Advancing Value-Based Maternity Care

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.
HCTTF continues to progress towards our goal of 75% of business in 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 polices and strategies to scale outcomes-driven maternity care more broadly.

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.

- **Comprehensive payments for mother and newborn**
  - Linking reimbursement for both maternal and infant quality outcomes and total cost

- **Value-based maternity payments**
  - Linking reimbursement to maternal outcomes and total cost

- **Perinatal fee schedule changes**
  - Paying differently for high-value vs. low-value care

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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.
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
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
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)

- 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.
## California Women Overwhelmingly Use OBs

**Maternity Care Provider Type**

**Prenatal Care and Birth, California, 2016**

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Prenatal Care</th>
<th>Birth</th>
</tr>
</thead>
<tbody>
<tr>
<td>Obstetrician</td>
<td>80%</td>
<td>73%</td>
</tr>
<tr>
<td>Midwife</td>
<td>7%</td>
<td>9%</td>
</tr>
<tr>
<td>Nurse practitioner</td>
<td>5%</td>
<td>13%</td>
</tr>
<tr>
<td>Family physician</td>
<td>4%</td>
<td>2%</td>
</tr>
<tr>
<td>Physician assistant</td>
<td>2%</td>
<td>1%</td>
</tr>
<tr>
<td>Doctor, not sure what type</td>
<td></td>
<td>2%</td>
</tr>
</tbody>
</table>

**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:**

### 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

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

“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.”

Notes: A labor doula is a nonclinician health worker who offers 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.
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)?

<table>
<thead>
<tr>
<th>Race/Ethnicity</th>
<th>Would consider</th>
<th>Definitely want</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall</td>
<td>29%</td>
<td>11%</td>
</tr>
<tr>
<td>Black</td>
<td>34%</td>
<td>14%</td>
</tr>
<tr>
<td>White</td>
<td>29%</td>
<td>12%</td>
</tr>
<tr>
<td>Latina</td>
<td>30%</td>
<td>10%</td>
</tr>
<tr>
<td>Asian/Pacific Islander</td>
<td>25%</td>
<td>7%</td>
</tr>
<tr>
<td>Medi-Cal</td>
<td>30%</td>
<td>11%</td>
</tr>
<tr>
<td>Private</td>
<td>27%</td>
<td>10%</td>
</tr>
</tbody>
</table>

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.


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.”
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)?

<table>
<thead>
<tr>
<th>Race/Ethnicity</th>
<th>Payer</th>
<th>Would consider</th>
<th>Definitely want</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall</td>
<td></td>
<td>15%</td>
<td>6%</td>
</tr>
<tr>
<td>Black</td>
<td></td>
<td>21%</td>
<td>8%</td>
</tr>
<tr>
<td>Latina</td>
<td></td>
<td>17%</td>
<td>7%</td>
</tr>
<tr>
<td>White</td>
<td></td>
<td>14%</td>
<td>7%</td>
</tr>
<tr>
<td>Asian/Pacific Islander</td>
<td></td>
<td>9%</td>
<td>3%</td>
</tr>
<tr>
<td>Medi-Cal</td>
<td></td>
<td>18%</td>
<td>8%</td>
</tr>
<tr>
<td>Private</td>
<td></td>
<td>12%</td>
<td>5%</td>
</tr>
</tbody>
</table>

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.


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.
“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.”
Providers Attempted to Induce Labor of 4 in 10 Respondents

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.

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

<table>
<thead>
<tr>
<th>Percentage Who Experienced Cumulative Number Among 10 Interventions Around the Time of Birth</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
</tr>
<tr>
<td>1</td>
</tr>
<tr>
<td>2</td>
</tr>
<tr>
<td>3</td>
</tr>
<tr>
<td>4</td>
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<tr>
<td>5</td>
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<tr>
<td>6</td>
</tr>
<tr>
<td>7</td>
</tr>
<tr>
<td>8</td>
</tr>
<tr>
<td>9</td>
</tr>
<tr>
<td>10</td>
</tr>
</tbody>
</table>

“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.”

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

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

<table>
<thead>
<tr>
<th>Mode of Birth</th>
<th>Vaginal, 69%</th>
<th>Vaginal birth after cesarean, 2%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unassisted</td>
<td>65%</td>
<td>2%</td>
</tr>
<tr>
<td>Vacuum or forceps assisted</td>
<td>2%</td>
<td>0%</td>
</tr>
<tr>
<td><strong>Total Cesarean, 31%</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Primary (first) cesarean, 16%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Repeat cesarean, 15%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unplanned</td>
<td>11%</td>
<td>2%</td>
</tr>
<tr>
<td>Planned</td>
<td>5%</td>
<td>13%</td>
</tr>
</tbody>
</table>

**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 (PDF);

**Majority of Women Had Vaginal Births**

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%

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.

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

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.

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.
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 = 287)

- Not at all: 6%
- A little: 25%
- Some: 28%
- A lot: 42%

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

- Not at all: 36%
- A little: 24%
- Some: 21%
- A lot: 18%

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.

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
- Medi-Cal: 13%
- Private: 17%

Language
- Usually speak English at home: 12%
- Usually speak Spanish at home: 19%

Race/Ethnicity
- Black: 8%
- Asian/Pacific Islander: 13%
- Latina: 15%
- White: 16%

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

<table>
<thead>
<tr>
<th></th>
<th>Sometimes</th>
<th>Usually</th>
<th>Always</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medi-Cal</td>
<td>5%</td>
<td>2%</td>
<td>2%</td>
</tr>
<tr>
<td>Private</td>
<td>1%</td>
<td>1%</td>
<td>&lt;1%</td>
</tr>
</tbody>
</table>

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.

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

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

<table>
<thead>
<tr>
<th>Intervention</th>
<th>Did not experience pressure</th>
<th>Experienced pressure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Induction*</td>
<td>75%</td>
<td>34%</td>
</tr>
<tr>
<td>Epidural</td>
<td>71%</td>
<td>77%</td>
</tr>
<tr>
<td>Primary cesarean*</td>
<td>60%</td>
<td>85%</td>
</tr>
<tr>
<td>Repeat cesarean</td>
<td>88%</td>
<td>88%</td>
</tr>
</tbody>
</table>

* 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.


“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.”
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)**

<table>
<thead>
<tr>
<th>Overall</th>
<th>None</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
</tr>
</thead>
<tbody>
<tr>
<td>9%</td>
<td>50%</td>
<td>24%</td>
<td>9%</td>
<td>7%</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Payer</th>
<th>None</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medi-Cal</td>
<td>9%</td>
<td>43%</td>
<td>25%</td>
<td>11%</td>
<td>9%</td>
</tr>
<tr>
<td></td>
<td>12%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Private</td>
<td>58%</td>
<td>23%</td>
<td>7%</td>
<td>6%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>6%</td>
<td></td>
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<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Race/Ethnicity</th>
<th>None</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Black</td>
<td>7%</td>
<td>41%</td>
<td>22%</td>
<td>14%</td>
<td>15%</td>
</tr>
<tr>
<td>Latina</td>
<td>10%</td>
<td>45%</td>
<td>26%</td>
<td>11%</td>
<td>8%</td>
</tr>
<tr>
<td>Asian/Pacific Islander</td>
<td>9%</td>
<td>57%</td>
<td>22%</td>
<td>7%</td>
<td>5%</td>
</tr>
<tr>
<td>White</td>
<td>7%</td>
<td>57%</td>
<td>24%</td>
<td>7%</td>
<td>5%</td>
</tr>
</tbody>
</table>

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.

“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.”
**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)

<table>
<thead>
<tr>
<th>Payer</th>
<th>Never</th>
<th>Sometimes</th>
<th>Usually</th>
<th>Always</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medi-Cal</td>
<td>18%</td>
<td>20%</td>
<td>12%</td>
<td>51%</td>
</tr>
<tr>
<td>Private</td>
<td>8%</td>
<td>14%</td>
<td>15%</td>
<td>63%</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Payer</th>
<th>Never</th>
<th>Sometimes</th>
<th>Usually</th>
<th>Always</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medi-Cal</td>
<td>17%</td>
<td>23%</td>
<td>15%</td>
<td>48%</td>
</tr>
<tr>
<td>Private</td>
<td>8%</td>
<td>17%</td>
<td>19%</td>
<td>56%</td>
</tr>
</tbody>
</table>

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

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

<table>
<thead>
<tr>
<th>Race/Ethnicity</th>
<th>Anxiety</th>
<th>Depression</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall</td>
<td>21%</td>
<td>11%</td>
</tr>
<tr>
<td>Black</td>
<td>30%</td>
<td>20%</td>
</tr>
<tr>
<td>Latina</td>
<td>22%</td>
<td>13%</td>
</tr>
<tr>
<td>White</td>
<td>20%</td>
<td>10%</td>
</tr>
<tr>
<td>Asian/Pacific Islander</td>
<td>18%</td>
<td>8%</td>
</tr>
<tr>
<td>Medi-Cal</td>
<td>23%</td>
<td>14%</td>
</tr>
<tr>
<td>Private</td>
<td>19%</td>
<td>8%</td>
</tr>
</tbody>
</table>

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.

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.

Many Women Reported Postpartum Symptoms of Anxiety and Depression

"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."

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

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.

### 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**

<table>
<thead>
<tr>
<th></th>
<th>Prenatal Anxiety (n = 520)</th>
<th>Prenatal Depression (n = 294)</th>
<th>Postpartum Anxiety (n = 225)</th>
<th>Postpartum Depression (n = 159)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Did you receive counseling or treatment?</strong></td>
<td>81% (Yes)</td>
<td>78% (Yes)</td>
<td>64% (Yes)</td>
<td>66% (Yes)</td>
</tr>
<tr>
<td><strong>No</strong></td>
<td>19% (No)</td>
<td>21% (No)</td>
<td>36% (No)</td>
<td>34% (No)</td>
</tr>
</tbody>
</table>

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.


“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

www.chcf.org/listening-to-mothers-ca

www.nationalpartnership.org/ltmca
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
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/](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
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
Objectives

• 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

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

- ~150K patients w/ BWPO PCPs
- ~90K risk pts w/ BWPO PCPs
- ~500K patients seen at BH
- 18K Medicaid ACO patients: new programs designed to address unique needs identified through utilization analysis
Medicaid data identifies care gaps and guides our clinical strategy

• 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?

• 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

• 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

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

• 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
HCA and Bree Collaborative Maternal-Infant Bundle

Judy Zerzan, MD, MPH
Chief Medical Officer
What we do at HCA

- 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.
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

Prenatal Care: 270 days prior to delivery
Facility and Professional services: 84 days post-delivery
Postpartum Care: Ideal is to move to 365 days post delivery including pediatric care

Single Payment
Structure

- 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

- **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

- 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

- 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?
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/