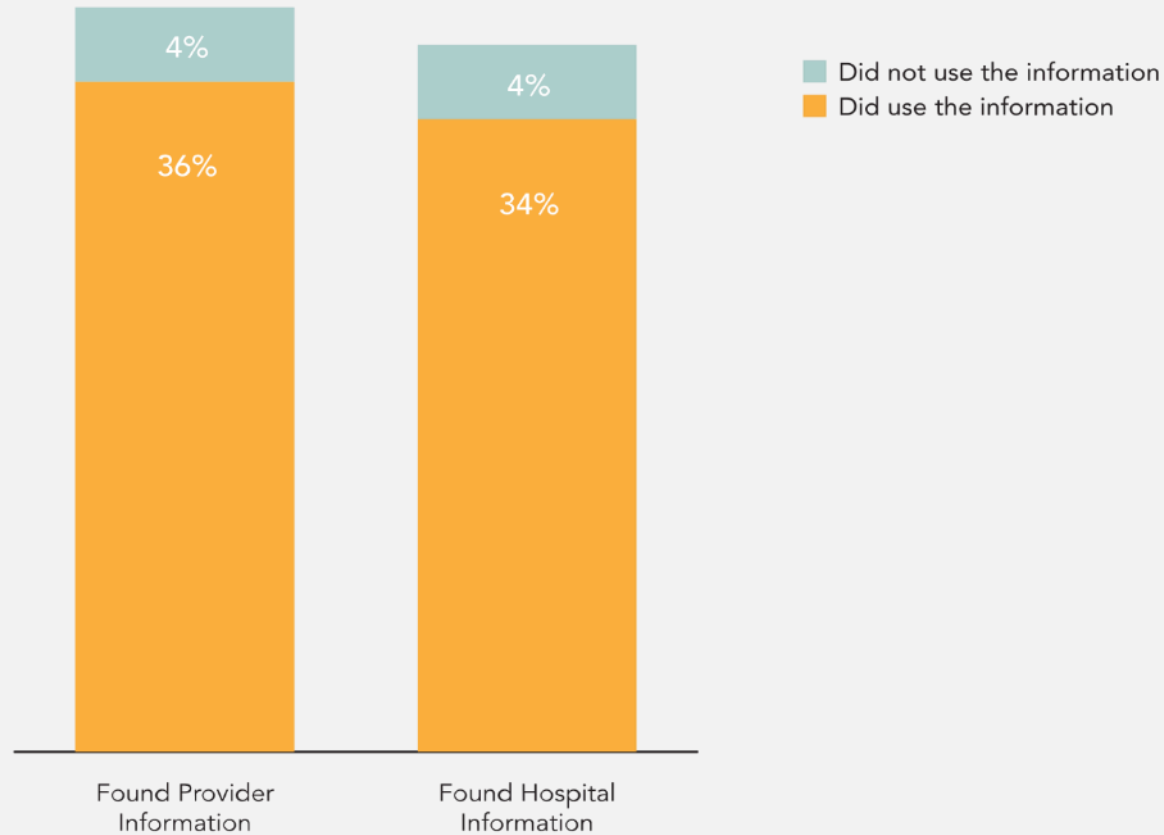


*Care Team and Place of Birth*

# Many Women Use Quality Information to Choose Providers and Hospitals

## Finding and Using Information About Quality Maternity Care Provider and Hospital, California, 2016

BASE: WOMEN WHO FOUND COMPARATIVE QUALITY INFORMATION (n = 1,309)



### Related results:

- *32% of women sought information about hospital cesarean rates.*
- *Just one in three were aware of variation in quality across obstetricians and across hospitals.*

Notes: "Not sure" and "did not find any information" not shown. Not all eligible respondents answered each item.

Source: Listening to Mothers in California (statewide survey of 2,539 women who gave birth in California hospitals in 2016), National Partnership for Women & Families, 2018, [www.chcf.org](http://www.chcf.org) (PDF).

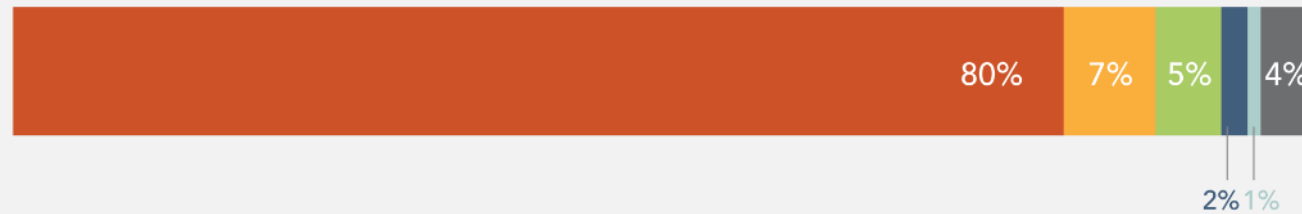
# California Women Overwhelmingly Use OBs

## Maternity Care Provider Type Prenatal Care and Birth, California, 2016

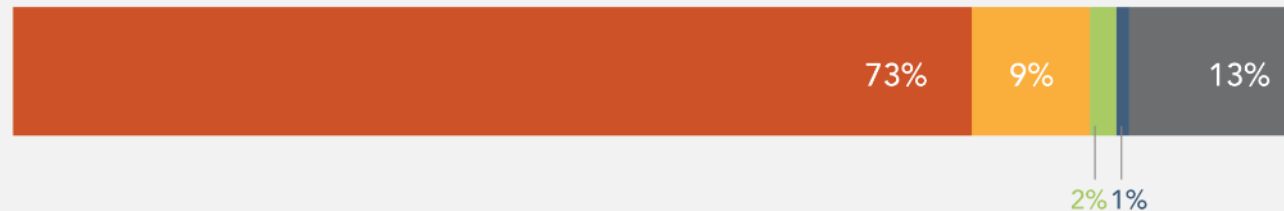
BASES: ALL WOMEN WHO ANSWERED THIS QUESTION

Obstetrician Midwife Nurse practitioner Family physician Physician assistant  
Doctor, not sure what type

Prenatal care (n = 2,519)



Birth (n = 2,506)



Notes: Not all eligible respondents answered each item. "Other" not shown. Prenatal care is the provider most often providing care during pregnancy. Birth is the provider who delivered the baby. Segments don't total 100% due to rounding.

Sources: Listening to Mothers in California (statewide survey of 2,539 women who gave birth in California hospitals in 2016), National Partnership for Women & Families, 2018, [www.chcf.org](http://www.chcf.org) (PDF); Dorothy Shaw et al., "Drivers of Maternity Care in High-Income Countries: Can Health Systems Support Woman-Centred Care?," *The Lancet* 388, no. 10057 (Nov. 5, 2016): 2282–95, doi:10.1016/S0140-6736(16)31527-6.

### Related results:

### Use patterns differ by race/ethnicity.

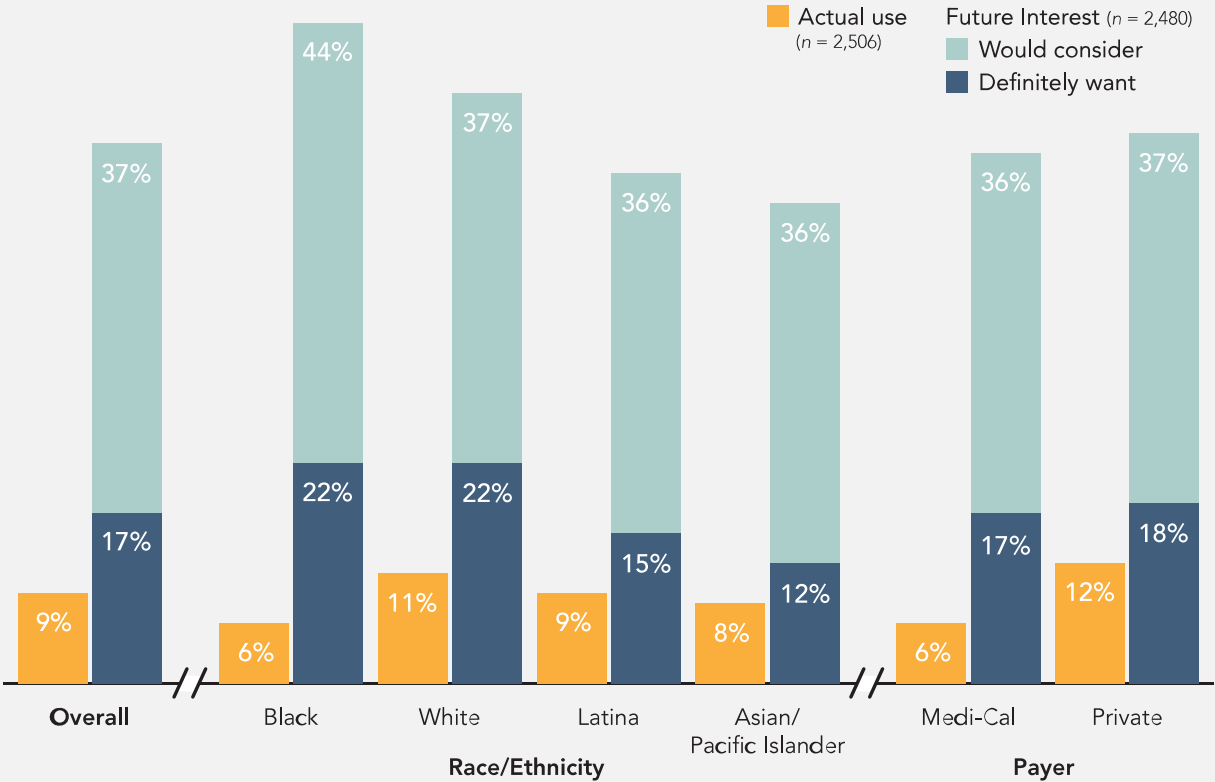
- *Asian/Pacific Islander women had highest usage of OB.*
  - *Prenatal care (88%)*
  - *Birth (81%)*
- *White women had highest usage of midwives.*
  - *Prenatal care (12%)*
  - *Birth (11%)*

# Most Women Open to Using Midwife for Future Birth

## Midwife Use: Actual Use as Birth Attendant in 2016 and Future Interest by Race/Ethnicity and Payer, California, 2016

BASES: ALL WOMEN WHO ANSWERED THIS QUESTION

If you have a future pregnancy, how open would you be to having a midwife as your maternity care provider (with doctor care, if needed)?



Notes: Data shown for use of midwife as birth provider. Midwives were the main prenatal care providers for 7% of survey participants (not shown). Not shown: "Would definitely not want this" and "not sure." Not all eligible respondents answered each item. Medi-Cal respondents were identified based upon a Medi-Cal record of a paid 2016 childbirth claim. Privately insured respondents self-identified in the survey. Differences within groups were not significant. Sources: Listening to Mothers in California (statewide survey of 2,539 women who gave birth in California hospitals in 2016), National Partnership for Women & Families, 2018; California Department of Health Care Services MIS/DSS Data Warehouse.

### The US is an outlier in midwife use:

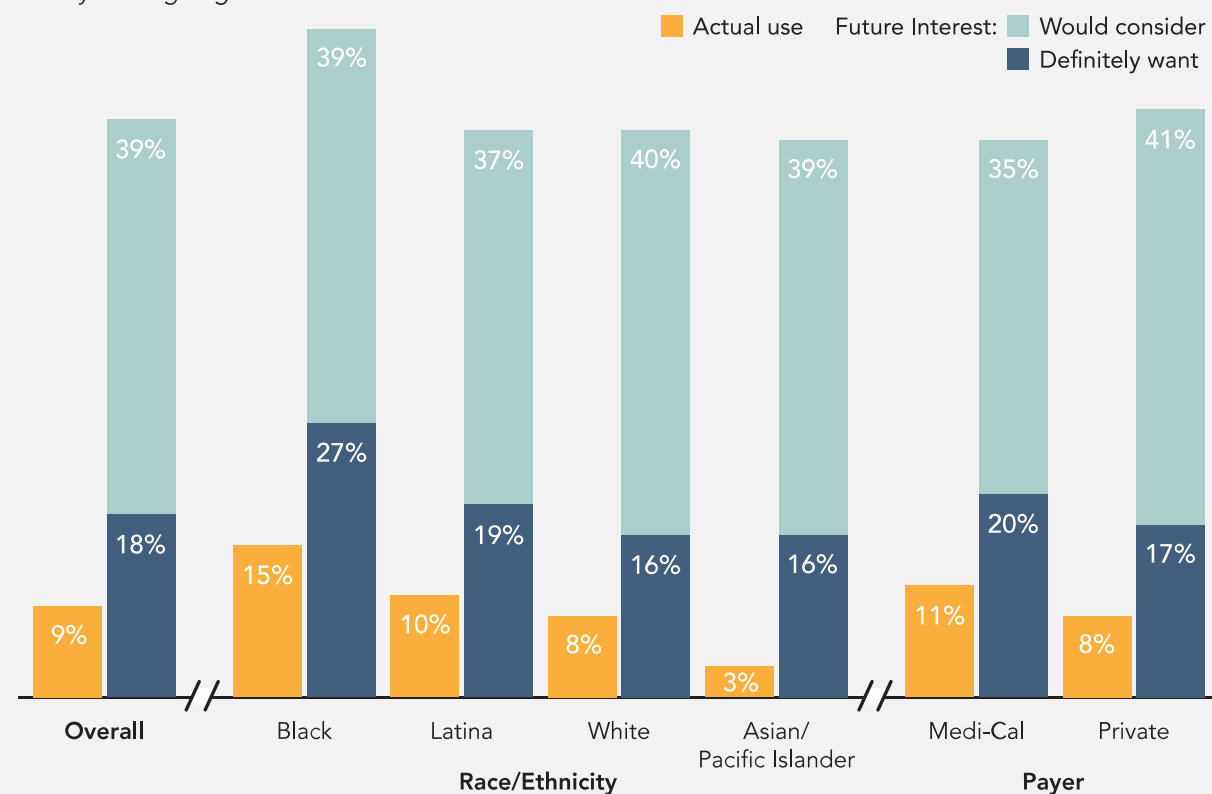
- Midwives are commonly used in high-income countries with strong maternal outcomes.
- Survey revealed lack of knowledge about midwives.
- Studies show midwives have similar outcomes and fewer interventions than doctors.
- 63% of those who would definitely not want a midwife in the future thought doctors provide higher quality care.

# Most Women Open to Using Doula for Future Birth

## Labor Doula Use: Actual of Doula Support and Future Interest by Race/Ethnicity and Payer, California, 2016

BASE: WOMEN WHO SPEAK PRIMARILY ENGLISH AT HOME (n = 1,433)

If you have a future pregnancy, how open would you be to having the support of a doula (trained labor companion) while you are giving birth?



Notes: A labor doula is a nonclinician health worker who offer continuous physical, emotional, and informational support to women around the time of birth. Due to evidence of overcounting the doula role among some non-English speakers, we limited our analyses of doula support to women who primarily speak English at home. "Would definitely not want this" and "not sure" not shown. Medi-Cal respondents were identified based upon a Medi-Cal record of a paid 2016 childbirth claim. Privately insured respondents self-identified in the survey. Not all eligible respondents answered each item.  $p < .01$  for differences by race/ethnicity and by payer. Sources: Listening to Mothers in California (statewide survey of 2,539 women who gave birth in California hospitals in 2016), National Partnership for Women & Families, 2018; California Department of Health Care Services MIS/DSS Data Warehouse

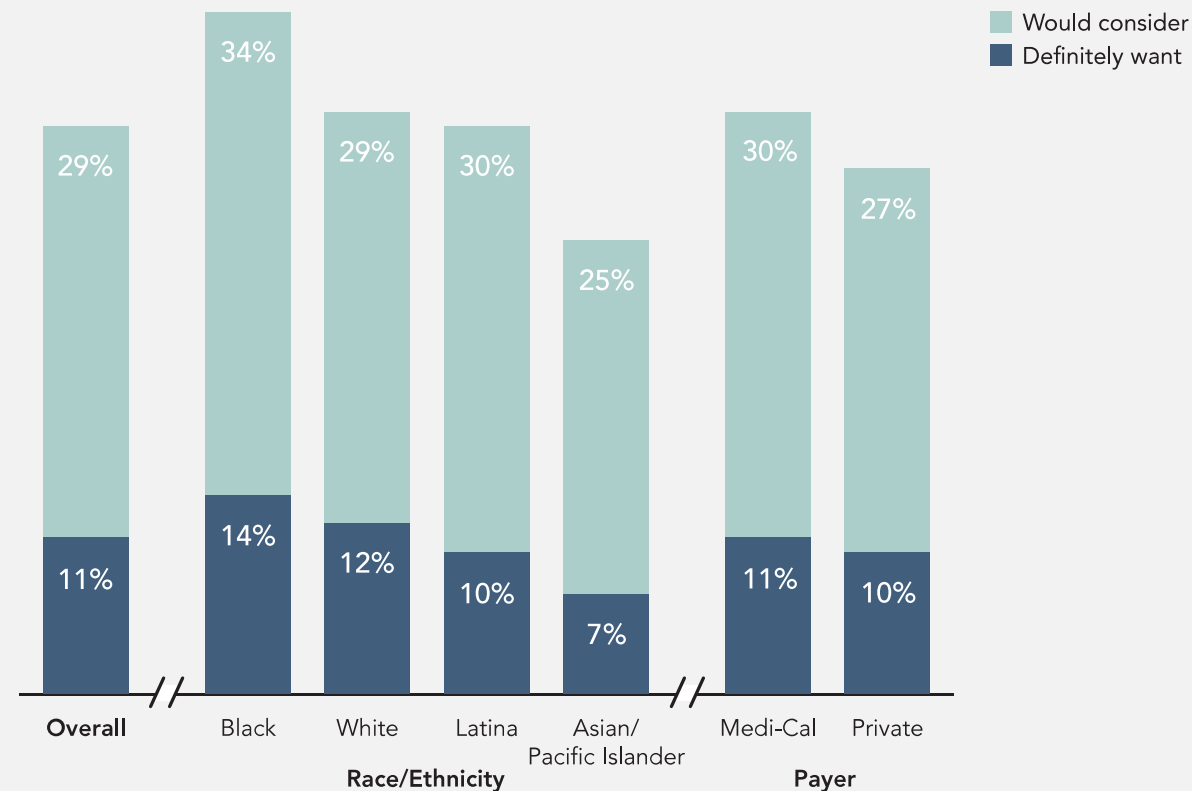
*"Our doula was the best thing about the care we got and I suspect the birth would have been drastically different without her support, influence, intervention and care."*

# Many Women Would Consider Birth Center for Future Birth

## Future Interest in Birth Center Use by Race/Ethnicity and Payer, California, 2016

BASE: ALL WOMEN WHO ANSWERED THIS QUESTION (n = 2,482)

If you have a future pregnancy, how open would you be to giving birth in a birth center that is separate from a hospital (with hospital care, if needed)?



From final 2016 birth certificate file:

- Only 0.3% of California women gave birth in a freestanding birth center per final 2016 birth certificate file.

*“I initially wanted a midwife, a doula and a birth center. Insurance wouldn’t cover this so we went with the traditional OB and hospital route.”*

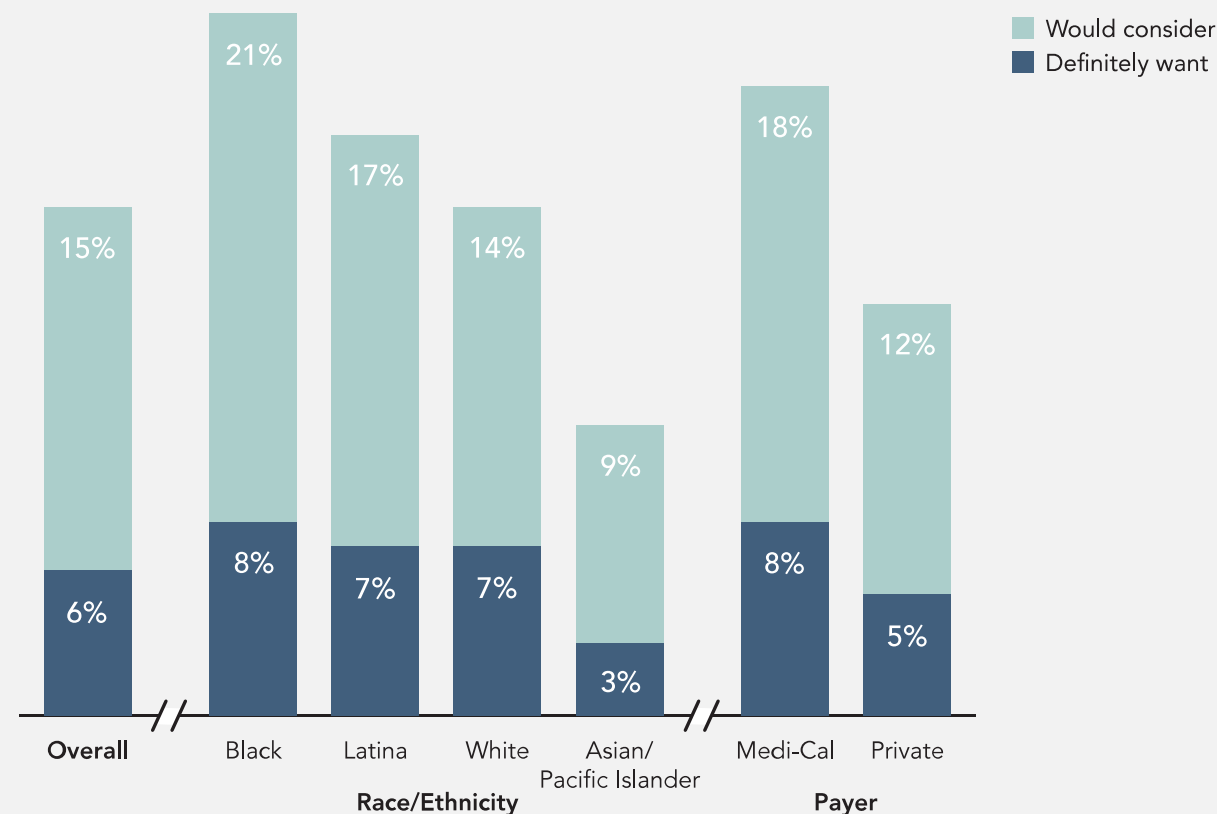
Notes: “Would definitely not want this” and “not sure” not shown. Medi-Cal respondents were identified based upon a Medi-Cal record of a paid 2016 childbirth claim. Privately insured respondents self-identified in the survey. Not all eligible respondents answered each item.  $p < .01$  for differences by race/ethnicity and by payer. Sources: Listening to Mothers in California (statewide survey of 2,539 women who gave birth in California hospitals in 2016), National Partnership for Women & Families, 2018; California Department of Health Care Services MIS/DSS Data Warehouse; Natality public-use data 2007–16 in CDC WONDER database, Centers for Disease Control and Prevention, February 2018, accessed March 6, 2018, [wonder.cdc.gov](https://wonder.cdc.gov).

# Fewer Women Expressed Interest in Home Birth in Future

## Future Interest in Home Birth by Race/Ethnicity and Payer, California, 2016

BASE: ALL WOMEN WHO ANSWERED THIS QUESTION (n = 2,482)

If you have a future pregnancy, how open would you be to giving birth at home (with hospital care, if needed)?



Notes: "Would definitely not want this" and "not sure" not shown. Medi-Cal respondents were identified based upon a Medi-Cal record of a paid 2016 childbirth claim. Privately insured respondents self-identified in the survey. Not all eligible respondents answered each item.  $p < .01$  for differences by race/ethnicity and by payer. Sources: Listening to Mothers in California (statewide survey of 2,539 women who gave birth in California hospitals in 2016), National Partnership for Women & Families, 2018; California Department of Health Care Services MIS/DSS Data Warehouse; Natality public-use data 2007–16 in CDC WONDER database, Centers for Disease Control and Prevention, February 2018, accessed March 6, 2018, [wonder.cdc.gov](https://wonder.cdc.gov).

### From final 2016 birth certificate file:

- Only 0.7% of California women gave birth at home per final 2016 birth certificate file.
- Black women more interested than women in other race/ethnicity groups.
- Women covered by Medi-Cal more interested than those with private insurance.



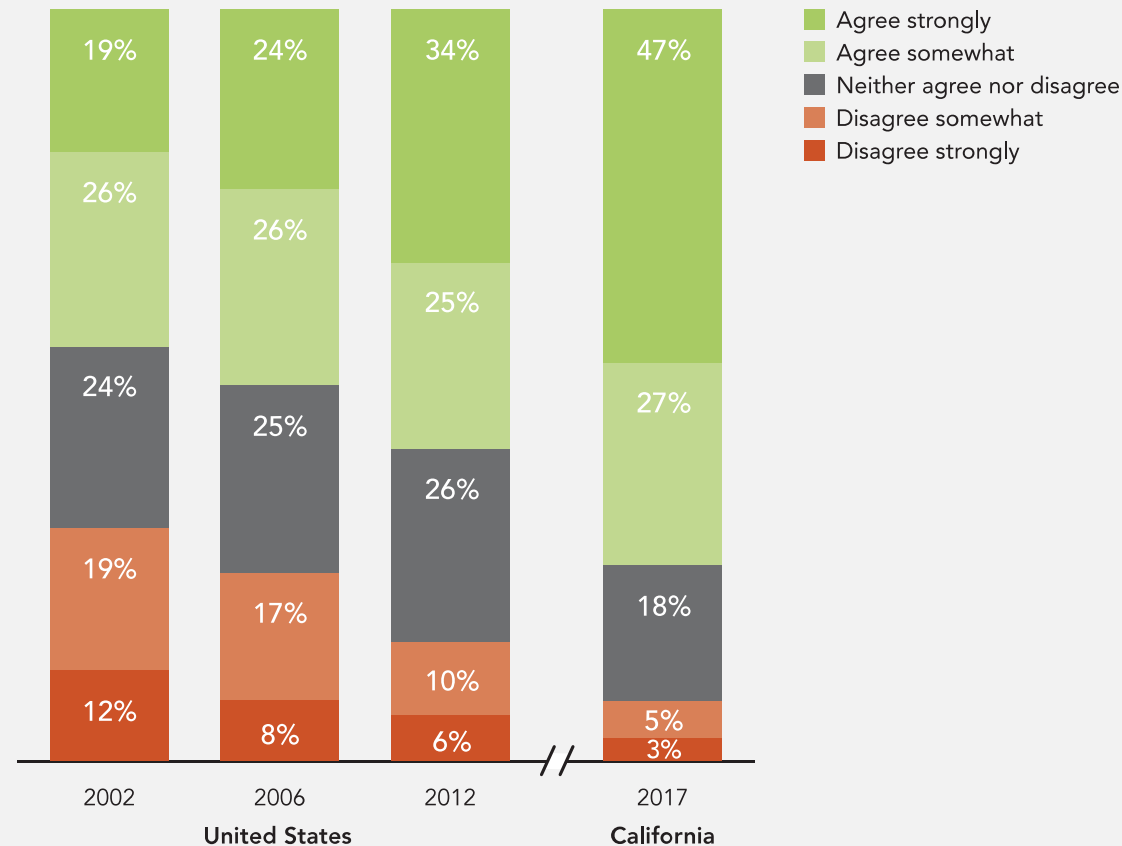
## Maternity Care Practices

# Women Do Not Want Childbirth to Be Interfered With

## Beliefs About Childbirth and Medical Interference United States, 2002 to 2012, Selected Years; California, 2017

BASE: ALL WOMEN WHO ANSWERED THIS QUESTION (n = 2,451)

*Childbirth is a process that should not be interfered with unless medically necessary.*



*“There was a question about birth being a process, and I think ... believing in mothers and trusting them during that process is important. We know our bodies. We know how we are feeling.... [In my case,] no one would listen.”*

Notes: Not all eligible respondents answered each item. Segments may not add to 100% due to rounding.

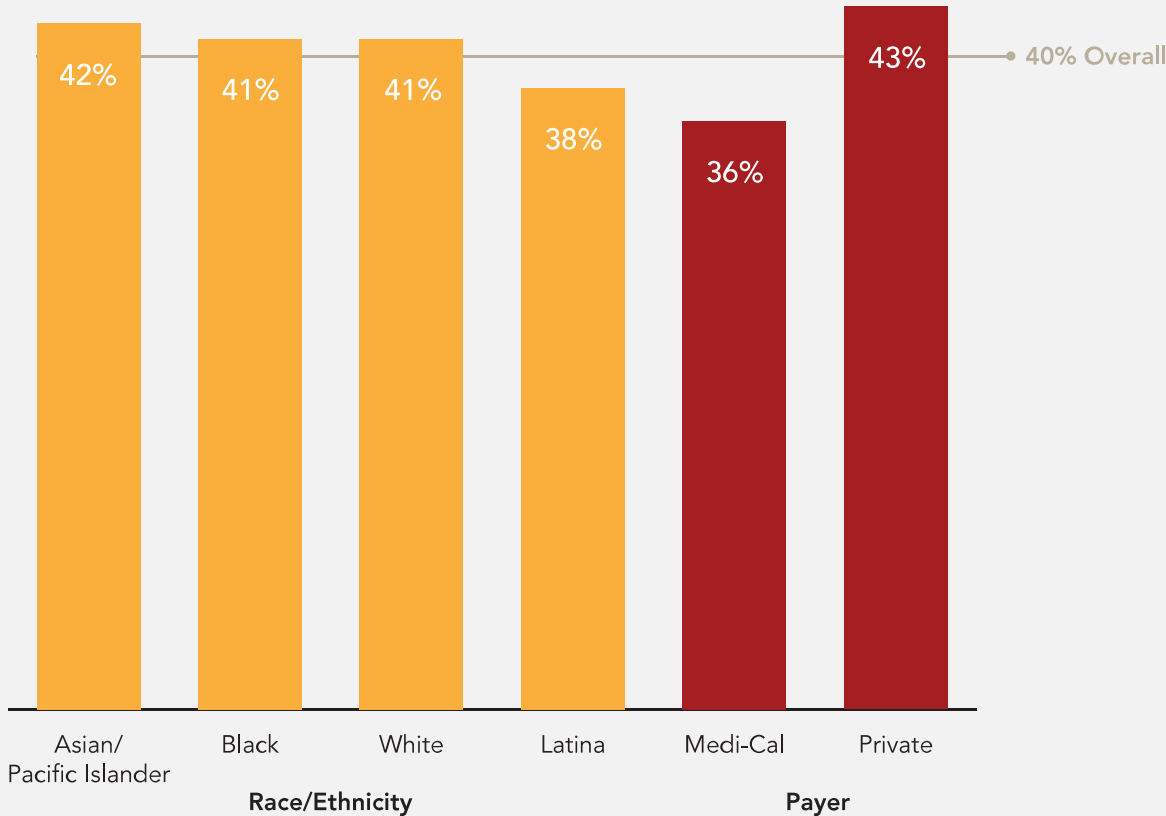
Sources: Listening to Mothers in California (statewide survey of 2,539 women who gave birth in California hospitals in 2016), National Partnership for Women & Families, 2018; Listening to Mothers III: Pregnancy and Birth, June 2013; Listening to Mothers II: Report of the Second National U.S. Survey of Women's Childbearing Experiences, October 2006; Listening to Mothers: Report of the First National U.S. Survey of Women's Childbearing Experiences, Maternity Center Association, October 2002, [www.nationalpartnership.org](http://www.nationalpartnership.org).

# Providers Attempted to Induce Labor of 4 in 10 Respondents

## Attempted Labor Induction by Race/Ethnicity and Payer, California, 2016

BASE: ALL WOMEN WHO ANSWERED THIS QUESTION (n = 2,521)

Did your maternity care provider try to induce your labor in any way?



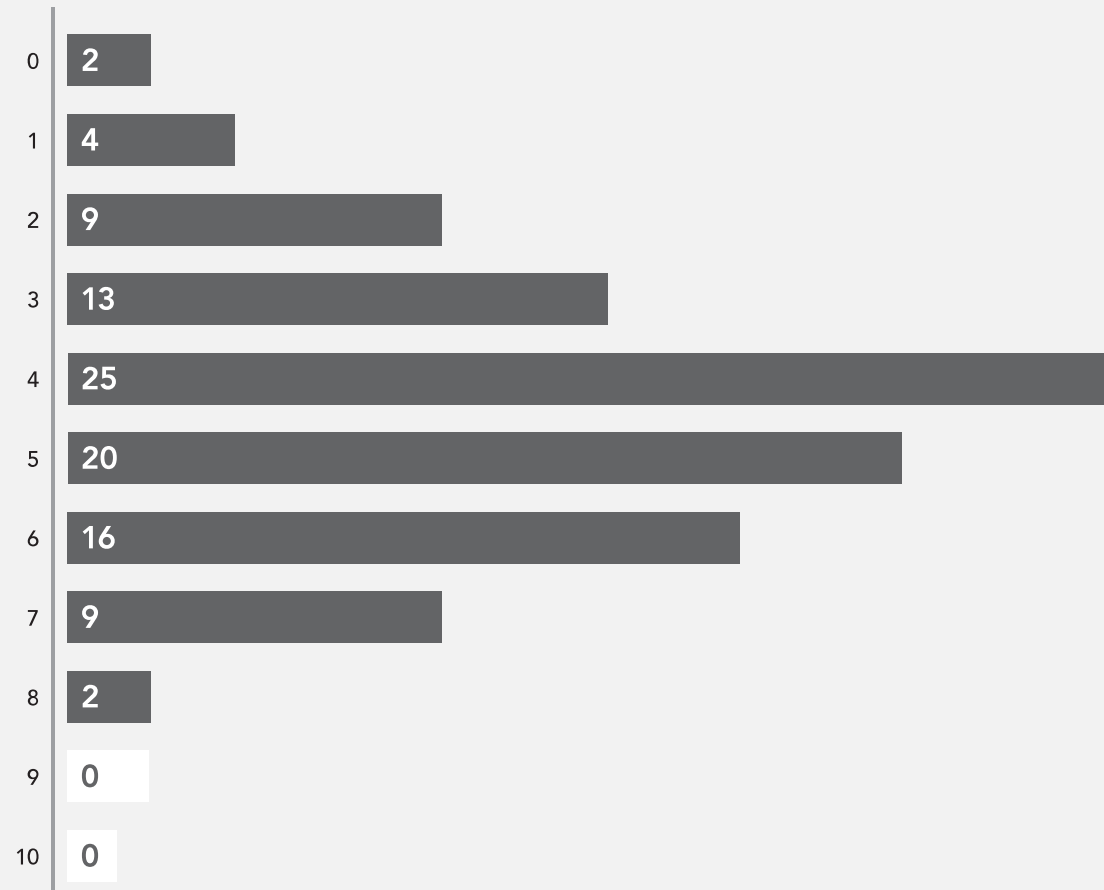
Notes: Medi-Cal respondents were identified based upon a Medi-Cal record of a paid 2016 childbirth claim. Privately insured respondents self-identified in the survey. Not all eligible respondents answered each item.  $p < .01$  for differences by payer. Differences by race/ethnicity were not significant.  
Sources: Listening to Mothers in California (statewide survey of 2,539 women who gave birth in California hospitals in 2016), National Partnership for Women & Families, 2018; California Department of Health Care Services MIS/DSS Data Warehouse

### Related results:

- More than 14% of all women and 37% of women with attempted induction identified only reasons not supported by best evidence for experiencing labor induction.
- 70% with attempted induced labor said that this had started their labor, and 10% were not sure.

# Nearly 3 in 4 Women Experienced 4 or More Interventions Around Time of Birth

Percentage Who Experienced Cumulative Number Among 10 Interventions Around the Time of Birth



Base: All women (n=2536)

Notes: Interventions include sweeping membranes, artificial rupture of membranes, synthetic oxytocin to induce and/or speed up labor, bladder catheter, intravenous line, electronic fetal monitoring, epidural for pain, narcotics for pain, vacuum or forceps, and cesarean birth. Vacuum or forceps data obtained from respondents' birth certificates

*“Once [at the hospital], the whole thing is just so intense; the monitoring, the IVs, the required positions, the rapidity with which you are asked to make decisions when you are in intense physical pain. It is not a therapeutic environment.”*

*“I felt like unnecessary intervention after intervention occurred.”*



*Vaginal and Cesarean Birth*

# Majority of Women Had Vaginal Births

## Sorting Every Birth by Mode of Birth and Further Breakdowns, California, 2016

BASE: ALL WOMEN WHO ANSWERED THIS QUESTION (n = 2,529)

	Vaginal, 69%	
	Vaginal/no previous cesarean, 67%	Vaginal birth after cesarean, 2%
Unassisted	65%	2%
Vacuum or forceps assisted	2%	0%
	Total Cesarean, 31%	
	Primary (first) cesarean, 16%	Repeat cesarean, 15%
Unplanned	11%	2%
Planned	5%	13%

Notes: Not all eligible respondents answered each item. "Other" not shown.

Sources: Listening to Mothers in California (statewide survey of 2,539 women who gave birth in California hospitals in 2016), National Partnership for Women & Families, 2018, [www.chcf.org](http://www.chcf.org) (PDF);

### Looking at all survey participants:

- 31% gave birth by cesarean
- Just 2% had, respectively,
  - a vaginal birth after cesarean (VBAC)
  - an assisted vaginal birth (with vacuum or forceps)
  - a repeat cesarean that was unplanned (occurred during labor)
- Among the 17% with a past cesarean, nearly all – 15% – had repeat cesareans, an untapped area for reducing cesarean births in California

# Over 40% of Black Women Gave Birth by Cesarean

## Total Cesarean Rates by Provider, Payer, and Race/Ethnicity, California, 2016

BASE: ALL WOMEN WHO ANSWERED THIS QUESTION (n = 2,529)

### Provider

Obstetrician

32%

Midwife

18%

### Payer

Medi-Cal

34%

Private

28%

### Race/Ethnicity

Black

42%

Asian/Pacific Islander

31%

Latina

31%

White

29%

• 31% Overall

*“Doctors DO encourage C-sections.... I don’t think my C-section was entirely necessary.”*

*“[The best thing about my care in the hospital was] the patience that the labor and delivery doctor had with me. He also didn’t jump the gun for me to get a C-section when he could have.”*

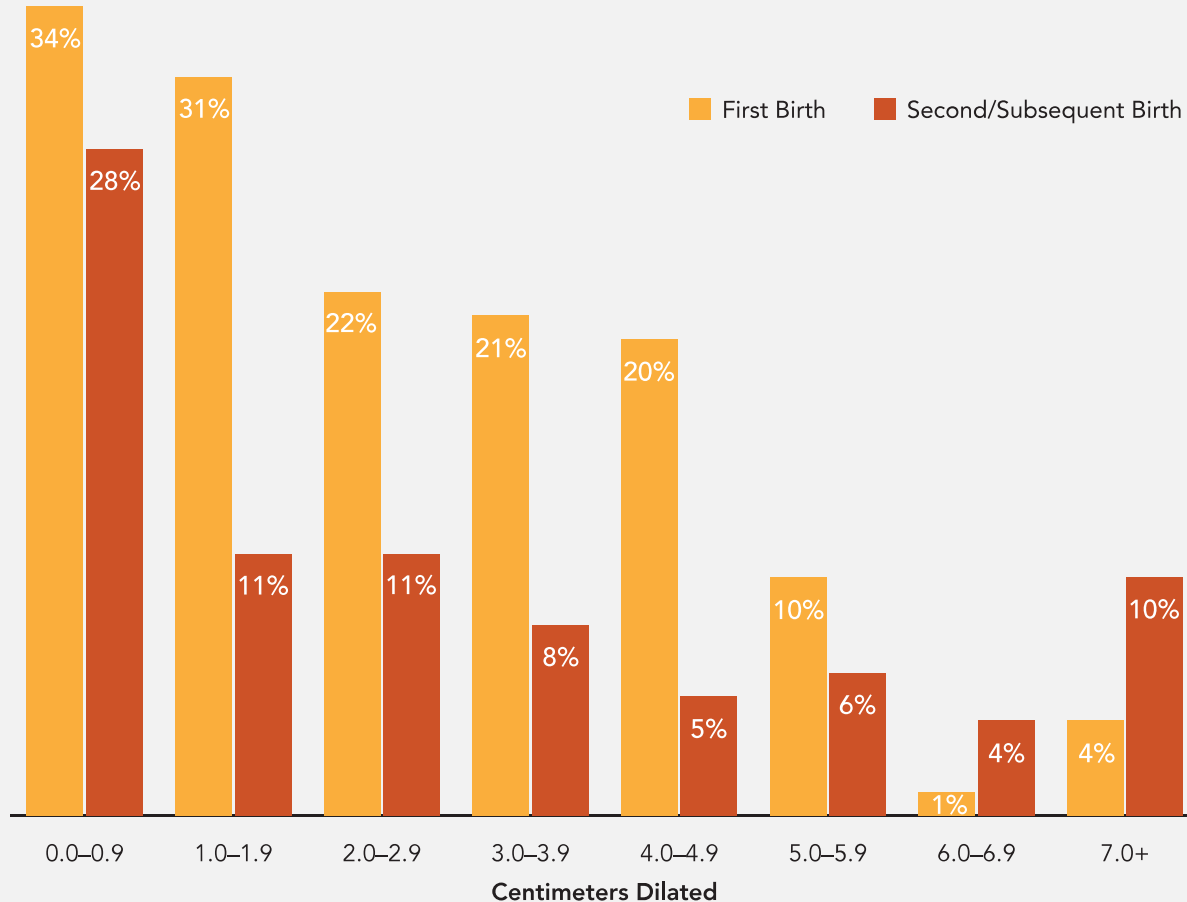
Notes: Not all eligible respondents answered each item. Provider type listed is the provider most often providing care during pregnancy. Medi-Cal respondents were identified based upon a Medi-Cal record of a paid 2016 childbirth claim. Privately insured respondents self-identified in the survey.  $p < .05$  for differences by race/ethnicity;  $p < .01$  for differences by payer and by provider.

Sources: Listening to Mothers in California (statewide survey of 2,539 women who gave birth in California hospitals in 2016), National Partnership for Women & Families, 2018; California Department of Health Care Services MIS/DSS Data Warehouse.

# Cesarean Rates Much Higher for Women Who Came to Hospital Early in Labor

## Cesarean Rate, by Centimeters Dilated at Admission California, 2016

BASE: WOMEN WHO HAD ONE OR MORE VAGINAL EXAMS AND EXPERIENCED LABOR ( $n = 1,461$ )



Notes: Not all eligible respondents answered each item.  $p < .01$  for differences in cesarean rate across dilation groups.

Source: Listening to Mothers in California (statewide survey of 2,539 women who gave birth in California hospitals in 2016), National Partnership for Women & Families, 2018.

### Dilation at first exam and cesarean rates:

- Only 23% of women who labored reported they were 5 cm or more dilated (i.e., in “active labor”) at first exam.
- Those women had very low cesarean rates.
- Benefits of delaying hospital admission are greatest for first-time mothers.

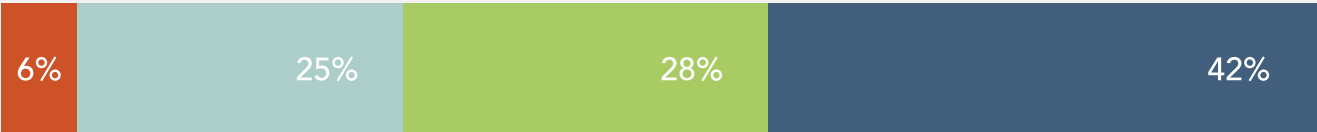
# Providers Focus Discussions on Why to Have Repeat Cesarean

## Discussion with Provider About Repeat Cesarean California, 2016

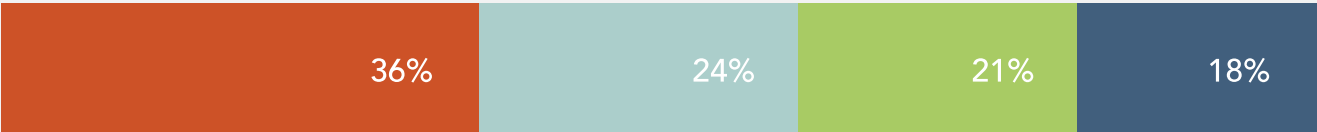
BASE: WOMEN WITH 1 OR 2 PRIOR CESAREANS WHO TALKED WITH A PROVIDER ABOUT SCHEDULING REPEAT CESAREAN BECAUSE OF PAST CESARIANS

How much did you and your maternity care provider talk about the reasons you might...

...want to schedule another c-section? (n = 285)



...not want to schedule another c-section? (n = 283)



■ Not at all   ■ A little   ■ Some   ■ A lot

### Related results (women's preferences regarding VBAC):

- Nearly half of women with repeat cesareans expressed interest in VBAC.
- Of those, nearly half did not have the option.
- In most instances, the option was not available because care provider and/or hospital did not allow VBAC.

Notes: Not all eligible respondents answered each item. Sections may not add to 100% due to rounding.  $p < .01$  for differences across groups in patterns of discussion for versus against a repeat cesarean.  
Source: Listening to Mothers in California (statewide survey of 2,539 women who gave birth in California hospitals in 2016), National Partnership for Women & Families, 2018.

# Only 15% of Women With a Past Cesarean Had a Vaginal Birth After Cesarean

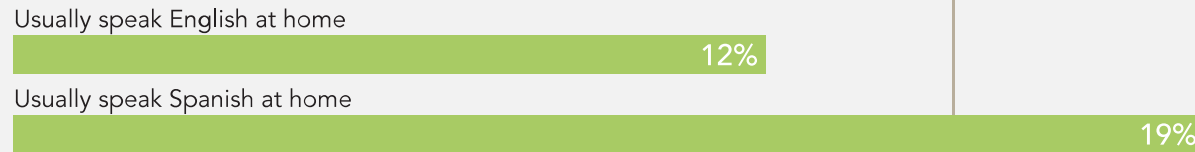
## Vaginal Birth After Cesarean (VBAC) Rates by Payer, Language, and Race/Ethnicity, California, 2016

BASE: ALL WOMEN WHO ANSWERED THIS QUESTION ( $n = 2,529$ )

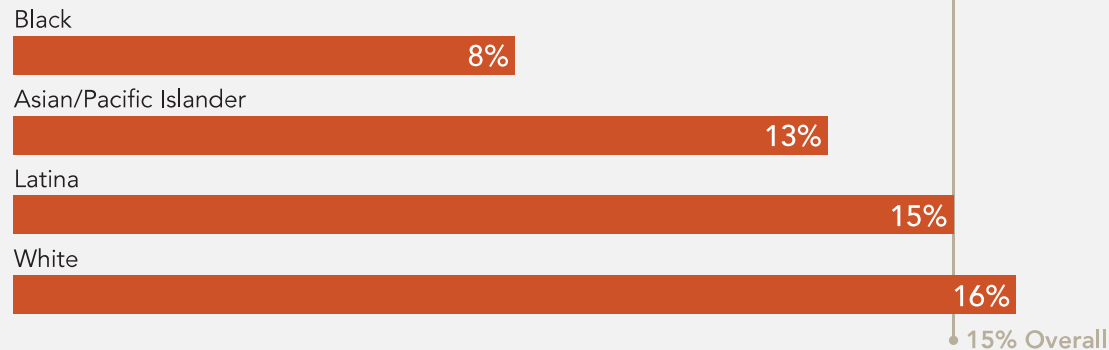
### Payer



### Language



### Race/Ethnicity



*"I had a lot of support during delivery which I believe helped me deliver vaginally after a C-section."*

Notes: Medi-Cal respondents were identified based upon a Medi-Cal record of a paid 2016 childbirth claim. Privately insured respondents self-identified in the survey. Not all eligible respondents answered each item.  $p < .01$  for differences by payer, by language, and by race/ethnicity.  
Sources: Listening to Mothers in California (statewide survey of 2,539 women who gave birth in California hospitals in 2016), National Partnership for Women & Families, 2018; California Department of Health Care Services MIS/DSS Data Warehouse.



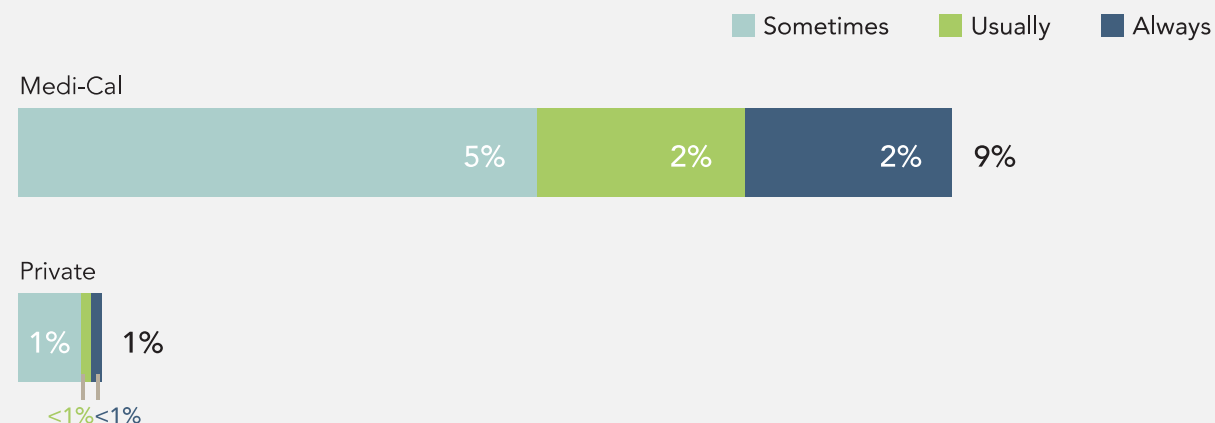
*Respectful and Disrespectful Treatment*

# Nearly 1 in 10 Women with Medi-Cal Coverage Felt Unfairly Treated

## Unfair Treatment Due to Type of Insurance by Payer, California, 2016

BASE: ALL WOMEN WHO ANSWERED THIS QUESTION ( $n = 2,501$ )

*During your recent hospital stay when you had your baby, how often were you treated unfairly because of the type of health insurance you had?*



### Related results:

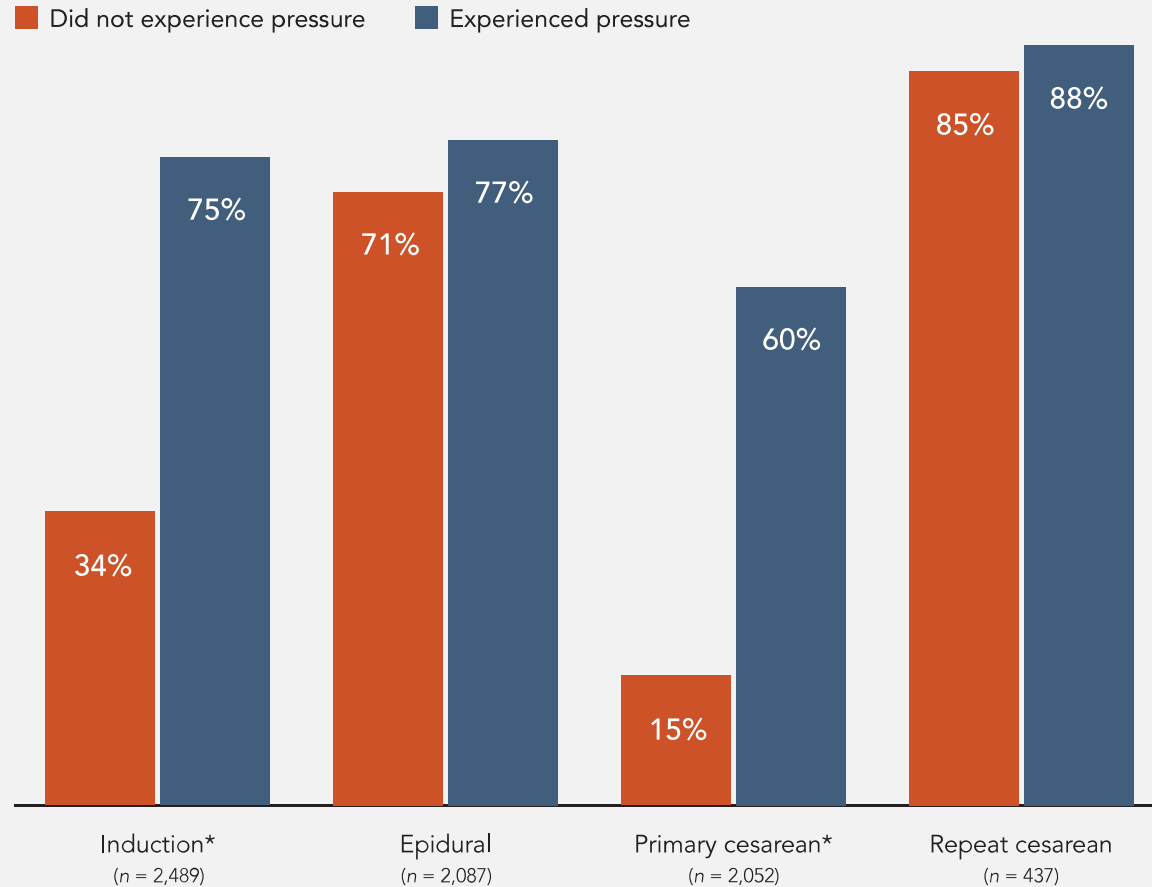
- **11% of Black women versus 1% of white women felt unfairly treated due to their race or ethnicity.**
- **13% of women who spoke an Asian language at home and 10% who spoke Spanish versus 3% of English speakers felt unfairly treated due to their language.**

Notes: "Never" not shown. Not all eligible respondents answered each item. Medi-Cal respondents were identified based upon a Medi-Cal record of a paid 2016 childbirth claim. Privately insured respondents self-identified in the survey.  $p < .01$  for differences by payer.

Sources: Listening to Mothers in California (statewide survey of 2,539 women who gave birth in California hospitals in 2016), National Partnership for Women & Families, 2018; California Department of Health Care Services MIS/DSS Data Warehouse.

# Use of Induction and Primary C-Section Associated with Provider Pressure

Rate of Interventions, No Pressure vs. Pressure  
by Intervention Type, California, 2016




*“The worst thing is I felt like I was being pressured into decisions.”*

*“I didn’t like how my doctor was trying to pressure me into a C-section and getting my tubes tied.”*

\*p < .01 for differences between “did not experience pressure” and “experienced pressure.”

Notes: Not all eligible respondents answered each item. Base for induction is all women, for epidural is women who experienced labor, for primary cesarean is women without a previous cesarean, for repeat cesarean is women with a previous cesarean.

Source: Listening to Mothers in California (statewide survey of 2,539 women who gave birth in California hospitals in 2016), National Partnership for Women & Families, 2018.

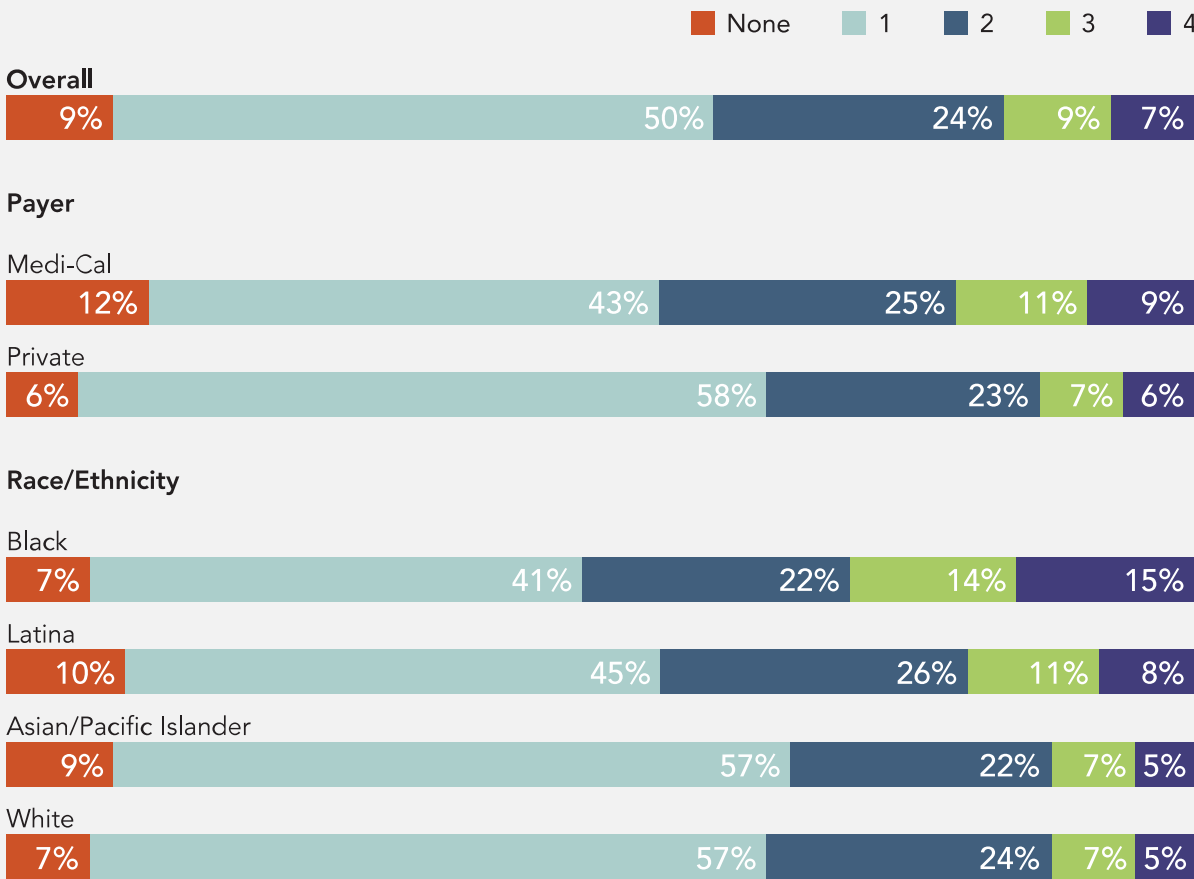
A close-up, low-angle shot of a woman with light brown hair and blue eyes, looking upwards and to the right with a contemplative expression. She is holding a newborn baby in her arms. The baby's head is resting against her chest. The background is dark and out of focus, featuring a warm, glowing light source, likely a fireplace, creating a soft, intimate atmosphere. The lighting is warm and directional, highlighting the woman's face and the baby's head.

## *Postpartum Experiences*

# Fewer than 1 in 10 Women Had No Postpartum Visit

## Number of Maternal Postpartum Office Visits by Payer and Race/Ethnicity, California, 2016

BASE: ALL WOMEN WHO ANSWERED THIS QUESTION (n = 2,444)



*“Overall I had a great birthing experience, but I was shocked by how little support the OBGYN office and doctors provided about everything beyond the childbirth process itself.”*

*“I would have loved to have more postpartum care and breastfeeding help.”*

Notes: Medi-Cal respondents were identified based upon a Medi-Cal record of a paid 2016 childbirth claim. Privately insured respondents self-identified in the survey. Not all eligible respondents answered each item. p < .01 for differences by race/ethnicity and by payer.  
Sources: Listening to Mothers in California (statewide survey of 2,539 women who gave birth in California hospitals in 2016), National Partnership for Women & Families, 2018; California Department of Health Care Services MIS/DSS Data Warehouse.

# Women with Medi-Cal Reported Less Emotional and Practical Support Since Birth

## Postpartum Emotional and Practical Support by Payer, California, 2016

BASE: ALL WOMEN WHO ANSWERED THIS QUESTION

Since the birth of your baby, how often do you have someone you can turn to for...

...emotional support, such as listening to your concerns and giving good advice?(n = 2,494)

Medi-Cal

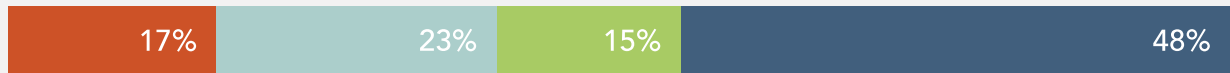


Private



..practical support, such as helping you get things done or get information you need?(n = 2,498)

Medi-Cal



Private



Never Sometimes Usually Always

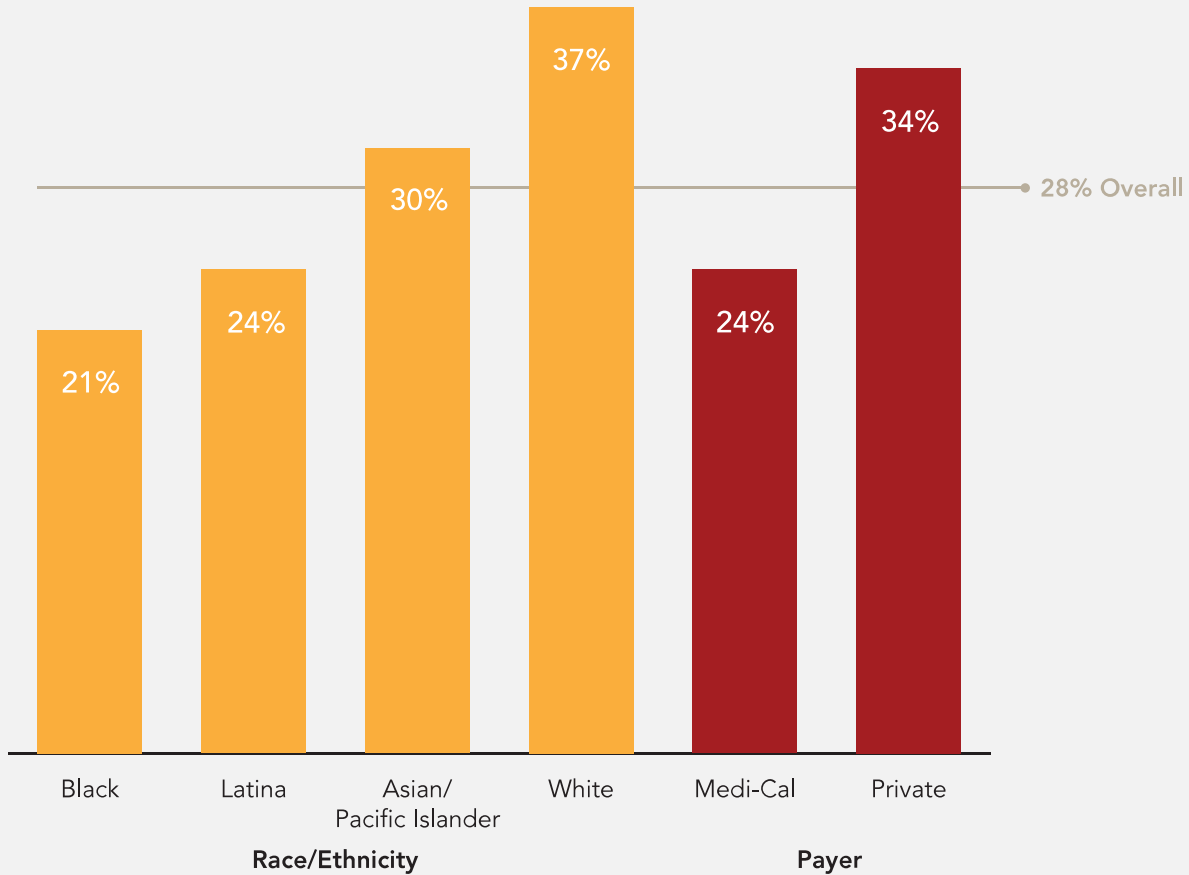
Notes: Not all eligible respondents answered each item. Medi-Cal respondents were identified based upon a Medi-Cal record of a paid 2016 childbirth claim. Privately insured respondents self-identified in the survey. Segments may not add to 100% due to rounding.  $p < .01$  for difference in emotional and in practical support by payer. Sources: Listening to Mothers in California (statewide survey of 2,539 women who gave birth in California hospitals in 2016), National Partnership for Women & Families, 2018; California Department of Health Care Services MIS/DSS Data Warehouse.

*“The lack of help after giving birth was stressful. Prenatal care was good, frequent, consistent. Afterwards, besides appointments for vaccines, you are all alone and on your own.”*

# Only 28% of Women Exclusively Fed Breast Milk for 6 Months

## Exclusive Breast Milk Feeding for Six Months by Race/Ethnicity and Payer, California, 2016

BASE: WOMEN WHO GAVE BIRTH AT LEAST 6 MONTHS PRIOR TO TAKING THE SURVEY (n = 713)



Notes: Medi-Cal respondents were identified based upon a Medi-Cal record of a paid 2016 childbirth claim. Privately insured respondents self-identified in the survey. Not all eligible respondents answered each item.  $p < .01$  for differences by race/ethnicity and by payer.  
Sources: Listening to Mothers in California (statewide survey of 2,539 women who gave birth in California hospitals in 2016), National Partnership for Women & Families, 2018; California Department of Health Care Services MIS/DSS Data Warehouse.

### Related result:

- *Just 42% who were breastfeeding at 1 week and not at time of survey felt they had fed breast milk as long as they liked.*

*“My biggest regret is not breastfeeding longer. I would recommend it to all mothers and I wish, as a first time mother, I would’ve gotten more help.”*

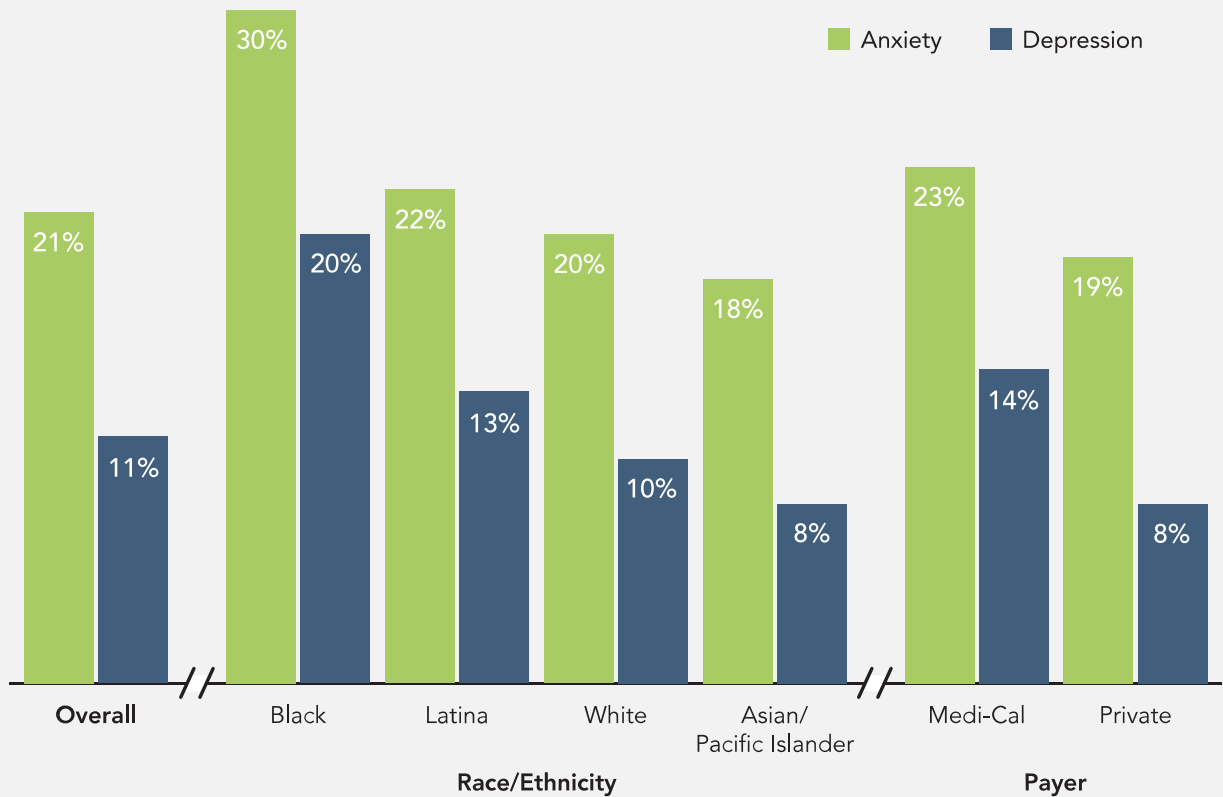


*Maternal Mental Health*

# More Women Reported Symptoms of Anxiety than Depression During Pregnancy

## Prenatal Symptoms of Anxiety and Depression by Race/Ethnicity and Payer, California, 2017

BASE: ALL WOMEN WHO ANSWERED THESE QUESTIONS (n = 2,519)



Notes: Women were asked to answer two questions each about the frequency of anxiety symptoms and depression symptoms, both “during your recent pregnancy” and “during the last two weeks.”\* Medi-Cal respondents were identified based upon a Medi-Cal record of a paid 2016 childbirth claim. Privately insured respondents self identified in the survey. Not all eligible respondents answered each item. Differences by race/ethnicity and by payer were not significant for prenatal anxiety.  $p < .01$  for differences by race/ethnicity and by payer for prenatal depression.

Sources: Listening to Mothers in California (statewide survey of 2,539 women who gave birth in California hospitals in 2016), National Partnership for Women & Families, 2018; California Department of Health Care Services MIS/DSS Data Warehouse. \*Kurt Kroenke et al., “An Ultra-Brief Screening Scale for Anxiety and Depression: The PHQ-4,” Psychosomatics 50, no. 6 (Nov.–Dec. 2009): 613–21, doi:10.1016/S0033-3182(09)70864-3.

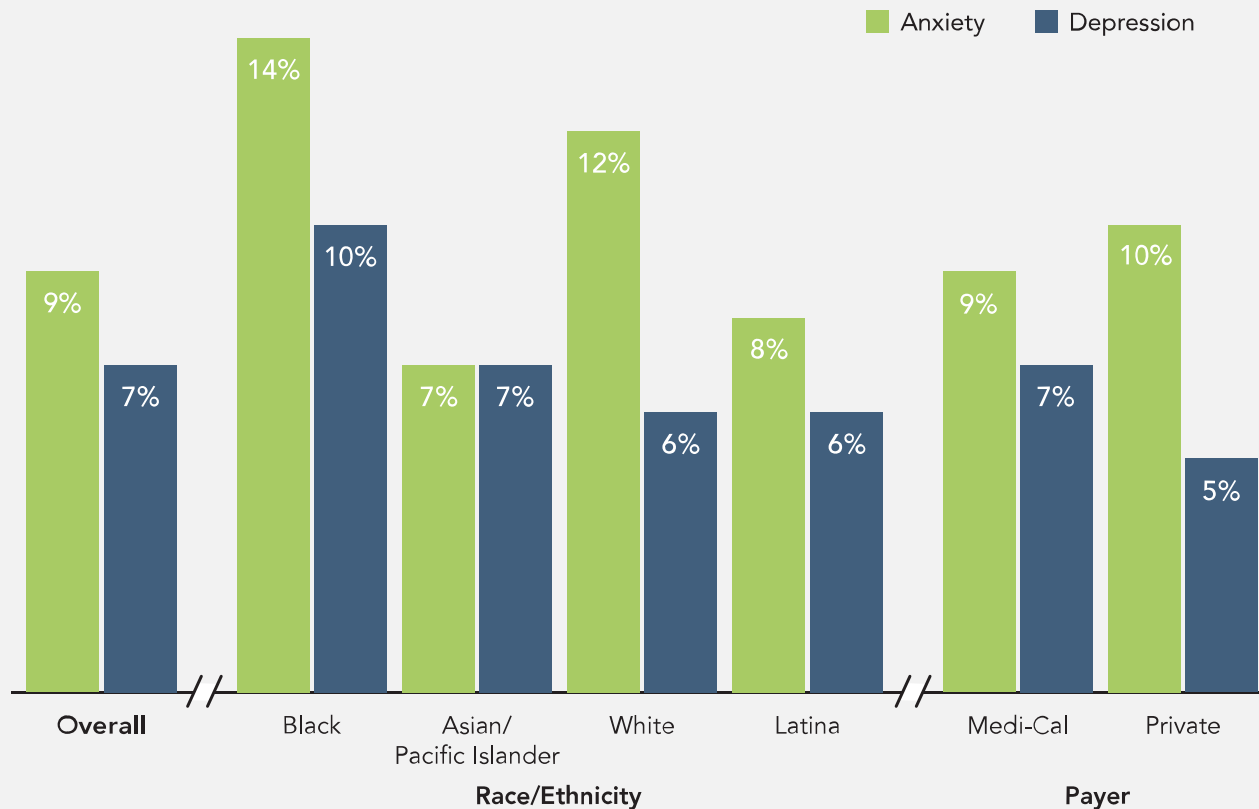
### Presence of symptoms varies:

- *Black women most frequently reported symptoms.*
  - 30% reported anxiety.
  - 20% reported depression.
- *Women with Medi-Cal coverage reported symptoms more frequently than women with private insurance.*
  - 23% reported anxiety.
  - 14% reported depression.

# Many Women Reported Postpartum Symptoms of Anxiety and Depression

## Postpartum Symptoms of Anxiety and Depression by Race/Ethnicity and Payer, California, 2017

BASE: ALL WOMEN WHO ANSWERED THESE QUESTIONS (n = 2,519)



*“After giving birth, I was full of anxiety. They should have someone to comfort women feeling that way.”*

*“After birth, I cried for weeks. I felt so down I had no support from my OB doctor. I didn’t get to see her after 6 weeks. It would be nice if there was more support for new mommies.”*

Notes: Women were asked two questions each about the frequency of anxiety symptoms and depression symptoms, both “during your recent pregnancy” and “during the last two weeks.” \* Medi-Cal respondents were identified based upon a Medi-Cal record of a paid 2016 childbirth claim. Privately insured respondents self-identified in the survey. Not all eligible respondents answered each item.

Sources: Listening to Mothers in California (statewide survey of 2,539 women who gave birth in California hospitals in 2016), National Partnership for Women & Families, 2018; California Department of Health Care Services MIS/DSS Data Warehouse. \*Kurt Kroenke et al., “An Ultra-Brief Screening Scale for Anxiety and Depression: The PHQ-4,” *Psychosomatics* 50, no. 6 (Nov.–Dec. 2009): 613–21, doi:10.1016/S0033-3182(09)70864-3.

# Minority of Women with Anxiety or Depression Symptoms Received Treatment

## Prenatal and Postpartum Counseling and Treatment Among Women Reporting Symptoms of Anxiety or Depression California, 2016

BASE: ALL WOMEN SCREENING POSITIVE FOR PRENATAL/POSTPARTUM ANXIETY OR DEPRESSION

Did you receive counseling or treatment?

■ No ■ Yes

### Prenatal



### Postpartum



Notes: Women were asked two questions each about the frequency of anxiety symptoms and depression symptoms both “during your recent pregnancy” and “during the last two weeks.” Not all eligible respondents answered each item.

Source: Listening to Mothers in California (statewide survey of 2,539 women who gave birth in California hospitals in 2016), National Partnership for Women & Families, 2018.

\*Kurt Kroenke et al., “An Ultra-Brief Screening Scale for Anxiety and Depression: The PHQ-4,” Psychosomatics 50, no. 6 (Nov.–Dec. 2009): 613–21, doi:10.1016/S0033-3182(09)70864-3.

*“There needs to be more measures taken to prevent PPD (postpartum depression) and places for mothers to go for help without feeling stigmatized for it.”*



## *Listening to Mothers in California: Resources*

# Where to Find Project Resources



The screenshot shows the California Health Care Foundation (CHCF) website. The header includes the CHCF logo, navigation links (ABOUT CHCF, OUR WORK, THE CHCF BLOG, GRANTS, INVESTMENTS, EVENTS, MEDIA, SEARCH), and social media icons. A secondary navigation bar highlights 'Topics', 'Projects', 'Resource Centers', and 'Collections'. The main content area features a photo of three pregnant women and a text box titled 'Listening to Mothers in California' with a description of the survey. Below this, a list of resources is provided, including highlights, findings, infographics, fact sheets, issue briefs, videos, and background materials. A footer note mentions the availability of the data set and codebook.

**California Health Care Foundation** HELP | SIGN UP

ABOUT CHCF OUR WORK ▼ THE CHCF BLOG GRANTS INVESTMENTS EVENTS MEDIA SEARCH

Topics Projects Resource Centers Collections

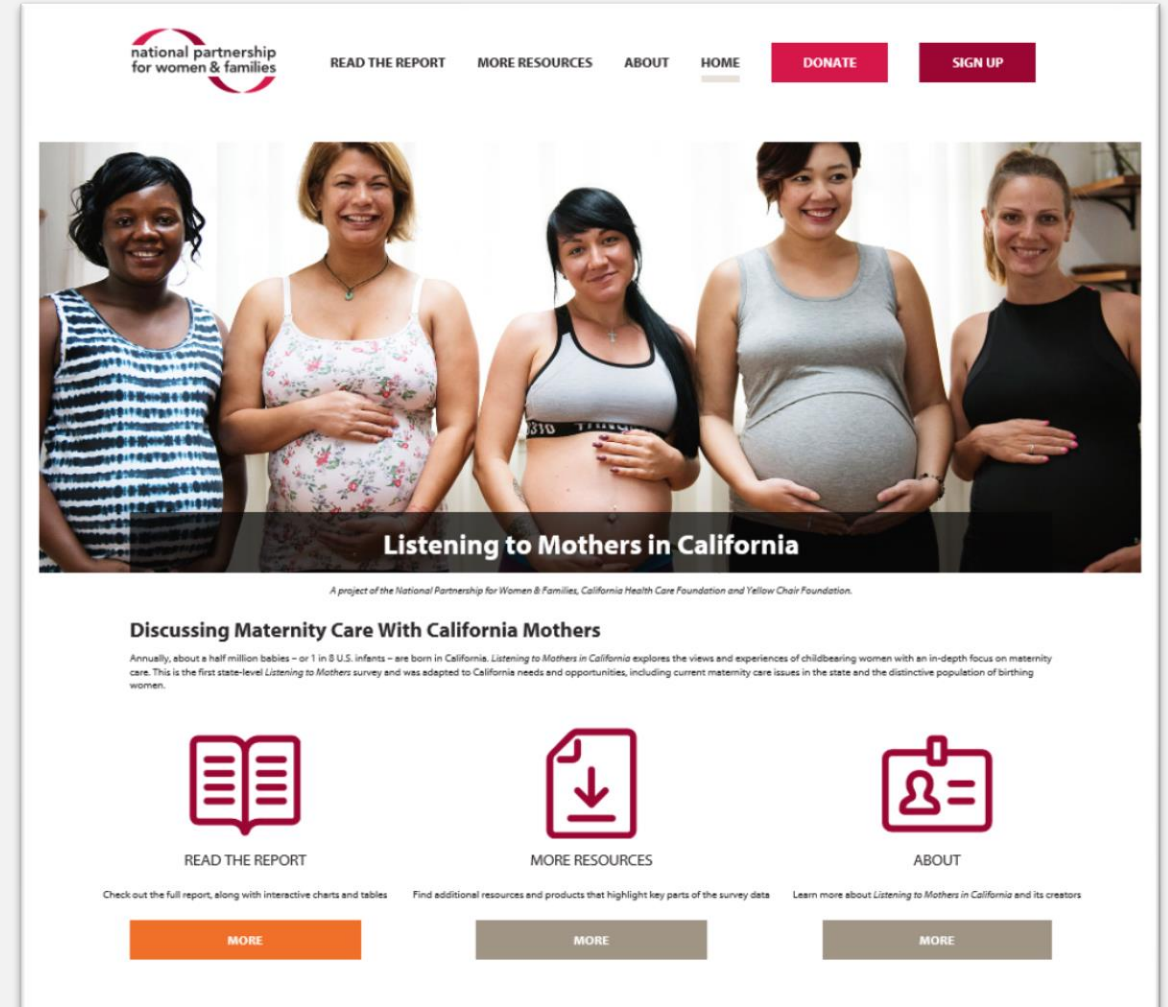
**Listening to Mothers in California**  
More than 2,500 women share their attitudes and experiences of childbirth. The results reveal what is and isn't working with maternity care in the Golden State.

*Listening to Mothers in California* is a statewide, population-based survey of women who gave birth in 2016. Led by the National Partnership for Women and Families, the project was funded by CHCF and the Yellow Chair Foundation. This collection features a variety of survey-related resources:

- **Highlights of survey results:** a [data snapshot](#), and a [file of individual data snapshot charts \(ZIP\)](#)
- **Comprehensive findings:** [full survey report \(PDF\)](#), and [interactive digital version of the full survey report](#)
- **Infographic** on the overmedicalization of childbirth
- **Fact sheets** on [care team and place of birth \(PDF\)](#), [cesarean births \(PDF\)](#), and [maternal mental health \(PDF\)](#)
- **Issue briefs** on the experiences of [Asian and Pacific Islander \(PDF\)](#), [Black \(PDF\)](#), and [Latina \(PDF\)](#) mothers
- **Videos** featuring stories from childbearing women and providers (see below)
- **Background materials** including the [survey methodology \(PDF\)](#), [a fact sheet about the survey \(PDF\)](#), and [the complete survey questionnaire \(PDF\)](#)
- **Webinar on September 20** ([register now](#), recording and presentation slides coming soon)

The data set and codebook will be available June 2019 via the [University of North Carolina Dataverse](#). All of the resources from this survey are available via [National Partnership](#) and through this collection.

[www.chcf.org/listening-to-mothers-ca](http://www.chcf.org/listening-to-mothers-ca)



The screenshot shows the National Partnership for Women & Families website. The header includes the logo, navigation links (READ THE REPORT, MORE RESOURCES, ABOUT, HOME), and buttons for DONATE and SIGN UP. The main content area features a photo of five pregnant women and a text box titled 'Listening to Mothers in California' with a description of the survey. Below this, a section titled 'Discussing Maternity Care With California Mothers' provides a brief overview of the survey. At the bottom, three columns with icons and text links lead to 'READ THE REPORT', 'MORE RESOURCES', and 'ABOUT' sections.

**national partnership for women & families** READ THE REPORT MORE RESOURCES ABOUT HOME DONATE SIGN UP

**Listening to Mothers in California**  
A project of the National Partnership for Women & Families, California Health Care Foundation and Yellow Chair Foundation.

**Discussing Maternity Care With California Mothers**  
Annually, about a half million babies – or 1 in 8 U.S. infants – are born in California. *Listening to Mothers in California* explores the views and experiences of childbearing women with an in-depth focus on maternity care. This is the first state-level *Listening to Mothers* survey and was adapted to California needs and opportunities, including current maternity care issues in the state and the distinctive population of birthing women.

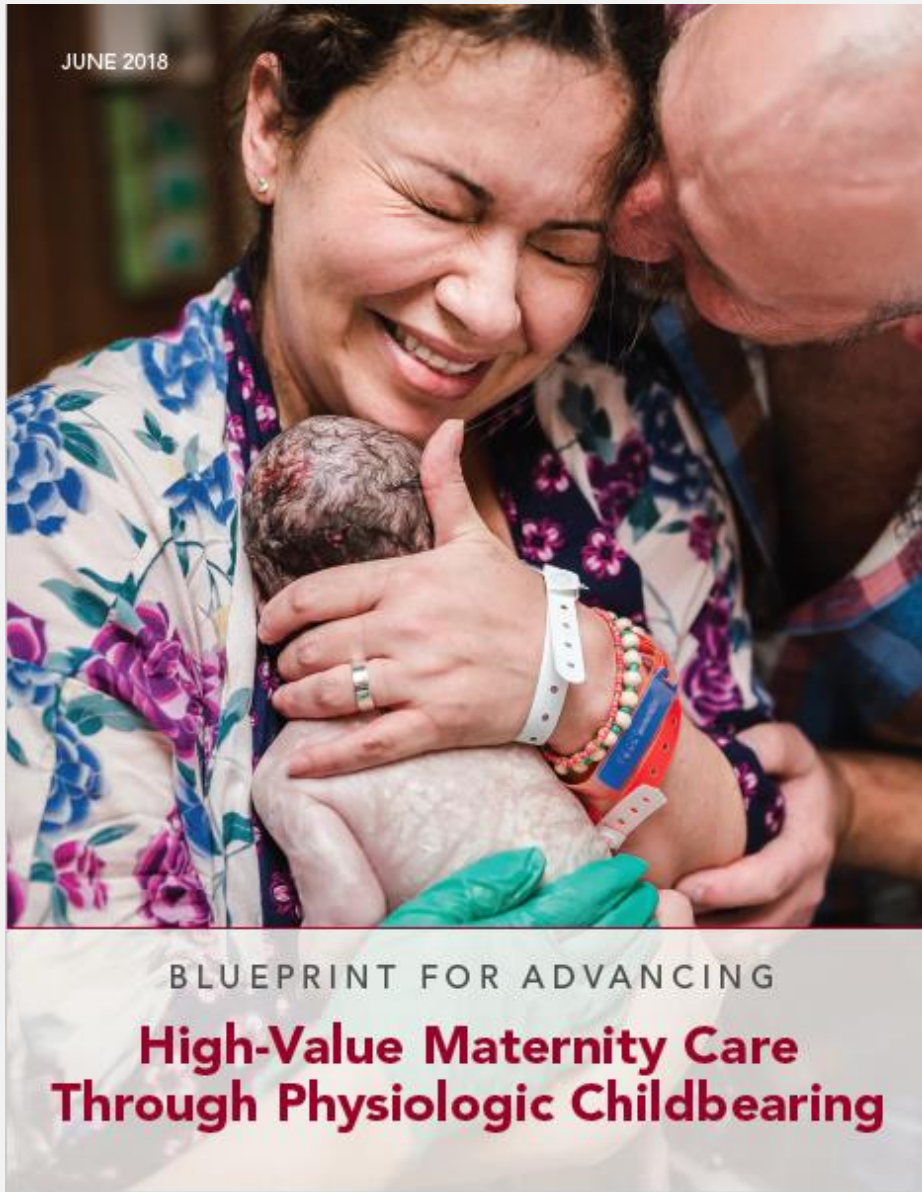
**READ THE REPORT**  
Check out the full report, along with interactive charts and tables

**MORE RESOURCES**  
Find additional resources and products that highlight key parts of the survey data

**ABOUT**  
Learn more about *Listening to Mothers in California* and its creators

[www.nationalpartnership.org/lmca](http://www.nationalpartnership.org/lmca)

# 2018 Consensus Plan for High-Value Maternity Care



- Timely, actionable guidance for policy makers and decision makers
- Developed by 17 national multi-stakeholder maternity care leaders
- 22 high-level recommendations with action steps and documentation across six effective change strategies
- First strategy is a roadmap for maternity care delivery and payment reform
- Download at [www.NationalPartnership.org/Blueprint](http://www.NationalPartnership.org/Blueprint)

# Thank you!

Soon, interested researchers will have access to full dataset and codebook at:  
The Odum Institute Dataverse, UNC <https://odum.unc.edu/archive/uncdataverse/>

*Listening to Mothers in California* survey contact  
Carol Sakala, PhD, MSPH [csakala@nationalpartnership.org](mailto:csakala@nationalpartnership.org)

With thanks to our generous funders:  
California Health Care Foundation  
Yellow Chair Foundation



California  
Health Care  
Foundation

YELLOW CHAIR FOUNDATION

BRIGHAM HEALTH



BRIGHAM AND  
WOMEN'S HOSPITAL

# How the Group Prenatal Care Program fits into the Massachusetts Medicaid ACO

Rebecca Cunningham, MD

*Medical Director, Care Management*

*Brigham and Women's Physicians Organization*

*Brigham and Women's Hospital*



HARVARD MEDICAL SCHOOL  
TEACHING HOSPITAL



# Objectives

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- Discuss rationale for investment in alternative care models within a Medicaid ACO environment
- Describe group prenatal care model and potential ACO impact
- Share lessons learned

# Brigham Health

- Brigham and Women's Hospital: 800 bed academic medical center
- Brigham and Women's Faulkner Hospital: 150 bed community hospital
- BWPO: 1200 physicians
- 15 primary care practices, 2 community health centers
- Founding member of Partners HealthCare System



# Medicaid ACOs launched in Massachusetts on 3/1/2018

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## Aim

- Improve care coordination & quality while reducing costs

## Rationale

- 1.8M people covered by Masshealth (1 in 4)
- 40% of state budget (\$15B)
- Opportunity to prevent costly acute care utilization

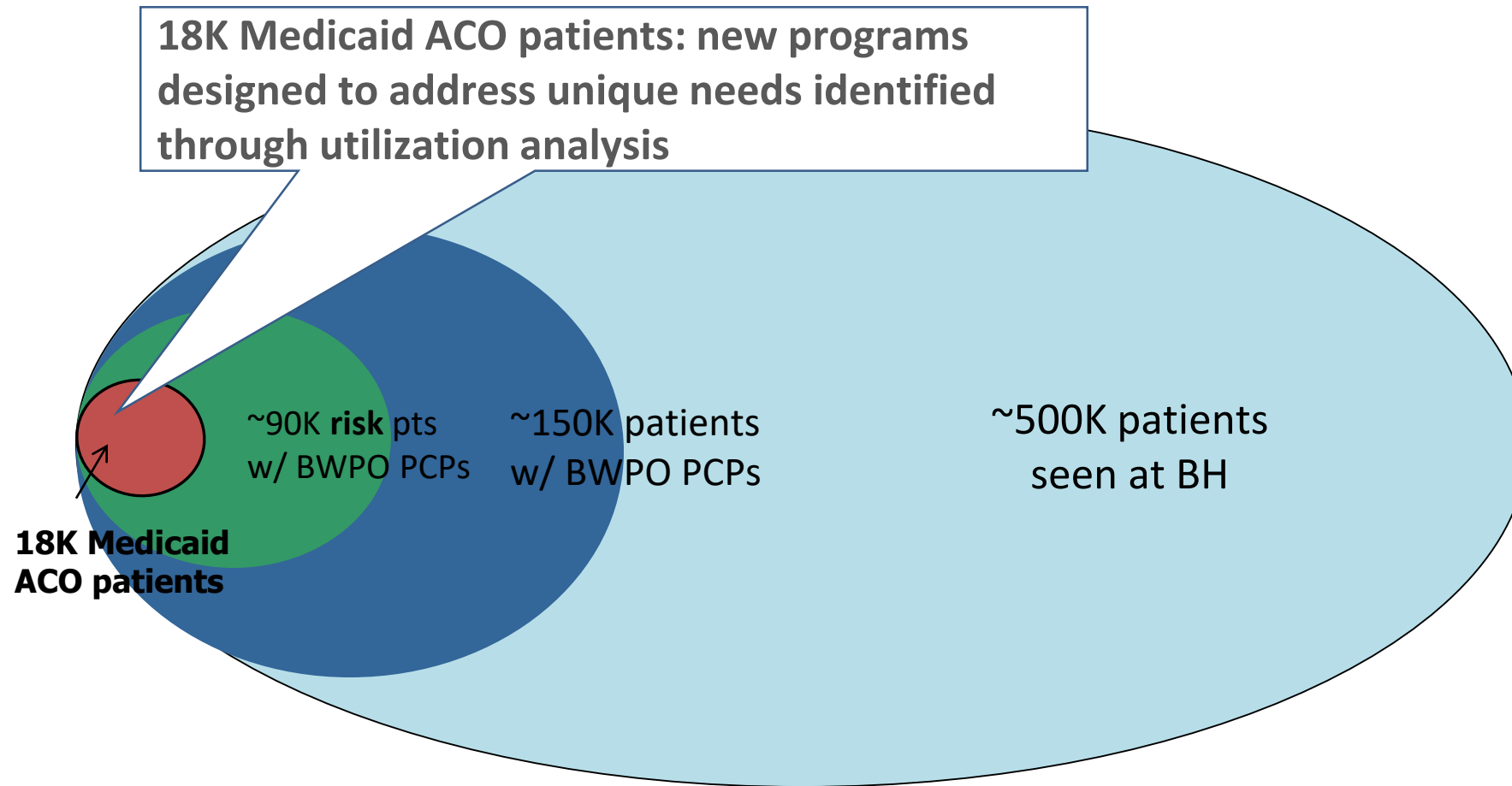
## Structure

- Partners HealthCare Choice is one of 17 ACOs
- Members assigned to ACOs based on their PCP
- 108K patients across Partners, 18K at Brigham Health

## Funding

- Delivery System Reform Incentive Program (DSRIP) funds support clinical programs & infrastructure
- \$1.8B DSRIP funds to MA, \$58M to Partners over 5y

# Population Health interventions focus on patients within our risk contracts



## Medicaid data identifies care gaps and guides our clinical strategy

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- High proportion of disabled adults with complex conditions
- SUDs and behavioral health disorders prevalent
  - Highest cost members: **40%** with SUDs  
**48%** behavioral health diagnosis
  - Inpatients with SUDs related complications drive costs on Cardiology + General Medical services
- High rates of NICU admissions per 1000 births at our community health centers

# New programs in development

- Medicaid population: unique needs + state investment prompting novel program development

Poor primary  
care access

- ED navigator
- Transitions clinic for rapid access

High rates of  
preterm birth &  
NICU

- Group Prenatal Care program
- SUDs treatment

Social  
determinants of  
health

- SDH screening & referral
- Collaboration with community partners

# What is the Group Prenatal Care model?

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- Integration of prenatal clinical health assessment, education and support within a group space
  - Initial, individual prenatal visit
  - 8 structured group sessions of 2 hours with ~8 women at similar gestational ages
    - Self-assessment + individual clinical evaluation with provider
    - Facilitated group discussion of pre-specified prenatal and parenting topics to empower women & provide social support
- Prior demonstrated benefits:
  - Increased adherence to recommended prenatal care
  - Improved prenatal knowledge and care satisfaction
  - Increased breastfeeding initiation
  - Reduction of preterm births in some studies

## Group Prenatal Care program: History at BWH



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- Group Prenatal Care model initially piloted at BWH Ambulatory Obstetrics Practices in 2015
  - Over 75% of ~1000 pregnant women cared for each year are publicly insured
  - Centering Pregnancy® model used
  - Rationale: preterm birth rate for mothers on MassHealth in 2015 was 8.4% vs. 5.1% for Massachusetts mothers participating in the Centering Pregnancy® program
- Goals of the BWH Group Prenatal Care Clinic (GPCC):
  - Improve birth preparation and birth experiences
  - Improve birth outcomes
  - Increase provider/staff satisfaction with care delivery
  - Enhance resident education

# Expansion of BWH GPCC with launch of Medicaid ACO

- Investment: \$200K DSRIP funds CY18 to support expansion of existing pilot program at BWH
- Aim: reach more patients & evaluate impact of program
- Key interventions: hired GPC coordinator & trained additional staff as facilitators

## Early results (56 GPC patients vs. matched control):

- NICU admissions:  15% (1.8% vs 17%)
- C-section rate:  15% (18% vs 33%)
- Estimated reduction in Medicaid expenditures:
  - \$124K-256K through avoided NICU stays

# GPCC Operational Needs

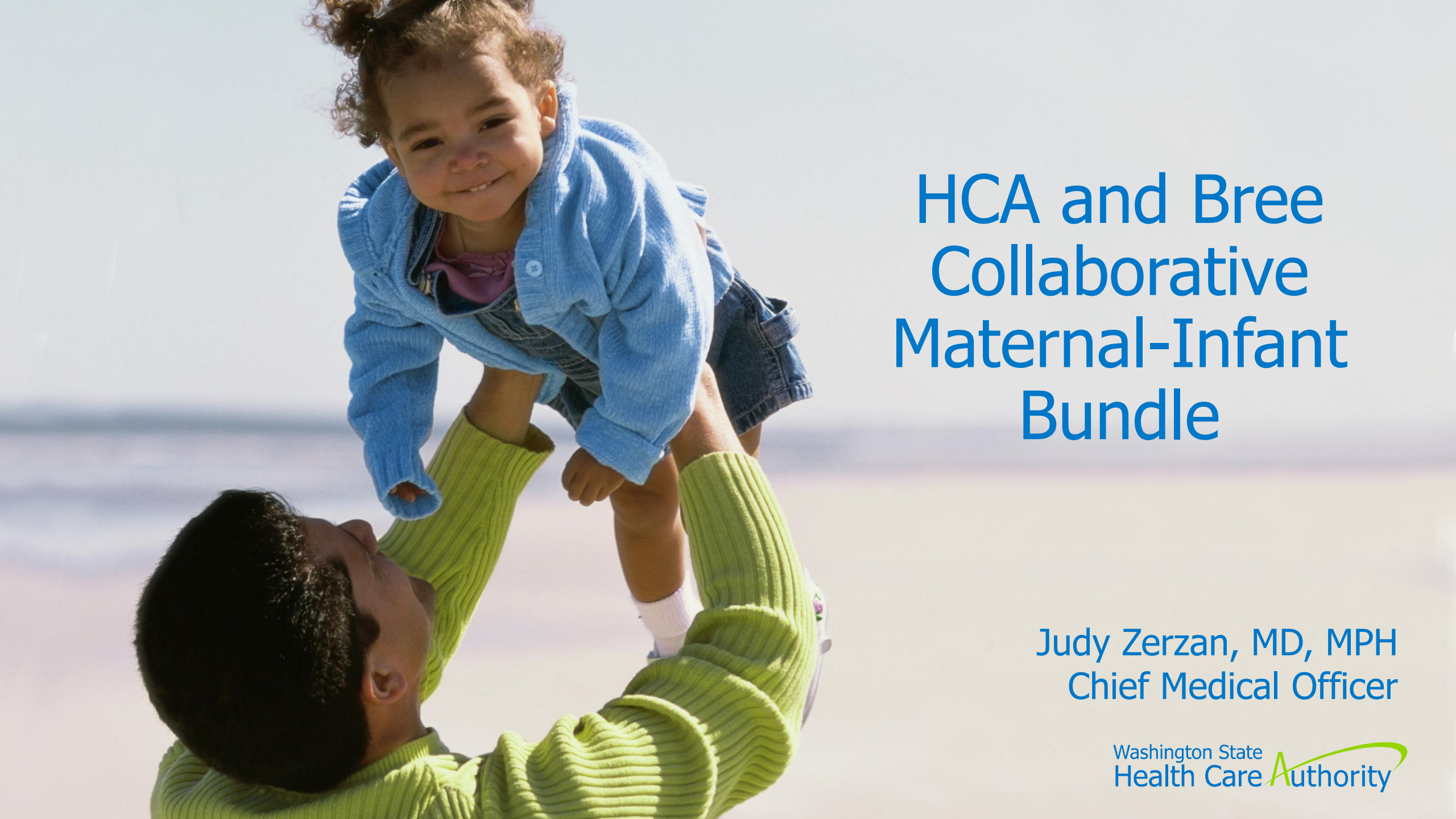
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- Clinic space for group visits, RN/MA staffing
- GPC Coordinator
- Staff training
- Curriculum materials + licensing fees
- Food for patients

# Lessons learned

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- BWH GPCC associated with improved outcomes for mothers and babies
- Investment in staff and training are key to maximize GPC capacity
  - GPC coordinator to support patient enrollment
  - Staff training to facilitate and support group visits
- Space for group visits can be a barrier
- Experience with the GPC practice model can enhance resident training

A photograph of a man with dark hair, wearing a bright green ribbed sweater, holding a young child with curly hair, wearing a blue corded jacket and denim shorts, up in the air. The man is looking up at the child with a smile. The background is a bright, out-of-focus outdoor scene, possibly a beach or park.

# HCA and Bree Collaborative Maternal-Infant Bundle

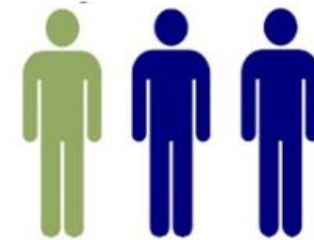
Judy Zerzan, MD, MPH  
Chief Medical Officer

# What we do at HCA

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- ▶ State's largest health care purchaser
- ▶ Medicaid (Apple Health)
  - 1.9 million people
  - ▶ Public Employees Benefits
    - 370,000 people
  - ▶ School Employees Benefits (2020)
    - 144,000 more covered lives coming
- ▶ Driving change through incentives
  - ▶ Reward patient-centered, high-quality care
  - ▶ Reward health plan and system performance
  - ▶ Drive standardization

We purchase care for 1 in 3 non-Medicare Washington residents.



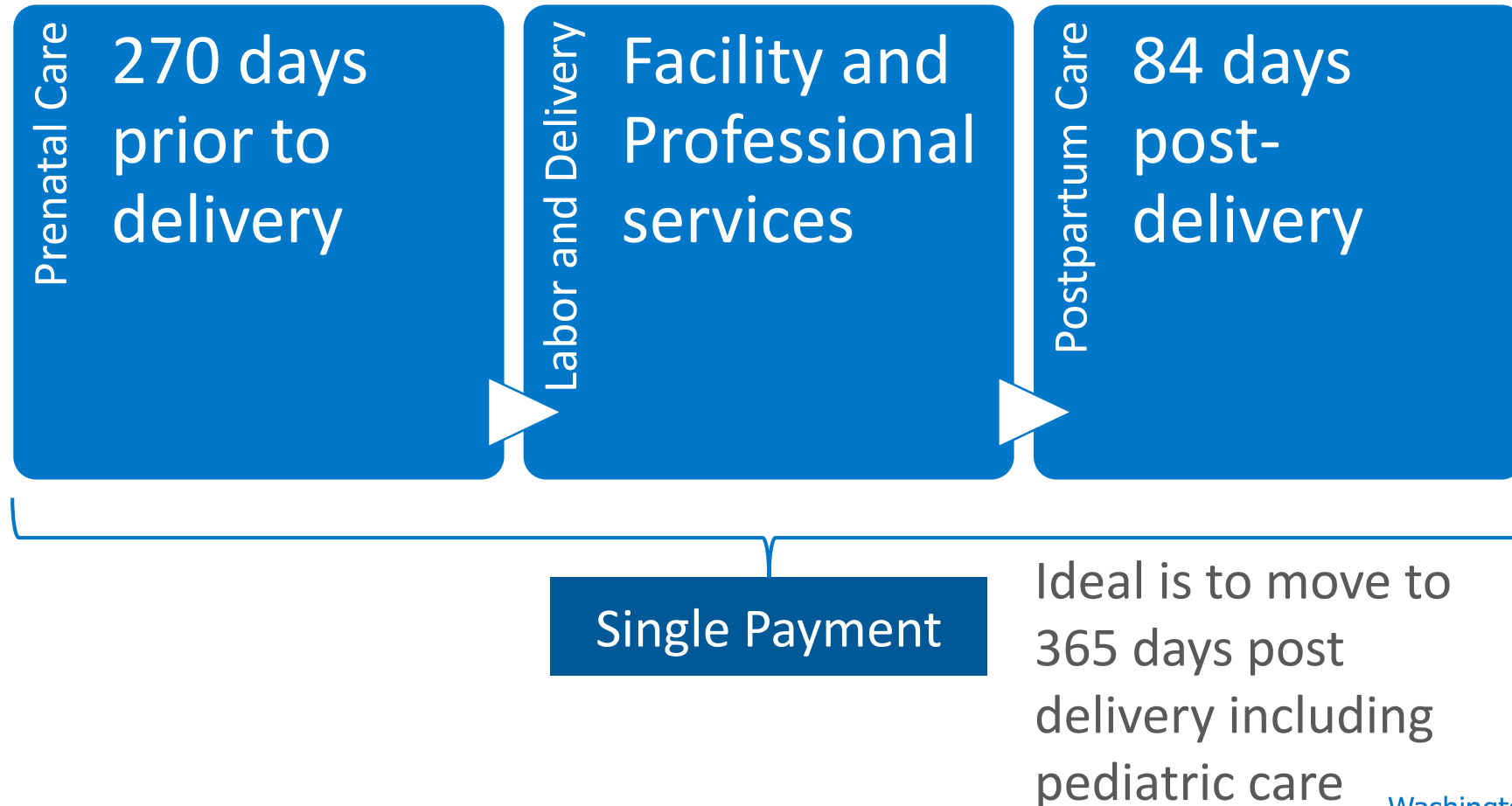
# Washington State Dr. Robert Bree Collaborative

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- ▶ Established by the Washington State Legislature in 2011
- ▶ Public and private health care stakeholders identify specific ways to improve health care quality, outcomes, and affordability
- ▶ Stakeholders are appointed by the Governor and represent public health care purchasers for Washington State, private health care purchasers (employers and union trusts), health plans, physicians and other health care providers, hospitals, and quality improvement organizations
- ▶ Topics selection criteria: high variation in the way that care is delivered, frequently used but do not lead to better care or patient health, or patient safety issues
- ▶ Form an expert workgroup to develop evidence-based recommendations
- ▶ Sent to the Washington State Health Care Authority to guide the type of health care provided to Medicaid enrollees, state employees, and other groups

# Overview

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# Structure

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- ▶ Fee-for-service with retrospective reconciliation initially
  - ▶ The workgroup recommends moving toward a prospective payment model
- ▶ Risk adjustment based on patient-specific factors
- ▶ Including prenatal care, labor and delivery, postpartum services for both facility and professional services
- ▶ Obstetric care provider or group is the accountable entity
- ▶ Exclusion criteria:
  - ▶ Age: younger than 16, older than 40
  - ▶ Cost below first percentile or higher than ninety-ninth percentile
  - ▶ Diagnoses within the episode window or 90 prior to or after episode window as determined by the payer or purchaser based on high-cost claims. See **Appendix D** for Exclusion criteria examples. The workgroup does not recommend basing exclusion criteria on behavioral health diagnoses including substance use disorder or drug use and/or body mass index (BMI).
  - ▶ Death within episode window

# Care Pathway

## Prenatal Care

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- ▶ **Intake visit** as soon as possible after positive pregnancy test
- ▶ At a minimum, monthly visits up to 28 weeks gestation at minimum
- ▶ At a minimum, biweekly visits up to 36 weeks gestation at minimum
- ▶ Content:
  - ▶ Cardiovascular disease
  - ▶ Behavioral Health Screening
  - ▶ Infectious Disease Screening
  - ▶ Gestational Diabetes Screening
  - ▶ Vaccination
  - ▶ Third trimester education (e.g., breastfeeding, birth spacing, shared decision making as appropriate)
  - ▶ Social Determinants of Health

# Care Pathway

## Labor Management and Delivery

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- ▶ Emphasizing a physiologic birth when safe (e.g., spontaneous onset and progression of labor, vaginal birth of the infant and placenta)
- ▶ Shared decision making, where appropriate
- ▶ Endorse standards within the Washington State Hospital Association Labor Management Bundle
- ▶ 2012 Bree Collaborative Obstetric guidelines
- ▶ Comprehensive, client-centered contraceptive counseling (including LARC)

# Care Pathway

## Postpartum Care

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- ▶ At least two visits with additional visits as needed
  - ▶ Three weeks postpartum visit
  - ▶ Additional comprehensive visit prior to 12 weeks postpartum including:
- ▶ Assessment of mood and emotional well-being including screening with a validated tool for depression (e.g., PHQ-9, Edinburgh Postnatal Depression Scale), anxiety (e.g., GAD), suicidality, and tobacco, alcohol, marijuana, and other drug use.
- ▶ Sexuality including contraception
- ▶ Infant care and feeding including breastfeeding
- ▶ Sleep and fatigue
- ▶ Patient support
- ▶ Postpartum discharge summary
- ▶ Connection to primary care

# Agenda

*Outcomes-Driven Maternity Care through Value Based Payment report*

Panel presentations:

- Survey of women's childbearing experiences
- Group prenatal care program under the Massachusetts Medicaid ACO
- Building a maternal-infant bundle in Washington State

Q&A session



# Questions?

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# Upcoming Webinar

## Social Determinants of Health, Social Risk Factors, and Social Needs: Defining Interventions and Partnership Opportunities

October 30th, 2019 3:00-4:00pm ET

### SPEAKERS

- **Dan Slater, MD**, Chair of Pediatrics and Chief Medical Officer of MassHealth ACO, **Atrius Health**
- **Merrill Friedman**, Senior Director of Disability Policy Engagement, **Anthem**
- **Sarita Mohanty**, Vice President of Care Coordination for Medicaid and Vulnerable Populations, **Kaiser Permanente**





For more information : <https://hcttf.org/>

