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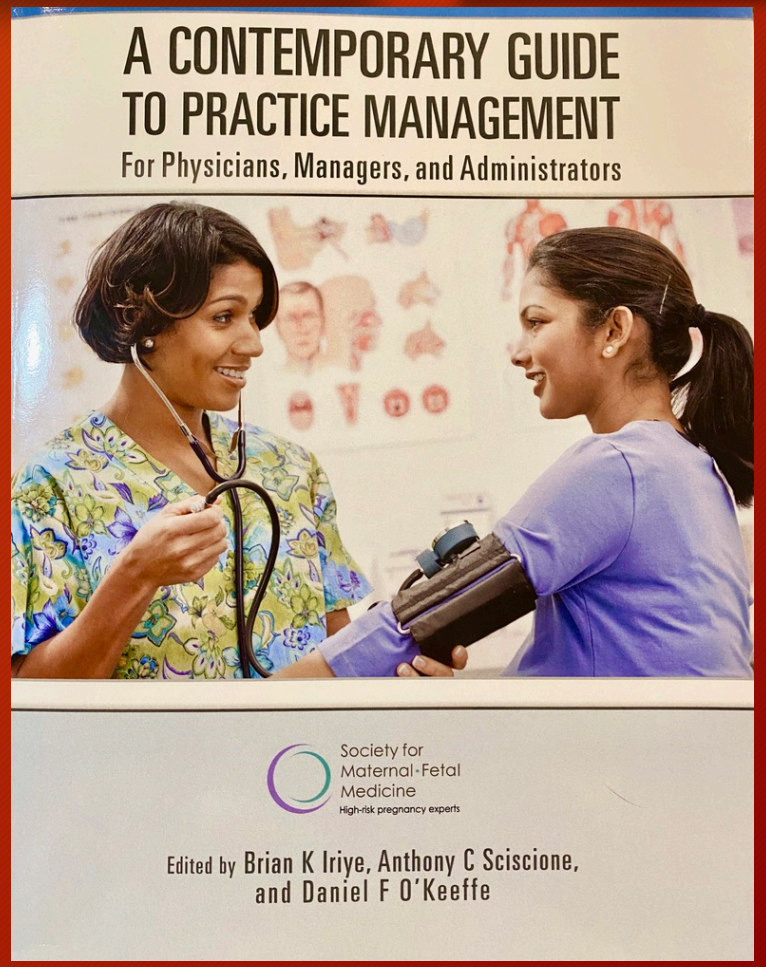
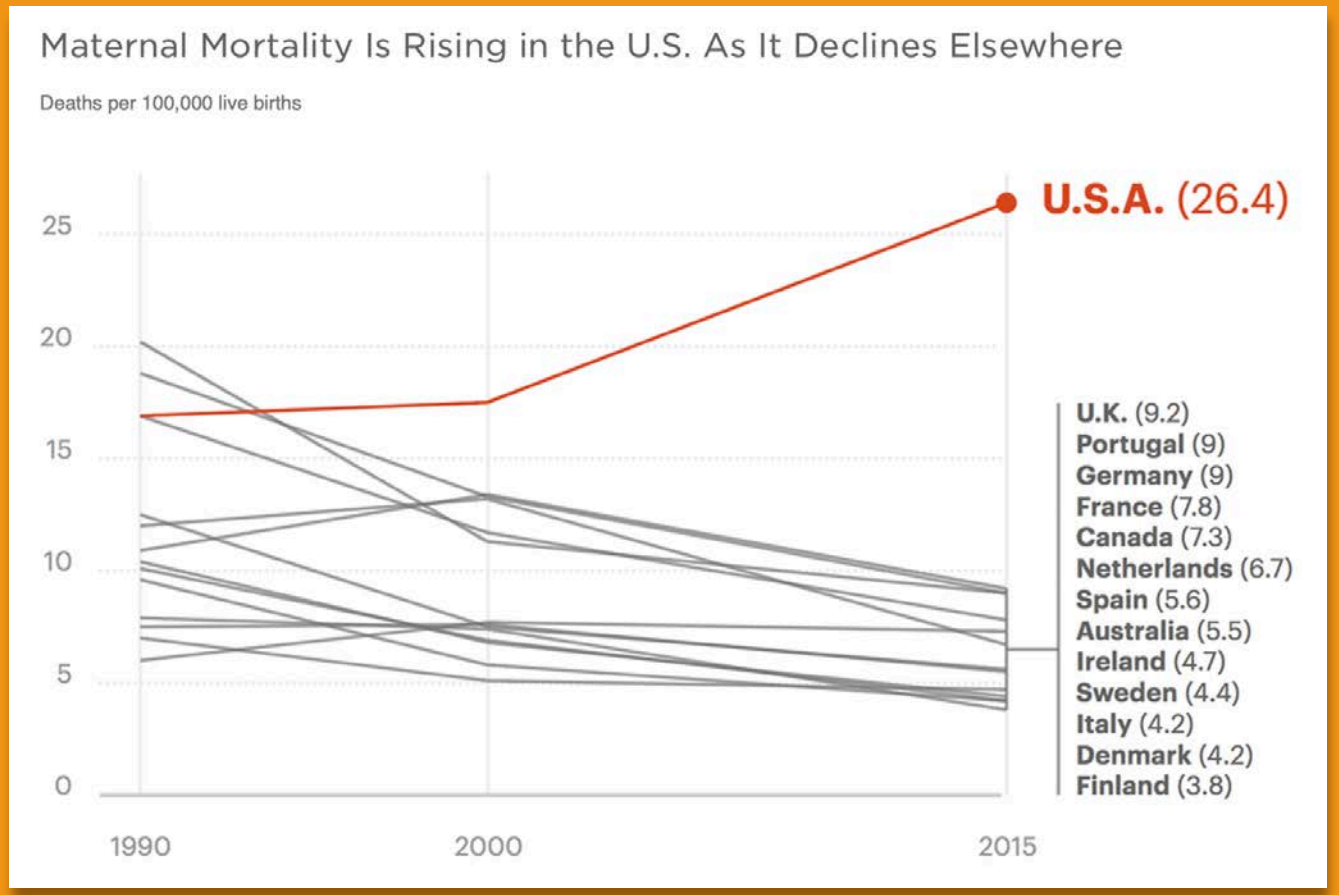
Background

- President, Society for Maternal Fetal Medicine
- Board, Perinatal Quality Foundation
- Director (2016) - Quality Measures in High Risk Pregnancies Workshop – American College of Ob/Gyn (ACOG), Society for Maternal Fetal Medicine (SMFM), National Institute of Child Health and Human Development (NICHD)
- Director (2020) - Implementation Science to Optimize Obstetric Outcomes- ACOG, SMFM, The National Institute for Children's Health Quality (NICHQ)



Maternal Mortality USA

- Only developed country with increasing rates
- Over 60% of maternal deaths are preventable



Maternal Mortality in Non-Hispanic Black Populations

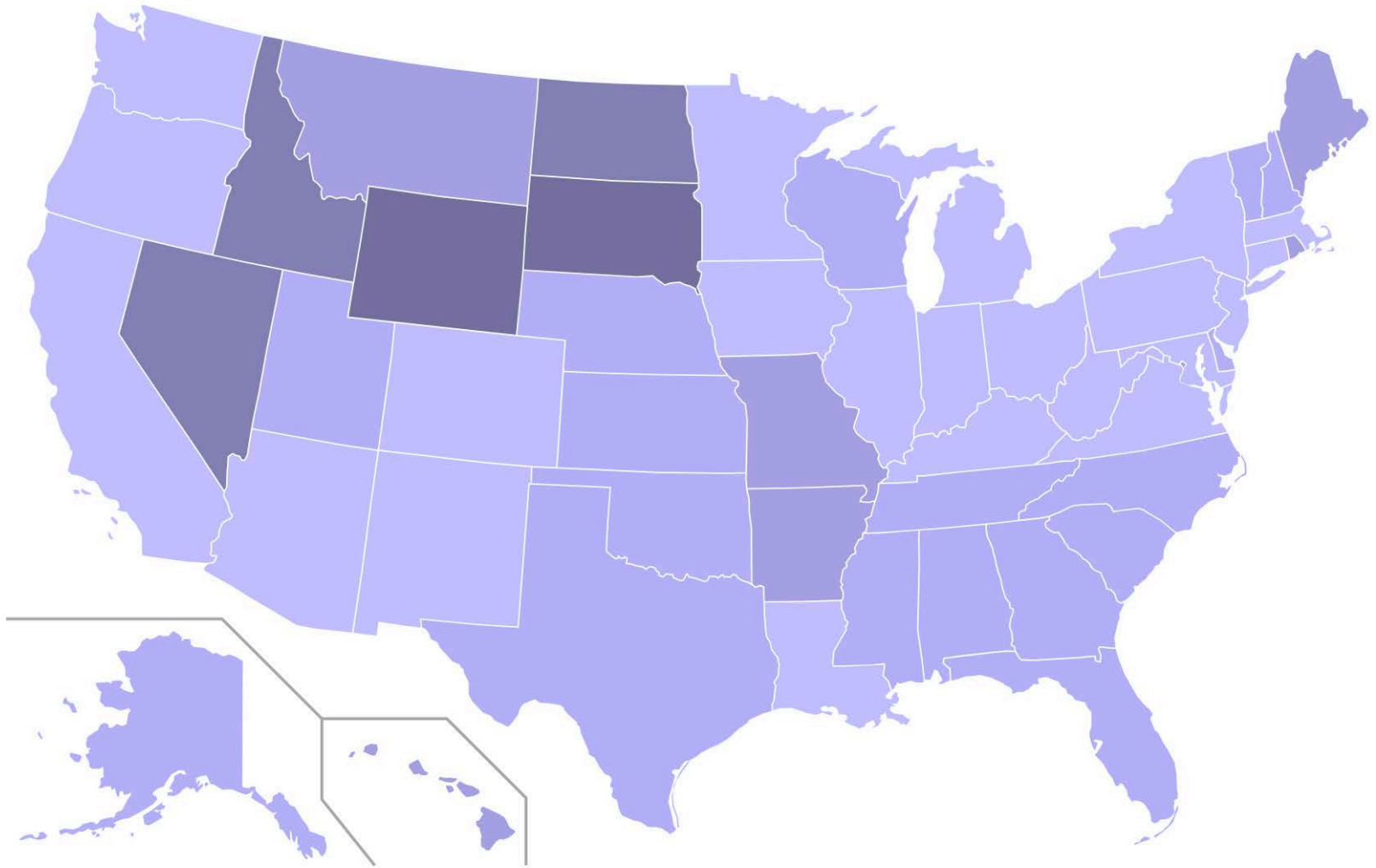
- Three times the rate of their white counterparts

- establishment of maternal mortality review committees;
- establishment of perinatal quality collaboratives;
- expansion of Medicaid; and
- reporting of data stratified by race and ethnicity.

SMFM examined four criteria related to maternal mortality for each state and the District of Columbia. States that met all four of the criteria are the lightest shade on the map; those states that met none of the criteria are the darkest. Learn more about the methodology behind the 2019 scorecard.

0 1 2 3 4

The map showcases states that have implemented these system-level changes. CLICK on a state for information on steps being taken to address maternal mortality and racial disparities.



SMFM Maternal Mortality Scorecard

1) MMRC (Maternal Mortality Review Committee)
2) PQC (Perinatal Quality Collaborative)
3) Medicaid Expansion
4) Outcome data by race

Maternal Morbidity

40 to 100 times maternal mortality

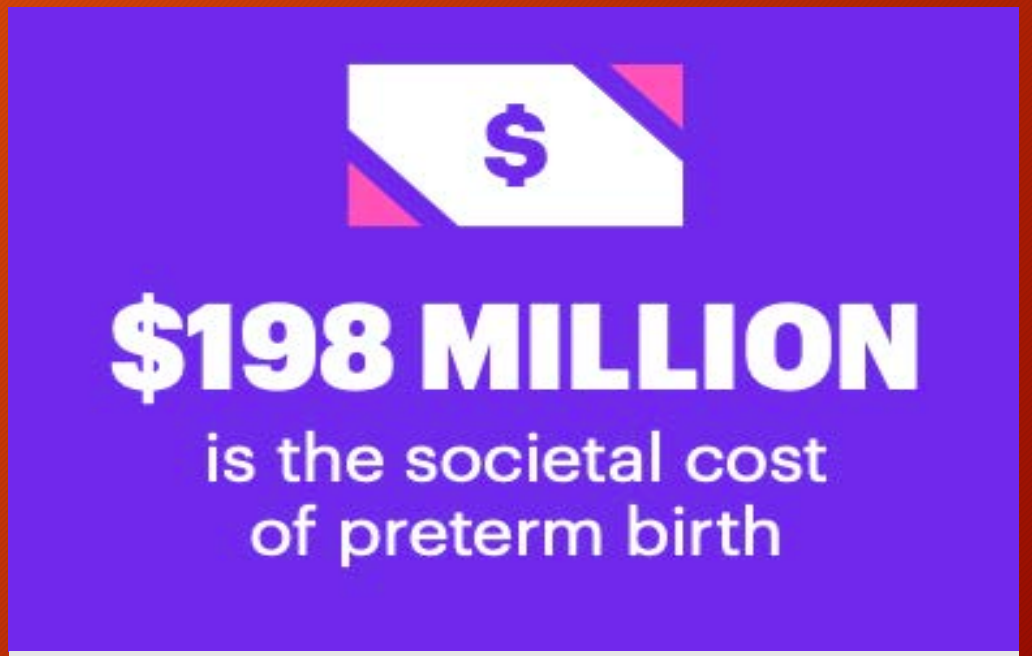
Increases in long term disability and cost

Roughly double the cost ($14.4K vs. $7.3 K from 2008-12 in NYC -Howland 2018). Difference likely over 10K per delivery is current dollars.

Diagnoses and Costs

- Liveborn infant is the 2nd most common diagnosis for hospital admission in the US
  - The 3rd most costly admission
  - Top 5 admissions are 20% of all cost
- In 2007 Preterm Birth (PTB) costs were estimated at $26 billion in US
    - Probable underestimate as only used four diagnoses and followed children to age 5. Also over 13 years ago
- Pregnancy itself is NOT one of the top 20 diagnoses for hospital cost

Preterm Birth In Nevada Annually



There is a high likelihood this is a drastic underestimation of cost

Source MOD: Peristats

Themes

- Maternal mortality and morbidity is too high and often preventable
- Health care inequities need to be addressed
- Major costs result from neonatal care and less from pregnancy

- Need to concentrate on resources for improvements in pregnancy care to prevent unneeded catastrophe and reduce costs of neonatal care.
- Spending on pregnancy is **preventative** in outcomes and cost
- It treats two patients for one price and alters lifetime health for the baby
- PREGNANCY CARE IS VALUE CARE

Policy Options to Improve Maternal Health

- Support a Perinatal Quality Collaborative
- Change poverty threshold for Medicaid Coverage for Pregnancy
- Provide 1 year of postpartum coverage
- Support payments of behavioral health in medical health offices and also telephonic services in pregnancy for behavioral health
- Support payment systems to **screen** patients for Medicaid Assisted Treatment (MAT)

Policy Options to Improve Maternal Health- MAKE A PUSH FOR QUALITY

- Encourage payors to develop systems to decrease NICU (neonatal intensive care unit) admission and NNLOS (Neonatal Length of Stay)
  - Increase payment for global OB care (54th out of 89th locales in payment despite greatest OB/GYN shortage in the nation)
  - Payment incentives for reduction in NICU or NNLOS
  - Disincentives for not following standards of care and having *preventable* poor outcomes
- Mandate Electronic Health Records (EHR) within the state need to place in checklists from major organizations into their basic systems for use within 6 months of publication.

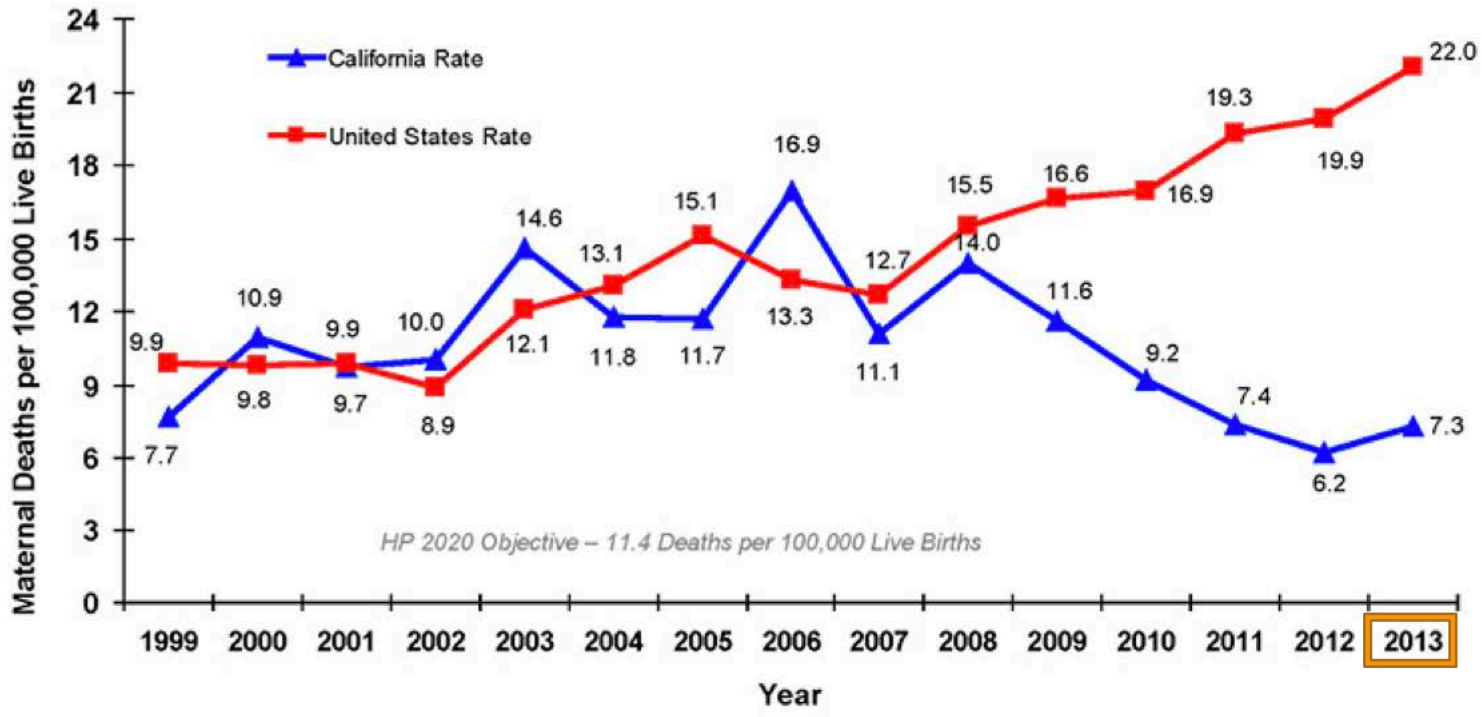
Perinatal Quality Collaboratives

A statewide team working to improve the quality of care for pregnancies.

These identify healthcare processes that need to be improved and use methods to make change

Nevada is 1 of only 14 states without a PQC beyond development stage-- This hurt our grant for MMRC

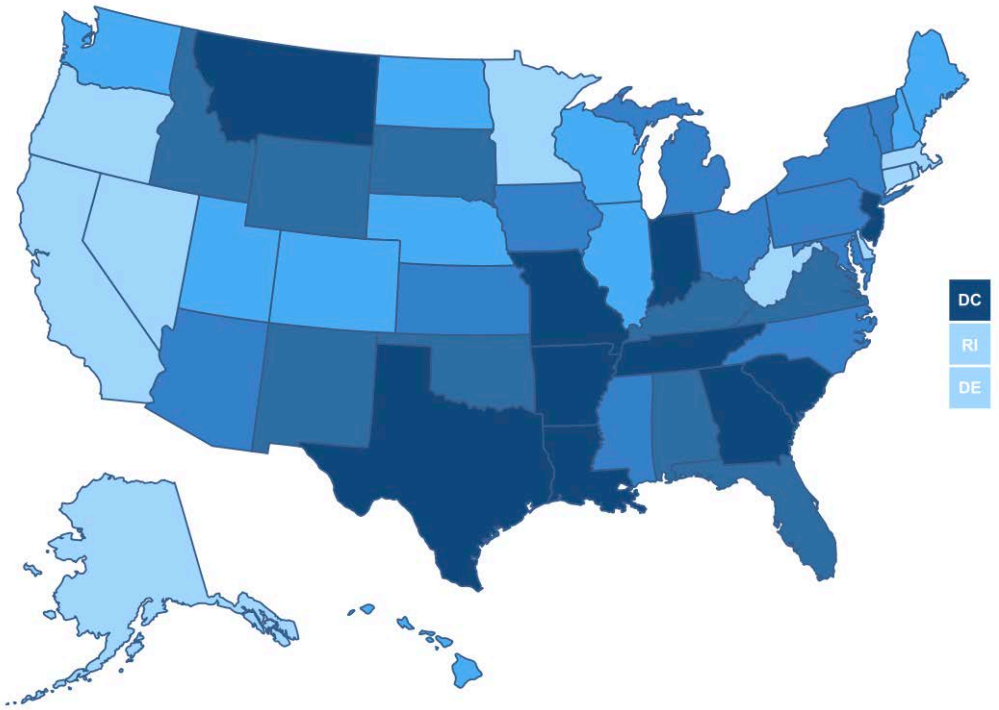
Maternal Mortality Rate, California and United States; 1999-2013



SOURCE: State of California, Department of Public Health, California Birth and Death Statistical Master Files, 1999-2013.

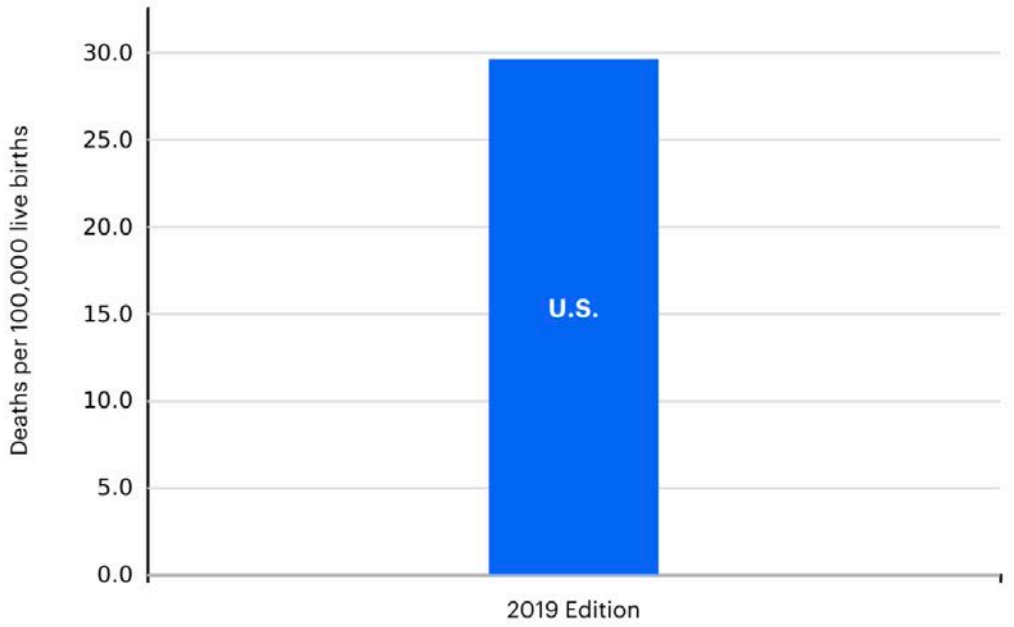
Example of PQC Success

Number of deaths from any cause related to or aggravated by pregnancy or its management (excluding accidental or incidental causes) during pregnancy and childbirth or within one year of termination of pregnancy, irrespective of the duration and site of the pregnancy, per 100,000 live births (5-year estimate)



<= 19.5	19.6 - 23.8	23.9 - 27.6	27.7 - 34.8	>= 34.9

Trend: Maternal Mortality, United States, 2019 Health Of Women And Children Report



Number of deaths from any cause related to or aggravated by pregnancy or its management (excluding accidental or incidental causes) during pregnancy and childbirth or within one year of termination of pregnancy, irrespective of the duration and site of the pregnancy, per 100,000 live births (5-year estimate)

United States

SOURCE:

- CDC WONDER Online Database, Mortality files

Maternal Mortality by State

STATE	RANK	VALUE
Alaska [13]	1	12.4
Massachusetts	2	13.7
Nevada	3	14.0
Delaware [13]	4	16.9
West Virginia	5	17.2
Minnesota	6	17.3
California	7	17.6
Connecticut	8	19.0
Rhode Island [13]	8	19.0
Oregon	10	19.5
Washington	11	19.7
Wisconsin	12	19.9
Illinois	13	21.4
North Dakota	14	21.7
Colorado	15	21.9
Nebraska	16	22.7
New Hampshire	17	22.8
Hawaii	18	22.9
Utah	19	23.0
Maine	20	23.8
Ohio	21	24.7
Maryland	22	25.0

Unclear why NV Maternal Mortality Rate (MMR) is low?

-Data?

-Maternal-fetal medicine co-management?

-But CA has seen a rise

-Nonetheless 60% of maternal deaths are preventable.

Other quality measures can be pushed by collaboratives

- Cesarean rates
- **Health Equity**
- Reduction of Severe Maternal Morbidity

PQC Successes in Other States

CMQCC reduced SMM by 20.8%

CMQCC reduced early elective deliveries by 55%

ILPQC reduced time to treatment for severe hypertension, decreased maternal morbidity

PQC Needs

- Director
- Website with video capability
- Data capability (REDcap or similar); our state does not have this capability
- Meeting capability
- Travel, Training/Education, Marketing

- Support: initial government funding, grants, user fees (hospitals)
- Have hospitals with proper implementation get fees per delivery.

REDCap = Research Electronic Data Capture – A system from Vanderbilt and used around the country

Funding levels for PQCs- 2016. (Source CDC)

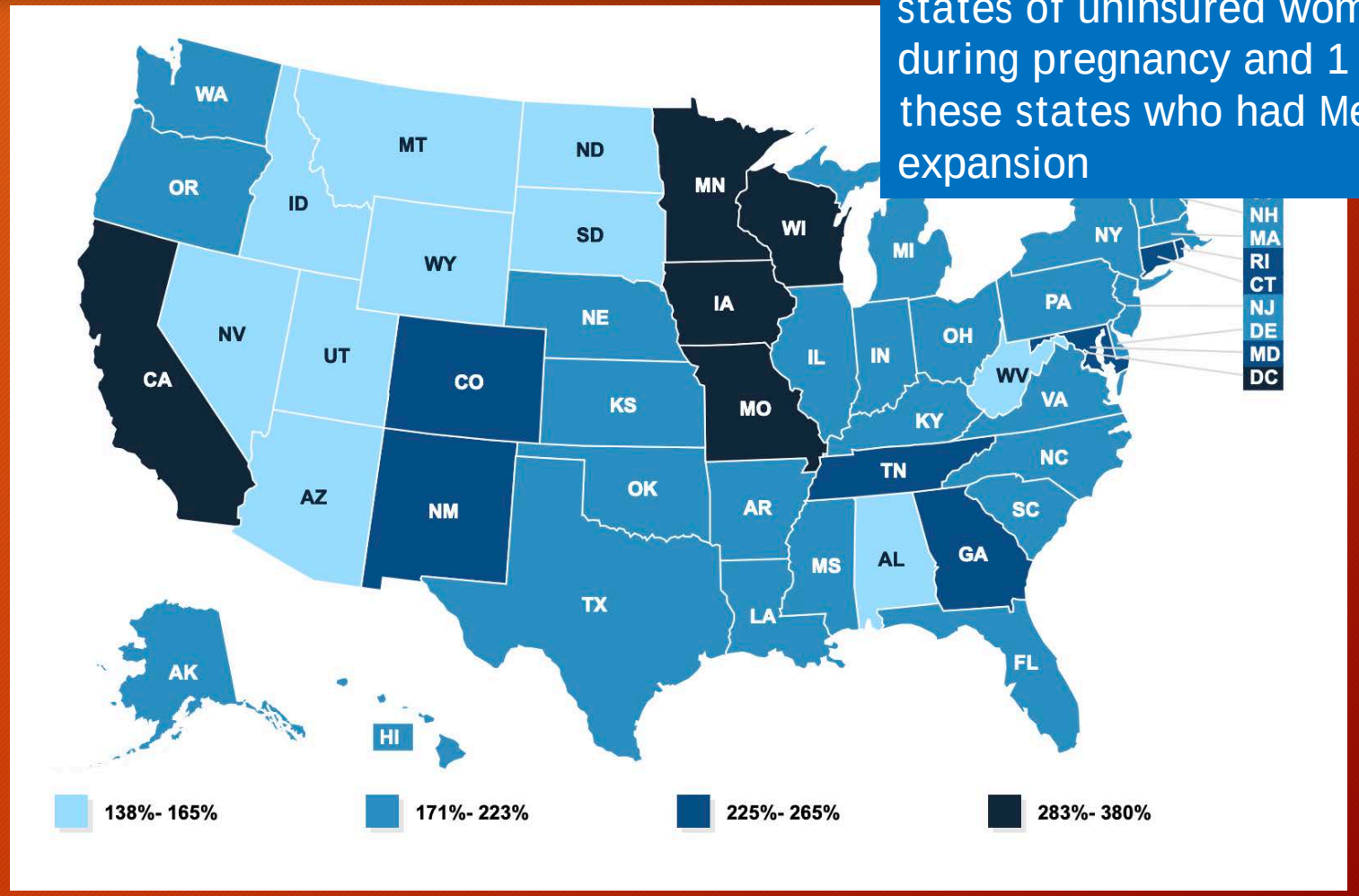
- Limited funding – 10K to 100K
- Moderate funding- 100K-500K
- Substantial funding- > 500K
- Nevada would likely need 250-300K for 2 years to start and then run based upon participation of hospitals, providers. Smaller 100-200K yearly thereafter with COLA increases

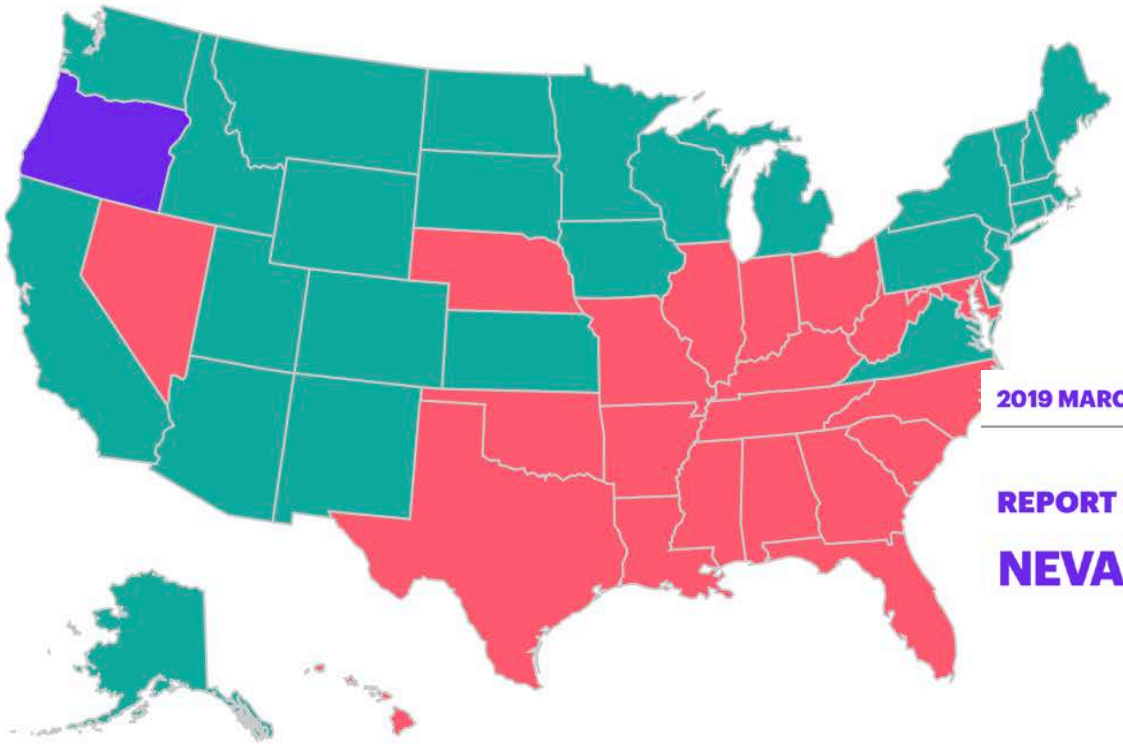
- However decreasing morbidity and improving outcomes also saves money
- Can incentivize PQC work by linking pay to participation for hospitals(+2%)
- Disincentivize non-participation by hospitals (-5%)
- Require modules of participation by doctors with disincentives for payment when not completed
- Or Can fund PQC later by fees for participation to PQC

Medicaid Coverage Threshold in Pregnancy

Nevada is still in the top 12 states of uninsured women during pregnancy and 1 of 2 of these states who had Medicaid expansion

Location	January 2019
25. Ohio	205%
United States [1]	**205%**
25. Virginia	205%
30. Nebraska	202%
31. New Hampshire	201%
31. North Carolina	201%
33. Kentucky	200%
33. Michigan	200%
35. Mississippi	199%
35. South Carolina	199%
37. Washington	198%
38. Florida	196%
38. Hawaii	196%
40. Oregon	190%
41. Kansas	171%
42. Nevada	165%
43. West Virginia	163%





Higher than US Rate of 10.0 (22)

Between MOD 2020 goal of 8.1 and US Rate (28)

Met or lower than MOD 2020 goal of 8.1 (1)

TABLE OF STATE PRETERM BIRTH RATES →

2019 MARCH OF DIMES REPORT CARD

DOWNLOAD FULL REPORT DOWNLOAD REPORT IN SPANISH

REPORT CARD FOR

NEVADA

PRETERM BIRTH RATE

10.1%

PREMATURITY GRADE

C-

IN AN AVERAGE WEEK IN NEVADA

Sources ?

697
babies are born

69
babies are born preterm ?

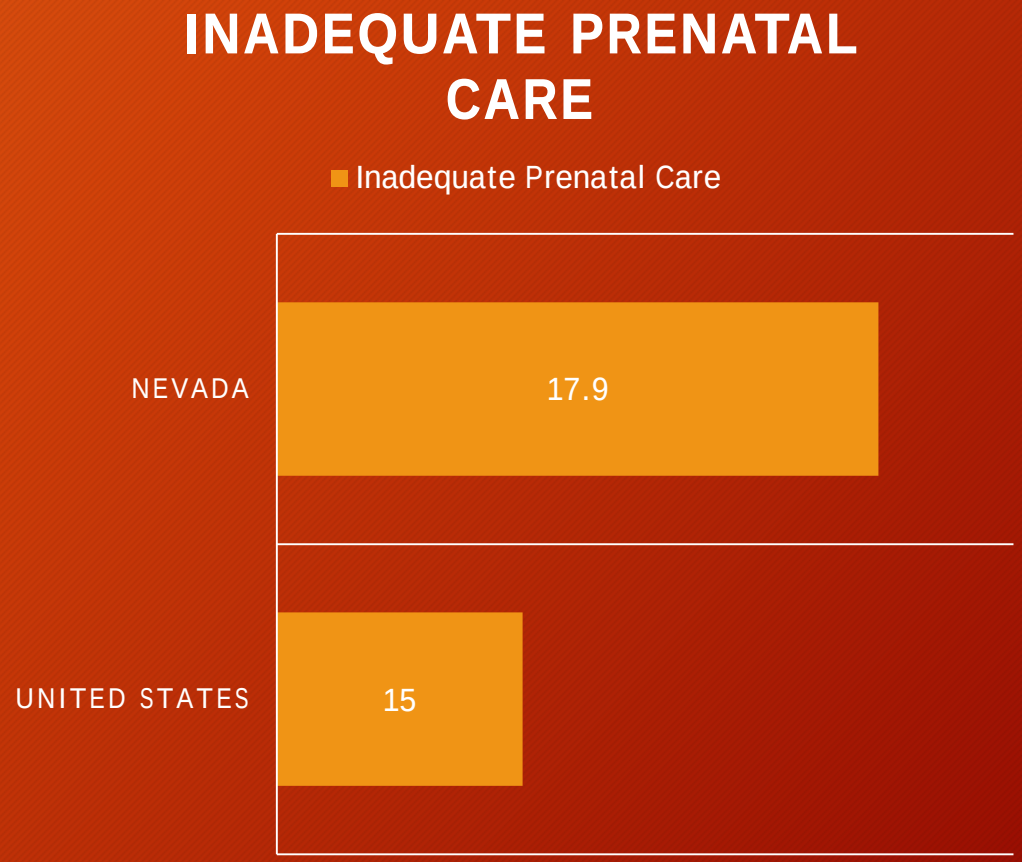
53
babies are born late preterm ?

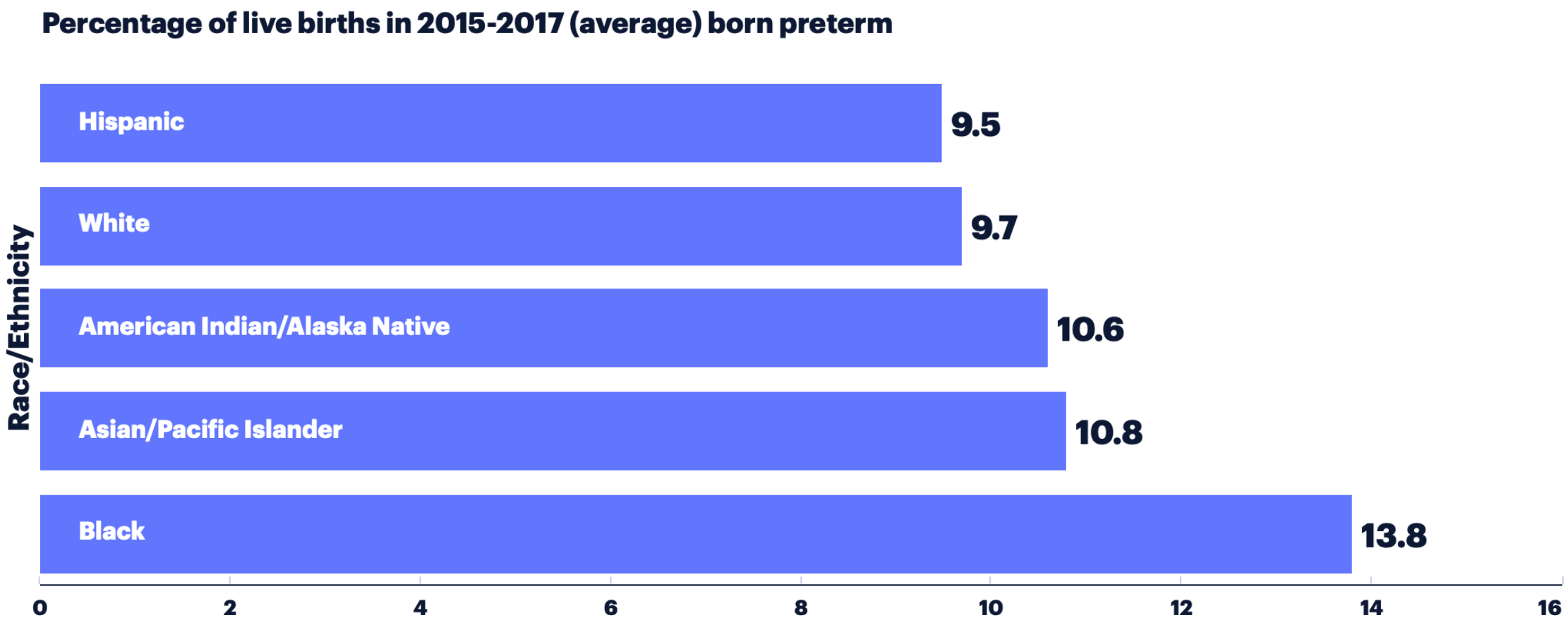
11
babies are born very preterm ?

Prematurity and Nevada

Uninsured Status Decreases Prenatal Care

- **Prenatal Care is associated with**
  - Reductions in Preterm Birth
  - Decreased Severe Maternal Morbidity (SMM)
  - Both reduce overall cost

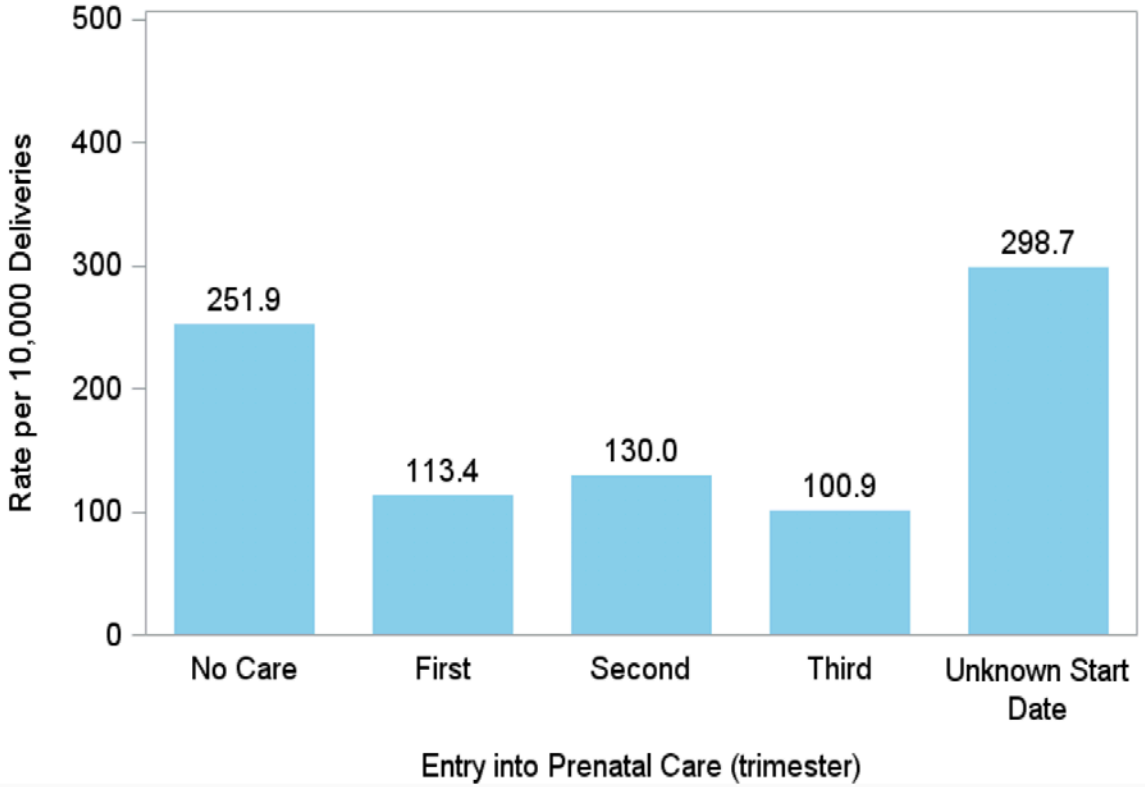




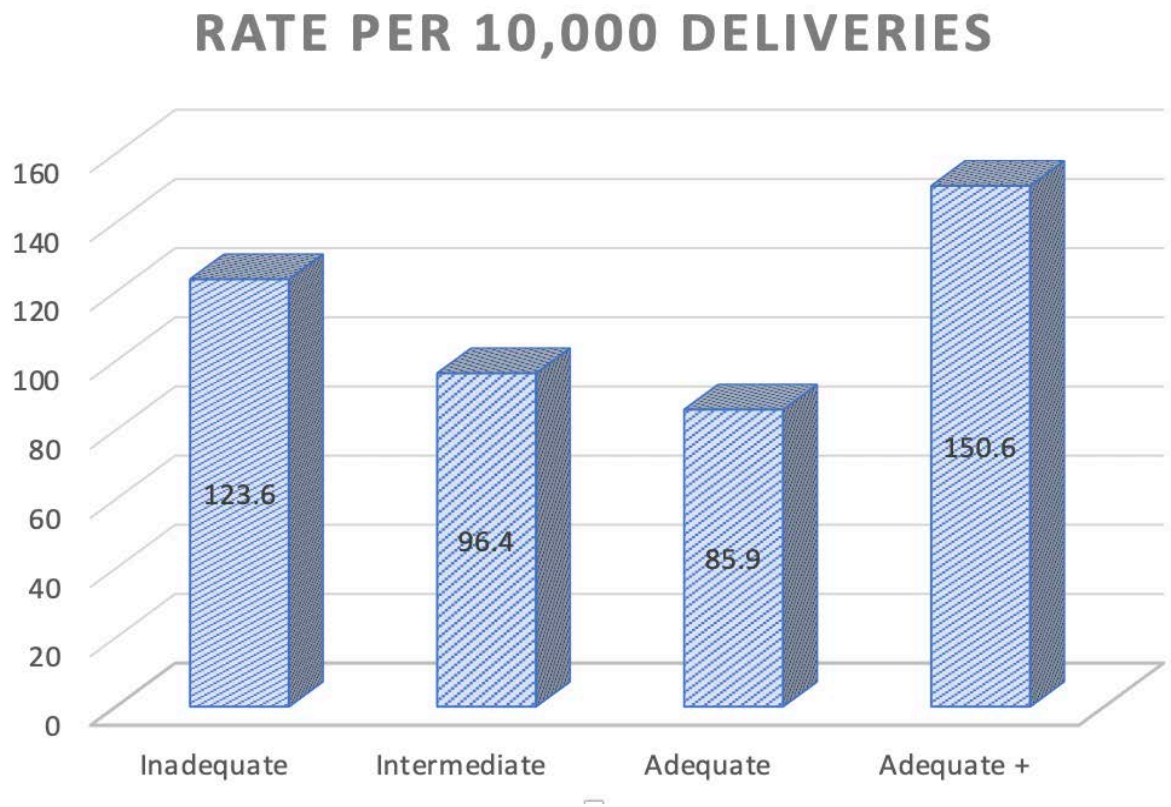
Preterm Birth is Another Health Care Inequity

Prenatal Care and Severe Maternal Morbidity in Nevada

Figure 11. Severe Maternal Morbidity by Time of Entry to Prenatal Care, Nevada, 2016

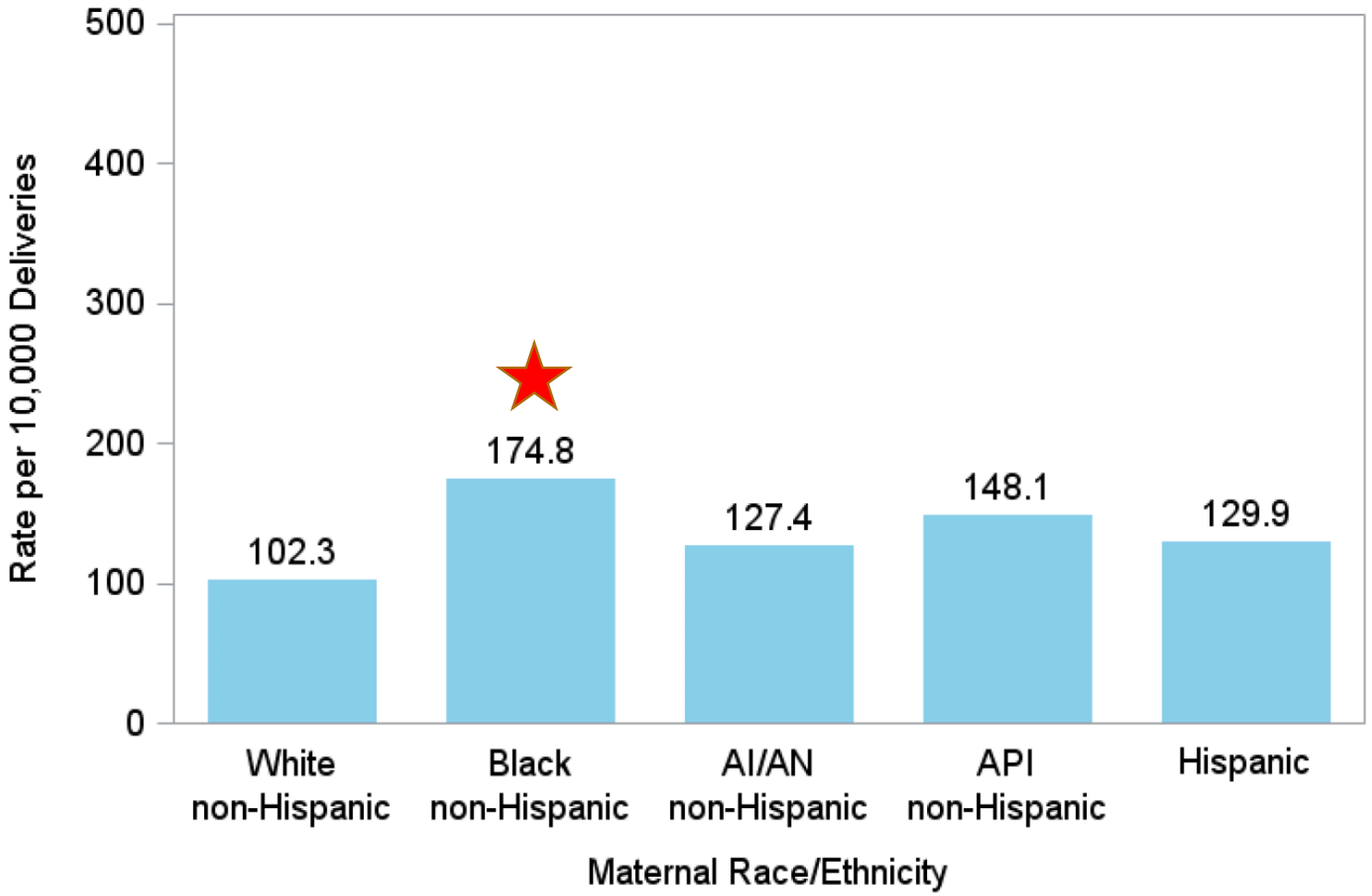


Severe Maternal Morbidity by Adequacy of Prenatal Care (# of visits), Nevada 2016



Severe Maternal Morbidity Report: 2016 Nevada (2019)

Figure 9. Severe Maternal Morbidity by Maternal Race/Ethnicity, Nevada, 2016



Severe Maternal Morbidity and Race in Nevada

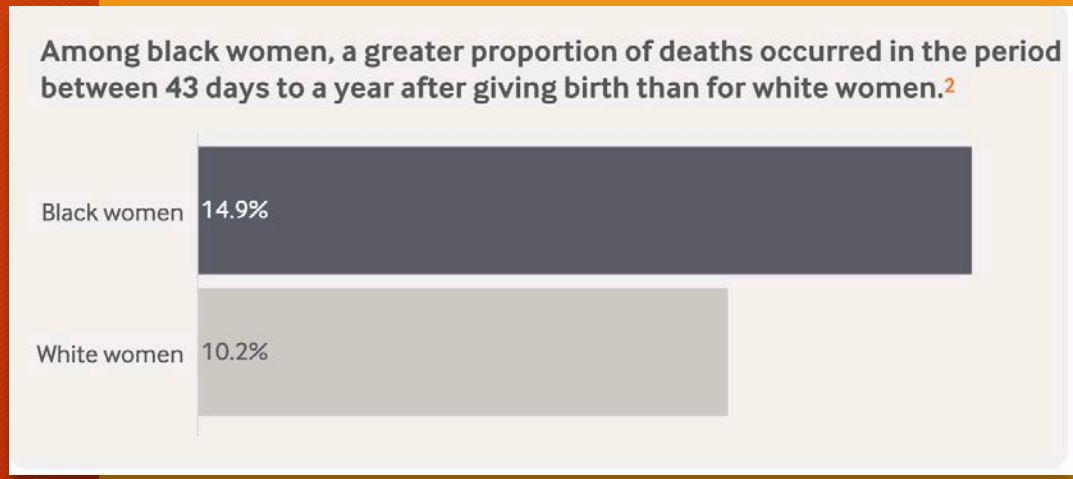
Unknown facts of Maternal Mortality

- 15-20% of maternal pregnancy associated deaths are due to overdose in some states
  - Almost all in the post partum (PP) period

- Patients on treatment 60 days after delivery
  - Lose doctors
  - Lose insurance
  - Increase social and financial stress

Expansion of Postpartum Medicaid Coverage

- Medicaid covers roughly 50% of births nationally
- Federal law requires states cover those up to 138% of Federal Poverty level (National avg 205%)
- Pregnancy coverage currently extends to 60 days postpartum
  - 39% of women on Medicaid do not have a single visit in NV
- 50% of all maternal deaths occur after delivery
  - 11.7% after 6 weeks postpartum



Increase Funding Level of Medicaid for Pregnancy

- States like NV with Medicaid expansion have shown earlier initiation of prenatal care
- Lower maternal mortality in states with expansion- we have expansion but at a lower level
- Importance of further expansion in NV
  - 13.7% women are in poverty
  - 38% of children living in single parent families
  - **35.3% of all families are under the 200% poverty line**
- **We should push for at the minimum the national average (205%) for pregnancy.**

Expanding Medicaid Coverage to 1 Year PP

- Recommended by ACOG and SMFM
- Allows for increased chances for follow up
- Decreases disruption in health care coverage and changes in providers
- Conditions uniquely affected
  - -Post partum depression
  - -Cardiac conditions
  - -Postpartum Contraception
  - -Hypertension/Preeclampsia
  - -Opioid Use Disorder
  - -Smoking Cessation

Two Generation Advantage

- 55% of all children living below the poverty level have a mother with some form of depression
  - Hurts mother-child bond
  - Implications on early child brain development
  - 1 in 5 women, regardless of income, have some depressive symptoms
- Smoking cessation for the current and next pregnancy
  - Medicaid enrollees twice as likely to smoke
  - Decreases SIDS, preterm birth, low birth weight
- Post-partum contraception (LARC – Long Acting Reproductive Contraception)
  - 1 year gives time to ensure child well being
  - Improves birth spacing (preterm birth, social stressors, further economic challenges)
  - 50% of all births are unplanned; 80% in population with substance use disorders

Implement Medicaid policies that integrate behavioral health into medical services for women of childbearing age

- Patients with public funded insurance have increased challenges (social determinants of health)
  - Transportation
  - Other Living conditions
  - Decreased cell phone with data services (hurts telemedicine)
  - Assisted by one stop shopping, telemedicine, telephonic conversations (not paid in any circumstance currently)
- Depression (data from Centers for Medicare and Medicaid Services, 2016)
  - 1 in 11 for those below the poverty level have SEVERE DEPRESSION
    - Only 30% seek help
  - 40-60% with some sort of depressive symptoms
- Opioid Use Disorder (OUD)

Implement Medicaid policies that integrate behavioral health into medical services for women of childbearing age

- Opioid Use Disorder
  - Behavioral health decreases relapse with patients undergoing treatment
  - One stop shopping improves compliance
- Care managers, Peer Recovery support counselors
  - Spend hours of non-compensated time on phone
- Mothers lose care in post partum (60 days)
- Switch of providers in post partum

Pregnancy Treatment for Opioid Use Disorder - MOTHER Project

- Pain specialists and MAT providers frequently drop pregnant patients Buprenorphine treatment during pregnancy (reduces Neonatal Abstinence Syndrome - NAS)
- Provide some behavioral health- Addiction specialist/care manager, peer recovery support (unfunded)
- Buprenorphine crosses placenta less than methadone
- MAT therapy reduces needles and straws (hepatitis, HIV), other behavior in effort to obtain drugs
- Only 1 patient of now 14 neonates received opioids for NAS (national avg >50%)

MOTHER Project

- Preventing Neonatal Abstinence Syndrome
  - Improves neonatal head circumference/brain size
  - Opioids have been linked recently to abnormal fetal brain development
  - Decreases cost
    - Average Cost Reduction $30-50K per each mother treated

MOTHER Project and Nevada

- FUTURE Needs
  - In reproductive age women, MAT therapy should be discussed with reproduction in mind
    - Over 80% of the babies with NAS have Medicaid
    - Buprenorphine >> Methadone due to neonatal effects
  - Need payment for behavioral health to wean patients safely and provide postpartum care and transition
  - Expanding Medicaid a year postpartum especially helps this vulnerable population
  - Need MORE REFERRALS!!

Recommend SBIRT Payments

- **S**creening, **B**rief **I**ntervention, **R**eferral to **T**reatment
- Screening- 1-3 question survey
  - If any questions + then given longer evaluation tool
- Brief Intervention
  - Time limited patient centered strategy focusing on insight and awareness, another 5-10 mins discussion at minimum, possibly 30 mins.
  - Designed to motivate further behavior change
- Referral to Treatment
  - Helping patients access treatment and navigate barriers

Barriers to SBIRT

- Additional time added to already short visits
- Practices have set up multi-disciplinary teams in larger practice.
- **Incorporation into EHR**
  - **Mandates for EHR Providers to place society generated checklists into their EHR basic systems within 180-365 days**
  - Would mandate checklists from major organizations including SMFM
- Need referral education if patients identified

Payment for SBIRT

- SBIRT is a screen for alcohol and drug use.
- SBIRT has been shown to reduce healthcare costs
  - ***Savings of $3.81-$5.60 for each dollar spent***
- SBIRT reduces severity of drug and alcohol use
- SBIRT reduces physical trauma and percentage of patients without specialized substance use treatment

- Recommended SBIRT is used by SAMHSA, VA, DD, White House Office of National Drug Policy

Payments to decrease NICU and NNLOS

- Avoid bundled payments for pregnancy
  - No reliable risk adjustment
  - No proper quality metrics
  - Could hurt access
  - Hence focus on process measures- doing things right should be rewarded
- The main metric that counts is NICU and NNLOS
  - Neonatal costs are much more than pregnancy care ***but is affected by pregnancy care***
- Increase provider payments to increase possible time spent with care but have payors place in process quality metrics with rewards and disincentives
  - NV currently 52nd place out of 89 areas in pregnancy payments
  - Meanwhile we have the lowest ob/gyn provider rate in the country

Payments to decrease NICU and NNLOS

- Quality metrics based on process such as checklists
- Mandate checklist implementation in EHR systems within 6 months of major organization publication into basic EHR systems
- Encourage shared savings agreements by Medicaid and managed care Medicaid

References

- Laurie Zephyrin, Akeiisa Coleman, Rachel Nuzum, and Yaphet Getachew, "Increasing Postpartum Medicaid Coverage Could Reduce Maternal Deaths and Improve Outcomes," *To the Point* (blog), Commonwealth Fund, Nov. 21, 2019. https://doi.org/10.26099/ejtb-tw04
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