

BORN TOO EARLY:

IMPROVING MATERNAL & CHILD HEALTH BY REDUCING EARLY ELECTIVE DELIVERIES

NIHCM FOUNDATION ISSUE BRIEF
MARCH 2014



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Nationwide, up to ten percent of all babies are scheduled for delivery via labor-inducing medication or cesarean section before 39 weeks gestation without medical indication.¹ Despite the serious neonatal and maternal health risks associated with early elective deliveries (EED), many women deliver during this time period due to provider preference, convenience, or for relief of symptoms.^{2,3} Evidence suggests that most women are unaware of the possible dangers of choosing to deliver their babies prior to 39 weeks gestation.⁴ Health plans and health plan foundations can play an important role in reducing EEDs by implementing payment reforms, collaborating with state and local government and community-based organizations, and educating health care providers and members about the dangers of EED.

This brief will discuss the health risks and costs associated with early elective deliveries, federal government and national initiatives to support full-term pregnancies, and health plan and health plan foundation approaches to reducing EED.

EARLY ELECTIVE DELIVERIES: PAYING THE PRICE

The potential negative health consequences of early elective delivery, along with the associated costs, are placing an unnecessary burden on infants, mothers and the health care system as a whole.

Infants Face An Increased Risk Of:

- Lower brain mass – the brain at 35 weeks weighs only two-thirds of what it does at 39-40 weeks⁵
- Low birth weight – the average preterm baby weighs less than 5 pounds while the average full-term baby weighs between 7 and 8 pounds⁶
- Feeding problems⁷
- Respiratory distress syndrome (RDS) – one in ten premature babies develop RDS⁸

- Longer hospital stays – the average newborn stay is 2 days versus 14 days for preterm infants⁹

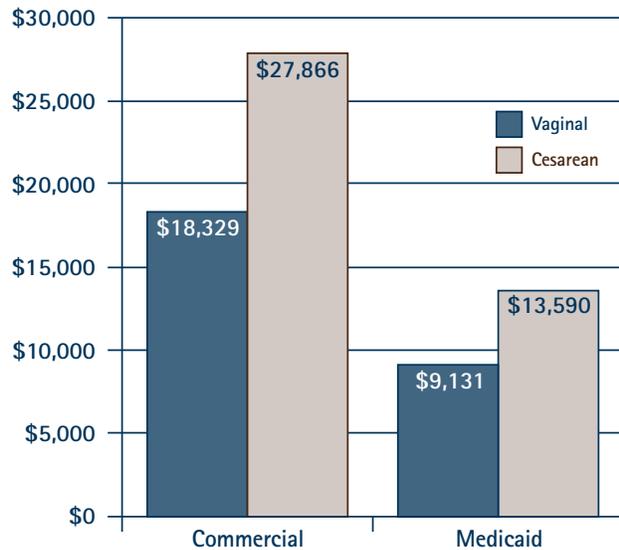
Mothers Face An Increased Risk Of:

- Postpartum depression¹⁰
- Cesarean delivery – elective inductions are two times more likely to result in cesarean delivery¹¹
- Complications requiring longer hospital stays – the average vaginal delivery stay is 2 days versus 4 days for a cesarean delivery with complications¹²

Price to the Health Care System:

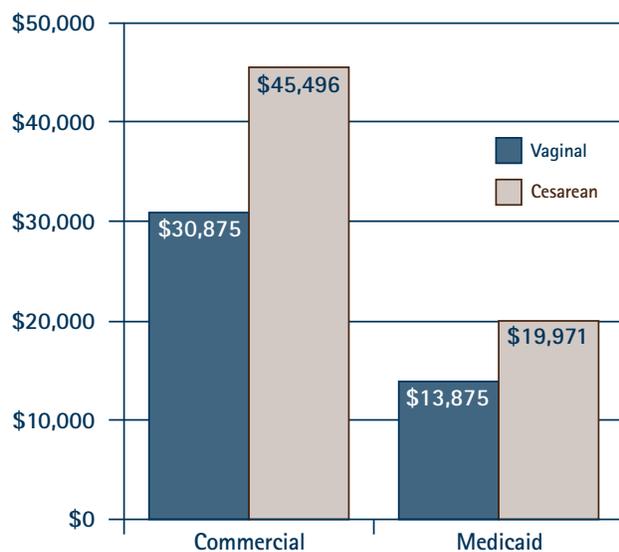
Elective induction of labor is associated with an increased risk of a cesarean delivery, and average total payments for cesarean births are close to 50 percent higher than payments for vaginal births (Figure 1). In addition, infants born prior to 39 weeks are more likely to have stays in the neonatal intensive care unit (NICU), at a considerable increased expense to both commercial insurers and Medicaid (Figure 2).

FIGURE 1. AVERAGE PAYMENTS FOR MATERNAL AND NEWBORN CARE: VAGINAL VS. CESAREAN BIRTH



Source: Truven Health Analytics. "The Cost of Having a Baby in the United States."

FIGURE 2. AVERAGE PAYMENTS FOR MATERNAL & NEWBORN CARE, INCLUDING NICU STAYS



Source: Truven Health Analytics. "The Cost of Having a Baby in the United States."

FEDERAL & NATIONAL INITIATIVES

Reducing early elective deliveries is key to reducing the nation's infant mortality rate and improving birth outcomes.¹³ The U.S. currently ranks 32nd in infant mortality compared to other industrialized nations, and the Department of Health and Human Services' Secretary's Advisory Committee on Infant Mortality has called for a reduction in the infant mortality rate from 6.15 to 5.5 per 1,000 live births by 2015.^{14,15} In order to achieve this goal, many federal government agencies and national organizations are spearheading important initiatives to prevent preterm birth and early elective deliveries.

These efforts include developing evidence-based interventions at the state level; improving hospital quality reporting to evaluate progress in reducing EEDs; sharing data, best practices, and other resources; and creating provider and consumer educational campaigns. More information on these diverse initiatives can be found in Appendix A.

HEALTH PLAN AND HEALTH PLAN FOUNDATION INITIATIVES

Preventing and eventually eliminating EEDs requires collaboration across federal, state and local governments, businesses, hospitals and health care providers. The following two sections highlight opportunities and examples of how health plans and health plan foundations are also critical leaders and partners in preventing EEDs and improving birth outcomes.

Payment Reform

According to the Catalyst for Payment Reform, higher payment rates for cesarean births, along with the convenience of scheduled births for patients, providers and hospitals, have led to an increase in planned inductions and cesarean deliveries.¹⁶ A variety of payment reforms have been proposed to encourage adherence to established guidelines recommending against elective delivery prior to 39 weeks gestation. The intent of these payment reforms is to align incentives through positive or negative payment structures and reduce the growing cost associated with medically unnecessary interventions.

To eliminate early elective deliveries, health plans can:

- Adopt a “hard stop” policy eliminating payment for all early elective deliveries^{17,18}
- Provide financial incentives for hospitals that reduce rates of early elective deliveries¹⁹
- Require prior authorization for early elective deliveries²⁰
- Remove the financial incentives for cesarean delivery by creating blended payment rates for delivery costs²¹

BlueCross BlueShield of South Carolina – Hard Stop Policy: The South Carolina Birth Outcomes Initiative (BOI) is a collaborative effort between the South Carolina Department of Health and Human Services (SCDHHS), South Carolina Hospital Association, March of Dimes, BlueCross BlueShield of South Carolina (BCBSSC) and over 100 other stakeholders to improve health outcomes for newborns. One of the goals of the BOI is to eliminate elective inductions for non-medically indicated deliveries prior to 39 weeks gestation. In 2011, 43 hospitals in South Carolina signed a pledge to end the practice of early elective deliveries for Medicaid participants. Claims submitted for early inductions were required to contain a modifier so that early elective induction rates could be tracked in more detail.

In January 2013, the state's largest commercial insurer, BCBSSC, announced that they would join the Medicaid program and stop paying for early elective deliveries. South Carolina is the first state in the nation to adopt this policy across public and private payers. According to a recent report published by the Catalyst for Payment Reform, this collaboration between the state and the largest commercial payer facilitated greater acceptance of the non-payment policy among providers without increasing administrative burden.

Medicaid and BCBSSC account for 85 percent of all births in the state, and so far this initiative has reduced early elective inductions by almost 50 percent. It is estimated that the initiative has saved the state and federal government more than \$6 million due to a decline in NICU admissions and reduced delivery-related expenses. BCBSSC reported savings of over \$2.5 million

Learn more about how the BOI was created, results to date and advice on how to replicate the initiative: *Using Education, Collaboration, and Payment Reform to Reduce Early Elective Deliveries: A Case Study of South Carolina's Birth Outcomes Initiative*. Available at: www.catalyzepaymentreform.org/images/documents/birthoutcomes.pdf

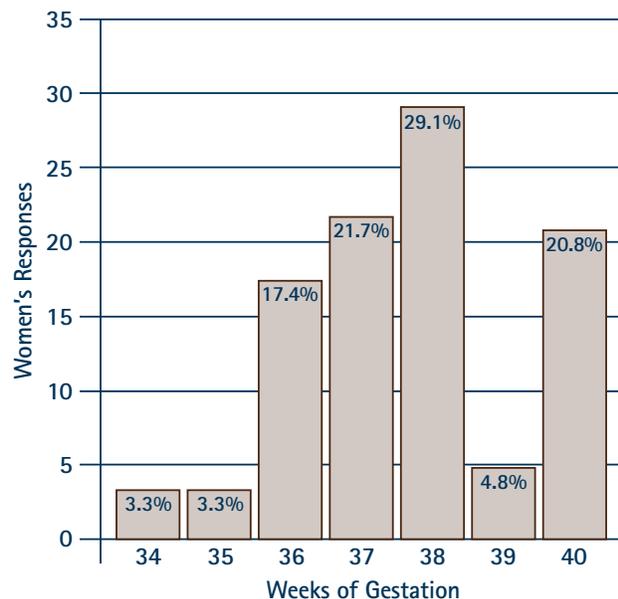
from avoided NICU admissions. The BOI has proven so impressive that 16 other states and six national entities are looking to it as a model to reduce EEDs.

Highmark Health – Financial Incentives for Hospitals: Highmark Health's QualityBLUE Hospital Pay for Performance Program, offered in Pennsylvania, West Virginia and Delaware, offers an optional perinatal performance indicator that focuses on improving the entire delivery process, including preventing early elective deliveries. The component specific to elective inductions is based on the Institute for Healthcare Improvement's "Elective Induction Bundle," which is a group of evidence-based interventions to guide the appropriate use of oxytocin to induce labor. Compliance with the perinatal performance indicator factors into a hospital's performance score, and a portion of its reimbursement is based on total program scores. Highmark reports that the performance indicator has helped hospitals reduce their rates of early elective deliveries.

Anthem Blue Cross and Blue Shield – Financial Incentives for Hospitals: Anthem Blue Cross and Blue Shield's Quality-In-Sights® Hospital Incentive Program (Q-HIP®), a hospital quality and pay-for-performance program, has adopted mandatory reporting of EED rates as part of a measurement scorecard tied to hospital payment across 14 states.^a

^a Q-HIP® is available in the following states: California, Colorado, Connecticut, Georgia, Indiana, Kentucky, Maine, Missouri, Nevada, New Hampshire, New York, Ohio, Virginia and Wisconsin.

FIGURE 3. THREE QUARTERS OF WOMEN UNDERESTIMATE DURATION OF FULL-TERM PREGNANCY



Source: Goldenberg et al. *Obstetrics & Gynecology*, 2009.

The program uses the Joint Commission's National Quality Core Measures: Perinatal Care Measure Set-PC-01 Elective Delivery, which assesses the percentage of patients with elective vaginal deliveries or elective cesarean sections between 37 and 39 weeks. In 2009, Anthem asked hospitals to adopt a policy prohibiting EEDs. In 2012 hospitals were eligible to receive bonus points based on their EED rates, and in 2013 the EED rate was added to the measurement scorecard as a mandatory reporting measure. Anthem credits this step-by-step approach as key to improving hospital compliance with EED reporting and eventually incorporating the measure into the measurement scorecard that is tied to payment. As of 2013, 88 percent of Q-HIP® hospitals have adopted a policy prohibiting EEDs. A new Enhanced Personal Health Care for Specialty Care pilot program launching in 2014 will require participating physician practices to adopt a hard stop policy for EEDs and eventually transition to tie a hospital's Q-HIP® performance to those practices performing deliveries at their facility.

Education

Evidence suggests that many women are unaware of the dangers of delivering their babies prior to 39 weeks gestation without a sound medical reason. Close to 75 percent of women believe that babies are considered full-term between 34 and 38 weeks gestation (Figure 3).²²

Health plans can play a key role in making the latest medical guidelines and information available to in-network health care providers and members. Health plans typically communicate with their in-network providers via newsletters, direct communication via phone calls or email messages or through the health plan website. Their members can be reached through newsletters, various forms of social media, and specialized health condition programs (such as prenatal programs). Health plan foundations also regularly provide health and wellness information to members of their communities through direct community outreach via conferences, grant-making and their website.

Health plans and health plan foundations can:

- Provide education on evidence-based guidelines for delivery prior to 39 weeks to hospitals, providers and other health care professionals
- Educate their members and the larger community on the health risks of elective delivery prior to 39 weeks

Anthem BlueCross BlueShield in Indiana – Provider Education

Anthem BlueCross BlueShield in Indiana partnered with the Indiana Family and Social Services Administration to produce a toolkit for providers called *40 Weeks of Pregnancy, Every Week Counts*. The toolkit includes research articles on reducing EED as well as slides and resources from the California Maternal Quality Care Collaborative Toolkit. The toolkit also includes educational materials for providers to distribute to their patients and display in their offices. The toolkit was mailed to Indiana providers, and health plan representatives also visited provider offices to discuss strategies to improve birth outcomes.²³

Anthem Blue Cross – Hospital Education

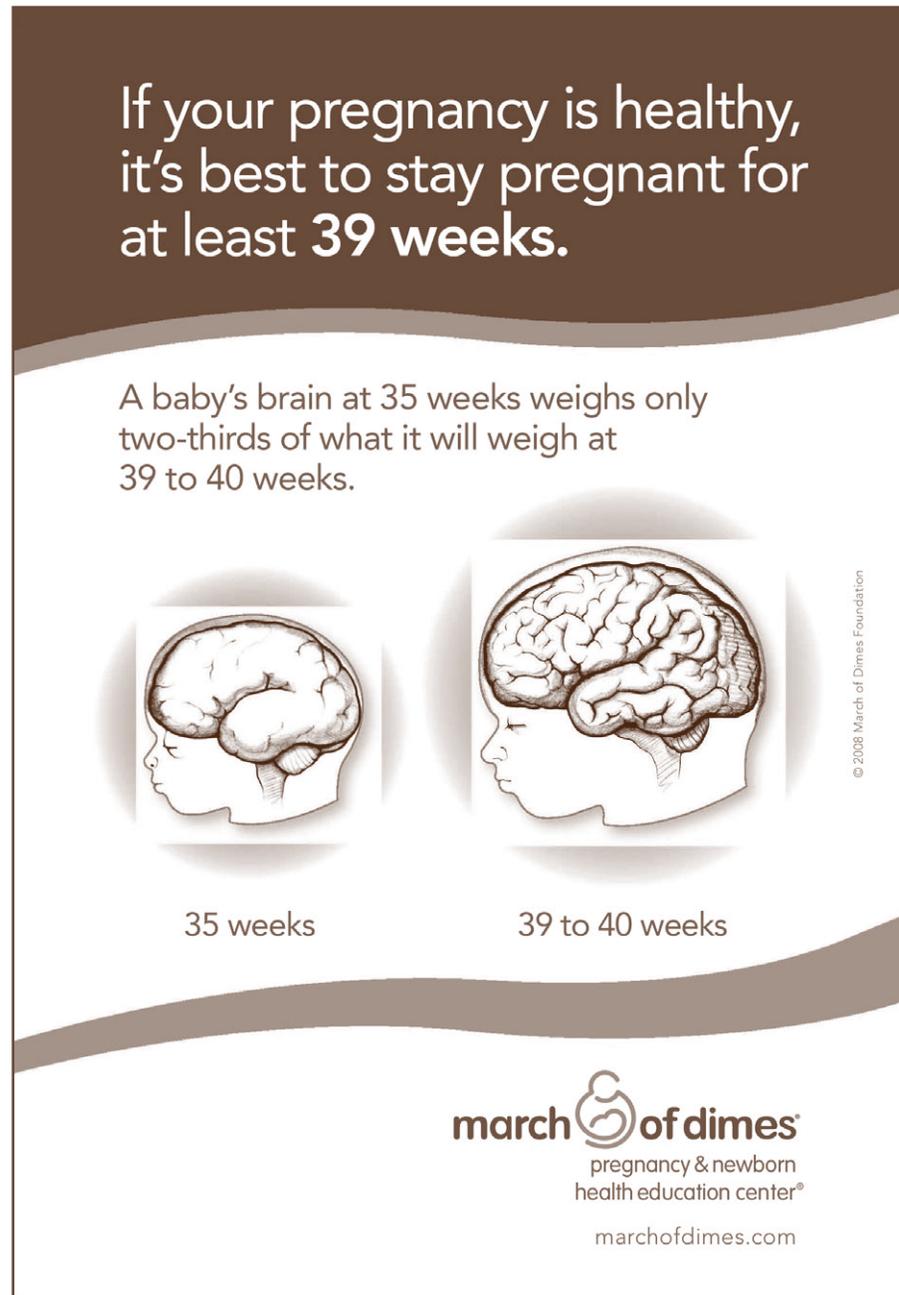
Patient Safety First...a California Partnership for Health (PSF) is a unique collaboration between Anthem Blue Cross, the National Health Foundation, and three regional hospital

associations to increase adoption of patient safety practices by California hospitals. One of PSF's priorities for its first three years was to reduce the number of EEDs in the associations' member hospitals from 9.94 percent in 2010 to less than 5 percent by the end of 2012. Through regional peer-to-peer learning, including in-person meetings and web-based modules that shared hospital best practices, the participating hospitals reduced EED rates to 2.57 percent by the end of 2012, well below the original 5 percent goal.²⁴

Blue Cross Blue Shield of Michigan – Hospital and Patient Education

Blue Cross Blue Shield of Michigan has been supporting the Michigan Health & Hospital Association Keystone Center (MHA Keystone Center) in improving and transforming the quality of health care in hospitals for over a decade. More than 70 Michigan hospitals recently participated in MHA Keystone Center's project focused on strengthening hospitals' EED reduction efforts. MHA Keystone Center collaborated with clinical experts to create a toolkit and guidelines for hospitals, which included options for how to work with clinical staff to reduce EED. The toolkit was deployed through face-to-face meetings and webinars, and MHA Keystone Center provided additional support to hospitals around EED data collection. MHA Keystone Center facilitated the sharing of best practices among hospitals and served as the bridge to clinical experts if hospitals faced any challenges. MHA Keystone Center also partnered with the March of Dimes to provide information for mothers-to-be on the importance of delivering their babies no

FIGURE 4.



sooner than 39 weeks gestation and feels strongly that this multifaceted approach was critical to the initiative's success. To date, EEDs have dropped by 82 percent across participating hospitals. Blue Cross Blue Shield of Michigan recently provided additional funds to continue to support MHA Keystone Center for the next five years.²⁵

WellPoint Foundation – Hospital, Provider and Patient Education

The WellPoint Foundation has a history of collaboration with the March of Dimes, a national organization committed to the health of mothers and babies. Currently, the Foundation is supporting the March of Dimes in implementing a two-year quality improvement (QI) initiative at 12 hospitals in California to reduce EED. The initiative is providing education to hospitals, providers and patients on the importance of the last weeks of pregnancy in the full-term, 39-week developmental process.²⁶

Blue Cross and Blue Shield of Minnesota – Member Education

Blue Cross and Blue Shield of Minnesota (BCBSMN) reaches out to all pregnant members to stress the importance of waiting until 39 weeks gestation before electively inducing labor. The March of Dimes 39-week post card (Figure 4), which compares the size of a fetal brain at 35 and 39 weeks, is distributed to all pregnant members who enroll in the Healthy Start Support and Education program. BCBSMN has also published an article about the benefits of waiting until 39 weeks to deliver and made that article available via the members-only portal of their website. BCBSMN members report EED rates of less than 1 percent.²⁷

CONCLUSION

Early elective deliveries can lead to adverse birth outcomes for mother and child, which have been associated with increased health care costs.²⁸ The federal, state and local governments, national and community-based organizations, and other stakeholders have been leading efforts to reduce the number of women who deliver prior to 39 weeks gestation without medical indication.

Health plans and health plan foundations can play an important role in these partnership efforts, as well as by directly communicating with providers and members and reforming payment to discourage EEDs. Achieving a decline in EED rates will both lower unnecessary health care spending and contribute to reducing our nation's infant mortality rate.

APPENDIX A: FEDERAL GOVERNMENT & NATIONAL ORGANIZATION INITIATIVES TO REDUCE EARLY ELECTIVE DELIVERIES

<p>COLLABORATIVE IMPROVEMENT & INNOVATION NETWORK – CoIIN INITIATIVE TO REDUCE INFANT MORTALITY²⁹</p> <p><i>Health Resources Services Administration's Maternal and Child Health Bureau</i></p>	<p>Goal: To reduce infant mortality</p> <p>Strategies: reducing early elective deliveries is one of the evidenced-based strategies to prevent infant mortality selected as a priority area by geographic Regions IV, V, and VI (AL, AR, FL, GA, IL, IN, KY, LA, MI, MN, MS, NC, NM, OH, OK, SC, TN, TX, and WI).</p> <p>Efforts to Date:</p> <ul style="list-style-type: none"> ■ Teams of public- and private-sector organizations meet via distance-based technology and communicate across all levels of the team to define the problem, construct an intervention, implement and evaluate the intervention and diffuse and adapt effective innovations in new settings. ■ Select CoIIN states have participated in campaigns to educate women about the importance of waiting until at least 39 weeks gestation to deliver. ■ Other states have created their own birth outcomes projects and quality collaboratives.
<p>STRONG START³⁰</p> <p><i>Centers for Medicare and Medicaid Services, Administration on Children and Families, and Health Resources Services Administration</i></p>	<p>Goal: To reduce preterm births and improve outcomes for newborns and pregnant women.</p> <p>Strategies:</p> <ul style="list-style-type: none"> ■ Public-private partnership and awareness campaign to reduce the rate of early elective deliveries. ■ Funding opportunity to test the effectiveness of specific enhanced prenatal care approaches for Medicaid or CHIP beneficiaries. <p>Efforts to Date:</p> <ul style="list-style-type: none"> ■ CMS added a new EED measure to the Inpatient Quality Reporting Program for payment determinations in FY 2015. ■ Strong Start created an early elective delivery Continuing Medical Education opportunity on Medscape. ■ Strong Start leveraged existing Partnership for Patients and participating Hospital Engagement Networks to reduce EED in participating hospitals. ■ Strong Start worked with WebMD to create a page dedicated to educating consumers on EED. <p>Resources:</p> <ul style="list-style-type: none"> ■ Strong Start has created toolkits to raise awareness of the dangers of EED specifically targeted toward providers and consumers. <ul style="list-style-type: none"> ■ Toolkit for Providers: http://cms.gov/Outreach-and-Education/Outreach/Partnerships/Downloads/StrongStartToolkitForProvidersMay2013.zip. ■ Toolkit for Consumers: http://cms.gov/Outreach-and-Education/Outreach/Partnerships/Downloads/StrongStartToolkitForConsumersMay2013.zip.

<p>MEDICAID MEDICAL DIRECTOR LEARNING NETWORK (MMDLN) PERINATAL PROJECT³¹</p> <p><i>Centers for Medicare and Medicaid Services and Agency for Health Care Research and Quality</i></p>	<p>Goal: To better understand elective deliveries in the Medicaid population.</p> <p>Strategies:</p> <ul style="list-style-type: none"> ■ Track trends in EED and birth outcomes. ■ Add to the knowledge base on the impact of EED on birth outcomes in the Medicaid population, while describing variation among the states. ■ Increase understanding of the cost of EED to Medicaid based on length and type of hospital stay. ■ Assist states with making policy and program decisions related to reducing EED. <p>Efforts to Date:</p> <ul style="list-style-type: none"> ■ Aggregated data are being shared through manuscripts on the Data Resource Center for Child and Adolescent Health website at http://www.childhealthdata.org/.
<p>NATIONAL CHILD AND MATERNAL HEALTH EDUCATION PROGRAM (NCMHEP)³²</p> <p><i>National Institute of Child Health and Human Development</i></p>	<p>Goal: To reduce the early elective deliveries.</p> <p>Strategy: Educate doctors and patients about the risks associated with EED.</p> <p>Efforts to Date:</p> <ul style="list-style-type: none"> ■ Developed a continuing medical education (CME) course about reducing EED, available at http://www.medscape.org/viewarticle/758756. ■ "Is It Worth It?" video discusses the risks to maternal and child health posed by EED. The video is available on YouTube (http://www.youtube.com/watch?v=-5T9NqtnQk8&feature=youtu.be) and is playing in health care provider offices across the county. ■ NCMHEP has created an infographic to educate women about the importance of waiting until 39 weeks to deliver (http://www.nichd.nih.gov/ncmhep/isitworthit/spreadtheword/Pages/index.aspx#infographic).
<p>2012 PRESIDENT'S CHALLENGE – HEALTHY BABIES PROJECT³³</p> <p><i>Association of State and Territorial Health Officials</i></p>	<p>Goal: To improve birth outcomes by reducing prematurity in the United States by 8 percent by 2014.</p> <p>Strategy: Reducing early elective deliveries has been identified as a common approach to reducing infant mortality and many of the project resources are focused on EED reduction.</p> <p>Efforts to Date: States have shared best practices and resources on successful strategies to reduce infant mortality and prematurity.</p> <p>Resources: Healthy Babies Clearinghouse available at http://www.astho.org/healthybabies/.</p>
<p>HEALTHY BABIES ARE WORTH THE WAIT³⁴</p> <p><i>March of Dimes, Johnson and Johnson Foundation and the Kentucky Department for Public Health</i></p>	<p>Goals:</p> <ul style="list-style-type: none"> ■ To decrease preterm births by providing resources to increase knowledge about factors that cause preterm birth. ■ To change the attitudes and behaviors of providers and consumers in order to impact community-specific risk factors. ■ To implement strategies to prevent preterm births. <p>Strategies:</p> <ul style="list-style-type: none"> ■ Consumer and professional education. ■ Public health interventions that augment existing public health services, and clinical interventions in prenatal and pre- and interconception periods. <p>Efforts to Date:</p> <ul style="list-style-type: none"> ■ HBWW: Preventing Preterm Births through Community-Based Interventions: An Implementation Manual (https://www.prematurityprevention.org/portal/server.pt) provides tools and resources for other states that want to partner with their local March of Dimes chapter to implement this initiative.

ADDITIONAL RESOURCES

INFANT MORTALITY TOOLKIT: RESOURCES FOR A PUBLIC HEALTH APPROACH – GEORGETOWN UNIVERSITY LIBRARY

- <http://www.mchlibrary.org/toolkits/infant-mortality.html>

MARCH OF DIMES 39 WEEKS RESOURCES

- Home page: <http://www.marchofdimes.com/pregnancy/pregnancy-39weeks.aspx>
- Infographic, Healthy babies are worth the wait: <http://www.marchofdimes.com/pregnancy/pregnancy-hbww.aspx>
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LABOR AND BIRTH RESOURCES

- <http://www.womenshealth.gov/pregnancy/childbirth-beyond/labor-birth.html#e>

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ABOUT NIHCM FOUNDATION

The National Institute for Health Care Management (NIHCM) Foundation is a nonprofit, nonpartisan research and educational foundation dedicated to improving the effectiveness, efficiency and quality of the U.S. health care system.

ABOUT THIS BRIEF

This paper was produced with support from the Health Resources and Services Administration's Maternal and Child Health Bureau, Public Health Service, United States Department of Health and Human Services, under the Alliance for Information on Maternal and Child Health cooperative agreement No. UC4MC21533. Its contents are solely the responsibility of the authors and do not necessarily represent the official views of the Maternal and Child Health Bureau.

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