Perinatal Practices

Health Services and Medical Management Division

January 2010

Legislative Report

Minnesota Department of **Human Services**

Executive Summary

Recent legislation aiming to minimize the rate of Cesarean section deliveries in the Minnesota Health Care Programs (MHCP) population directed the Department of Human Services (DHS) to implement payment rate changes and consider the development of best practice standards and guidelines related to C-sections. This report summarizes the series of actions that have taken place in response to these legislative directives. These actions include the planned implementation of a blended payment rate for births and the establishment of an ad-hoc advisory subgroup of the Health Services Advisory Council (HSAC). As the single largest payer of births in the State of Minnesota, DHS is in the unique position of being able to convene a representative group of payers and practitioners to influence community practice related to perinatal care.

Introduction

The rising use of cesarean delivery, both nationwide and in Minnesota, prompted the Department of Human Services (DHS) to examine the claims experience across the Minnesota Health Care Programs (MHCP), focusing on Cesarean-section deliveries. This analysis culminated in an analysis completed in February of 2009, that highlighted the variability of cesarean-section rates by facility.

In the 2009 legislative session, many bills were proposed and two bills were passed that related to c-section rates in Minnesota. They are as follows:

> **Amendment 256B.0625 subdivision 3c, Citation Chapter 79, Article 5, Section 26.**
> Health Services Policy Committee shall review cesarean section rates for the fee-for-service medical assistance population. The committee may develop best practice policies related to the minimization of cesarean sections, including but not limited to standards and guidelines for health care providers and health care facilities. The Committee Report and findings are due by January 15, 2010.
>
> **Amendment 256B.756, 256.969, subdivision 28, Citation Chapter 79, Article 5, Section 50 - Tech Changes Chapter 173, Article 1, sections 14, 31**
> Reimbursement and Payment Rates for Births: Establishes the professional services payment rates related to labor, delivery, antepartum, and postpartum care for the following diagnostic related groups (DRGs): cesarean section deliveries without complications, vaginal deliveries with complications, and vaginal deliveries without complications. The rate shall be consistent with an increase in the proportion of birth by vaginal delivery and a reduction in the percentage of births by cesarean section. The calculated single rate must not reflect a shift of greater than five percent in the current proportion of all births delivered vaginally and by cesarean section. These rates are effective for services provided on or after October 1, 2009, and are required to be reflected in managed care plan payments for services provided on or after October 1, 2009.

These legislative directives can be summarized as follows:

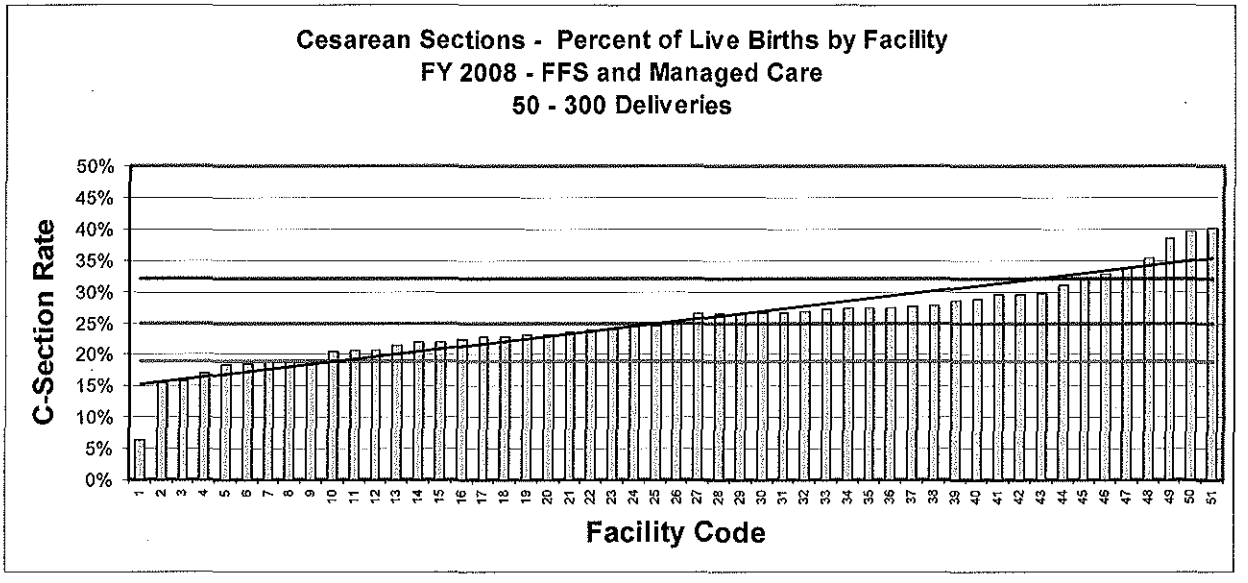
- Review the C-section rates by facility for the FFS-MA population
- Develop a blended payment rate for deliveries that assumes up to 5% fewer C-sections
- Make this rate effective on October 1, 2009
- Consider development of best practice standards and guidelines related to C-sections
- Prepare a report by January 15, 2010

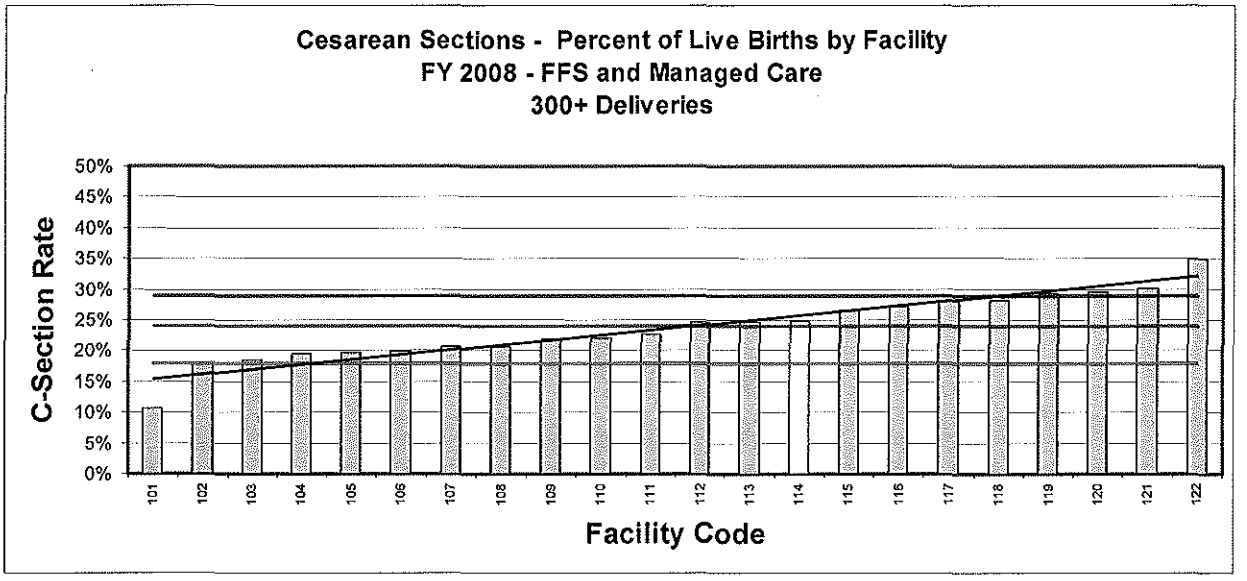
This report summarizes the series of actions that have taken place in response to these legislative directives.

Cesarean Section Rates by Facility

In the summer of 2009, DHS staff compared C-section rates by facility as follows: These data represent fee-for-service and managed-care MHCP claims by facility during the State fiscal year 2008, and include claims having third-party liability and spend down. Facilities with fewer than 50 births (FFS and MC) were excluded from the analysis, as they represented the bottom 5% of total deliveries and would be more likely to have results that were affected by random chance.. Facilities were then divided into two categories: 50-300 deliveries, and over 300 deliveries, to reflect facilities lacking and with Neonatal Intensive Care Unit (NICU) level II or III status. Each code represents a unique facility. Code 114 (un-shaded) represents managed care claims for 2,829 deliveries that had an incorrect provider number, and could not be tracked to a facility. An additional 1,066 claims were resubmitted with a correct provider number; the duplicated claims are not included in this analysis, but were present in the 2009 fiscal note.

In these charts, the blue line represents the mean, while the red and green lines represent one standard deviation higher and lower, respectively, relative to the mean. The black line is the linear trend of data.





For the facilities with 50 – 300 births, the mean percentage of deliveries by C-section was 25%, with a standard deviation of 6%. These rates ranged from 6% to 40% among these 51 facilities. Only 22 facilities had over 300 births, with the mean percentage of deliveries by C-section at 24%, and a standard deviation of 5%. The rates for this group ranged from 11% to 35%. When taking the entire population into account, with a total of 26,195 live births, including 6,350 C-section births, the C-section rate for deliveries averaged 24%, but with a standard deviation of 21%, reflecting very high differences among facilities with small numbers of deliveries.

Overall, the degree of variation in rates between facilities with more than 50 live births points to practice pattern differences that are likely not fully explained by population differences. Even when looking at the highest-volume facilities in the state (loosely corresponding to the most highly equipped – level III and level II – NICUs), the highest and lowest cesarean delivery rate range is more than 20%. (The range varies by more than 30% in lower-volume facilities).

These data highlight the need for objective, evidence-based information on which mothers and infants are most likely to benefit from cesarean delivery and other delivery practices such as inductions.

Blended Payment Rate for Cesarean Sections

On October 1, 2009, a blended rate of payment was implemented for deliveries that assumed up to 5% fewer cesarean deliveries. The calculations used to derive this payment rate are provided in Appendix A. Prior to the implementation, all facilities were notified of the impending change, and were invited to participate in a public forum that was held on September 8, 2009. A survey administered at the meeting revealed that a wide variety of professionals were in attendance, ranging from hospital administrators and finance directors to nurse managers, midwifes, and obstetricians. They represented a diverse group of organizations located throughout the State of Minnesota. See Appendix B for more information regarding the attendance at this meeting.

At this public forum, the blended rate calculations were explained to the attendees, and opportunities for comment and discussion were provided. The group exchanged ideas regarding the causes for Cesarean deliveries, and many participants voiced an interest in participating in an ongoing forum to examine best practices for perinatal care in Minnesota.

Ad-Hoc Perinatal Practices Advisory Group (PPAG) to the Health Services Advisory Council (HSAC)

As a result of the interest in perinatal best practices expressed by attendees at the September 8th meeting, a subgroup of HSAC was planned. The Charter is available in Appendix C. On November 2nd, 2009, the group met for the first time. At this meeting, they developed the following list of priorities:

PPAG Priorities

- Define the complicated C-section
  - Look at DRG definitions for facility billing
  - Review provider coding options
- Decrease elective inductions with unfavorable cervix or before 39 weeks.
  - Learn from local and national sources regarding their experiences
- Explore consumer education - particularly with diverse populations.
  - Link with local organizations that serve diverse populations
  - Look into possibility of partnering with national organizations.
  - Survey what area organizations are doing to manage patient expectations

- Investigate whether multiple gestation rates are atypically high among MA patients*
  - Rates should be 1% or less

The group noted that lack of community definitions regarding what constituted a complicated Cesarean section could handicap the ability of the new blended rates to curb utilization of uncomplicated C-sections. Concern was expressed that the higher rate of reimbursement for complicated C-sections could result in financial incentives for "up-coding" uncomplicated Cesarean procedures to maximize revenue. Secondly, a key factor in the overall utilization of Cesarean sections was felt by many to be the increasing use of inducing labor for non-medical, or elective, reasons. As significant work to reduce the number of elective inductions was currently underway in a number of organizations in the medical community, the group decided to focus on leveraging the knowledge that was being gained in this arena. In addition, as many perinatal initiatives were already underway in other states, it was decided to synthesize the available information from those sources as well to guide policy discussion. An identification of state initiatives is available in Appendix D.

In addition, the group identified key constituencies that were not currently represented in the membership. When PPAG met again on January 4th, 2010, membership included additional representation from a variety of professions and organizations. This membership of this advisory committee is documented in Appendix E. The work of this collaborative group is ongoing; a report to HSAC is anticipated in the summer of 2010.

Conclusions and Recommendations

Both on the national scene and in Minnesota, diverse efforts are underway to improve perinatal care. The Department of Human Services, as the single largest payer of births in the State of Minnesota, is in the unique position of being able to convene a representative group of payers and practitioners to help to develop community standards related to Cesarean section billing and best practices related to elective induction of labor.

The potential benefits of this collaborative process are far-reaching and compelling. Not only is there an opportunity to make a fiscal impact, but there is the real potential to reduce complications of delivery for both mothers and babies and positively affect the long-term health of the next generation of Minnesotans.

It is recommended that the work of this group continue. A final report to HSAC is anticipated to be available in the summer of 2010.

* This was determined not to be an issue for the MHCP population based on an analysis of claims data and birth certificate data from an unpublished study conducted by the Birth Certificate and Medicaid Data Match Project.

Appendix A: Blended Rates Calculations

Factor:* 4.5%

Projected Facility Savings:	**$**	**2,248,131.00**
Projected Professional Savings:	**$**	**391,977.26**
Total:	**$**	**2,640,108.26**

Rates are for fee for service births only. Quantities reflect both fee for service and managed care births.
The overall volume of professional delivery claims is lower than the facility volume. This is due to third party liability coverage and/or professional claim denial.
Per legislative mandate, the maximum payment for facility rates for DRGs 373, 371, and 372 is $3,528.
*Quantities were adjusted to reflect a decrease in the number of normal c-sections by the FACTOR percentage. The quantities of normal and complicated vaginal births were adjusted to reflect a commensurate increase in births, weighted proportionate to their percentage of vaginal births.
Similar CPT codes were grouped according to whether they included ante- and/or post-delivery services.
The CPT codes were matched to DRGs, based on historical data and clinical fit.

Quantities for the standard base rates were adjusted to reflect a decrease in the number of normal c-sections (not VBAC) by the factor percentage. The quantities of normal and complicated (VBAC) vaginal births were adjusted to reflect a commensurate increase in births, weighted proportionate to their percentage of vaginal births.
For each grouping of CPT codes, an adjusted rate was calculated to reflect the blended rate of all births except attempted VBAC leading to C-Section (complicated C-section).
As there is no CPT code that reflects complicated c-sections that are not due to attempted VBAC, CPT codes for cesarean deliveries that link to DRG 370 (complicated c-section) facility claims will have payment retroactively adjusted to reflect complicated cesarean deliveries.

Baseline - Facility

DRG	Description	DRG Rate		Volume	Facility $	Proportion
373	Vaginal Birth - normal	$ 3,144.00		16,872	$ 53,045,568.00	64.4%
371	C-Section - normal	$ 5,266.00		3,894	$ 20,505,804.00	14.9%
372	Vaginal Birth with Complications	$ 4,187.00		2,973	$ 12,447,951.00	11.3%
370	C-Section - with Complications	$ 7,236.00		2,456	$ 17,771,616.00	9.4%
			Totals:	**26,195**	**$ 103,770,939.00**	

Adjusted - Facility

DRG	Description	DRG Rate		Volume	Facility $	Proportion
373	Vaginal Birth - normal	$ 3,528.00		17,874	$ 63,060,112.32	68.2%
371	C-Section - normal	$ 3,528.00		2,715	$ 9,579,313.80	10.4%
372	Vaginal Birth with Complications	$ 3,528.00		3,150	$ 11,111,765.88	12.0%
370	C-Section - with Complications	$ 7,236.00		2,456	$ 17,771,616.00	9.4%
			Totals:	**26,195**	**$ 101,522,808.00**	
			Projected Facility Fee Savings:	**$**	**2,248,131.00**	**2.2%**

Baseline - Professional

CPT	Description	DRG Match	Total Prof. Rate	Volume	Prof $		Base Prof Rate (Delivery Only)	Additions to Base Prof Rate
	Ante, Delivery, Post							
59400	Antepartum, Vaginal, Postpartum	373	$ 776.62	9,150	$ 7,106,073.00		$ 469.68	$ 306.94
59510	Antepartum, Cesarean, Postpartum	371	$ 1,147.42	2,401	$ 2,754,955.42		$ 840.48	$ 306.94
59610	VBAC Ante-, Vaginal, Postpartum	372	$ 1,147.42	228	$ 261,611.76		$ 840.48	$ 306.94
59618	Attempted VBAC with Ante-, Post	370	$ 1,190.05	50	$ 59,502.50		$ 885.92	$ 304.13
			Total:	11,829	$ 10,182,142.68			
	Delivery Only							
59409	Vaginal delivery only	373	$ 469.68	3,374	$ 1,584,700.32		$ 469.68	$ -
59514	Cesarean only	371	$ 840.48	2,592	$ 2,178,524.16		$ 840.48	$ -
59612	VBAC only	372	$ 840.48	108	$ 90,771.84		$ 840.48	$ -
59620	Attempted VBAC only	370	$ 885.92	42	$ 37,208.64		$ 885.92	$ -
			Total:	6,116	$ 3,891,204.96			
	Delivery, Post Only							
59410	Vaginal delivery with postpartum	373	$ 494.40	4,580	$ 2,264,352.00		$ 469.68	$ 24.72
59515	Cesarean with postpartum	371	$ 865.20	1,460	$ 1,263,192.00		$ 840.48	$ 24.72
59614	VBAC with Postpartum	372	$ 865.20	153	$ 132,375.60		$ 840.48	$ 24.72
59622	Attempted VBAC with Postpartum	370	$ 908.61	25	$ 22,715.25		$ 885.92	$ 22.69
			Total:	6,218	$ 3,682,634.85			
			Totals:	**24,163**	**$ 17,755,982.49**			

Standard Base Rate Adjustments							
	Standard Categories	Total Quantity	Volume Shift	Adjusted Volume	Base Prof. Rate (Delivery Only)	$ Adjusted for Volume Shift	Blended Standard Rate
373	Vaginal delivery	17,104	1,057	18,161	$ 469.68	$ 8,529,911.26	$ 560.43
371	Cesarean	6,453	(1,087)	5,366	$ 840.48	$ 4,509,734.12	$ 560.43
372	VBAC	489	30	519	$ 840.48	$ 436,396.24	$ 560.43
			Subtotals:	24,046		$ 13,476,041.62	
370	Attempted VBAC only	117	0	117	$ 885.92	$ 103,652.64	$ 885.92
	Total:	24,163					

Adjusted - Professional								
CPT	Description		Additions to Base Rate	Blended Standard Rate	New Blended Rate	Volume Shift	Adjusted Volume	Projected $
	Ante, Delivery, Post							
59400	Antepartum, Vaginal, Postpartum		$ 306.94	$ 560.43	$ 867.37	519	$ 9,669.36	$ 8,386,892.42
59510	Antepartum, Cesarean, Postpartum		$ 306.94	$ 560.43	$ 867.37	-532	$ 1,868.70	$ 1,620,845.46
59610	VBAC Antepartum, Vaginal, Postpartum		$ 306.94	$ 560.43	$ 867.37	13	$ 240.94	$ 208,984.86
59618	Attempted VBAC with Antepartum, Postpartum		$ 304.13	$ 885.92	$ 1,190.05	0	$ 50.00	$ 59,502.50
	Delivery Only							$ -
59409	Vaginal delivery only		$ -	$ 560.43	$ 560.43	267	$ 3,640.68	$ 2,040,339.50
59514	Cesarean only		$ -	$ 560.43	$ 560.43	-275	$ 2,316.78	$ 1,298,387.41
59612	VBAC only		$ -	$ 560.43	$ 560.43	9	$ 116.54	$ 65,310.22
59620	Attempted VBAC only		$ -	$ 885.92	$ 885.92	0	$ 42.00	$ 37,208.64
	Delivery, Post Only							
59410	Vaginal delivery with postpartum		$ 24.72	$ 560.43	$ 585.15	271	$ 4,850.76	$ 2,838,413.29
59515	Cesarean with postpartum		$ 24.72	$ 560.43	$ 585.15	-280	$ 1,180.19	$ 690,585.32
59614	VBAC with Postpartum		$ 24.72	$ 560.43	$ 585.15	9	$ 162.05	$ 94,820.36
59622	Attempted VBAC with Postpartum		$ 22.69	$ 885.92	$ 908.61	0	$ 25.00	$ 22,715.25

Projected Professional Costs: $ 17,364,005.23
Projected Professional Savings: $ 391,977.26
Proportion: 2.2%

Appendix B: Survey from Blended Rate Informational Meeting on 9/8/2009

The following are results of a participant survey administered on September 8, 2009. Twenty-three persons responded in total.

Roles:

- Hospital Administrator – 2
- Nurse-Midwife – 2
- Nurse Manager – 2
- Nurse – OB Coordinator - 1
- Nurse Perinatal – 1
- Obstetrician – 3
- OB Site Manaager – 2
- Finance Director – 2
- Other - Hospital Assoc Lobbyist – 1
- Other - Med. Professional Assoc Staff – 1
- Other - Contracting Payor – 1
- Other - Hospital Performance Improvement Staff – 1
- Other - Clinical Safety Director – 1
- Other – VP Network Management – 1
- Anonymous – 2

Affiliation:

- Allina – 5
- Fairview – 4
- HealthEast – 1
- Lake Region Healthcare – Fergus Falls – 1
- Medica – 1
- MN Academy of Family Physicians – 1
- MN Hospital Association – 1
- MN State University – Mankato – 1
- North Metro Midwives – 1
- Park Nicollet – 1
- Perham Memorial Hospital – 1
- St Francis Regional Medical Center – 1
- St. Gabriel's Hospital – Little Falls – 1

In response to the following narrative question, these were the replies received:

What do you think affects the decision to perform Cesarean Sections?

- Complacency that it is a procedure with minimal risk - by both provider and public. Liability for providers. Reimbursement - belief that it is safest way to deliver a baby.
- More pressure to do obstetrical births
- Patient understanding of risks and options.
- Patient health and preference, risk of liability
- Varies- May increase C/S rate or no change. Doubt it will decrease the rate - MDH will save its money anyway.
- Patient & Physician Input
- In our facility, lack of staff to offer VBAC. If this increases the VBAC rate it will push OB's away from rural hospitals.
- Patient choice/pressure, media, legal outcome concerns
- Medications, repeat elective cesarean sections, litigation and publicized difficult outcomes for VBAC.
- Community driven- Mother performance- physician performance for scheduling and clinical judgment - rest benefit of safety for Mother and baby.
- Physician practice and comfort level
- The perinatal bundles that we adopted . Which means to meet certain criteria for induction to lower the induction rate thereby lowers c/s rate.
- Philosophy of practitioner and facility. Time required (by all) to avoid c/s $$. Threat of liability. Women's expressed desire. Perinatal care needs a culture change.
- Many factors influence decisions for C-births patients , families, providers, and nursing staff. Of course, risk mgt & liability are factors as well.
- Patient Preference, physician/facility financial incentive
- Patient influences, public opinion, elective induction of labor.
- Patient- Physician Interaction
- Patient needs, convenience, historical practice patterns, medical need, provider training, type of provider, provider coverage
- Repeats, failed labor, fetal distress
- Lack of access to OB in rural areas causes scheduled C-sections in order to serve the community. Lack of proper perinatal care. More high risk pregnancies in the MA population.

Appendix C: PPAG Charter

Minnesota Department of Human Services
Ad-Hoc Perinatal Practices Advisory Group Charter

The Minnesota Department of Human Services (DHS) Ad-hoc Perinatal Practices Advisory Group (PPAG) was created to advise the Health Services Advisory Council (HSAC) regarding best practices for perinatal services covered under Minnesota's Health Care Programs. Authority for the development of this group comes from Minnesota Statutes, 256B.0625, subdivision 3c.

Objective: PPAG will advise HSAC regarding best practices for perinatal care for Minnesota's public health care programs in order to promote the optimal health and safety of the new born and mother. Goals include but are not limited to:

1. Reduction in premature birth
2. Reduction in unnecessary cesarean birth (or a decrease in the variation in Cesarean birth rates)
3. Equity in care practices between culturally diverse groups.

PPAG Guiding Principles

Quality of Care

1) Quality of medical care for the patients served by DHS is the primary concern of the agency, HSAC, and this advisory group.

2) The use of evidence will guide this advisory group. Scientific evidence will be sought, and conclusions drawn concerning the effect of services on health outcomes.
   - Consideration will be given to safety, available scientific evidence, clinical effectiveness, professional standards, and expert opinion.
   - Consensus among the medical community can be used and play a role when no definitive evidence exists or evidence is insufficient at the present time.
   - Policies are flexible to permit exceptions and take clinical circumstances into consideration.

3) Health care services and technology must improve the net health outcome.
   - A recommendation necessitates good evidence that the procedure is effective in reducing morbidity and mortality: medical benefits must outweigh risks.
   - Services must be as beneficial as any established alternative and improvement must be attainable outside the investigational setting.

Value of Care

4) Reasoned and defensible coverage decisions are essential for a fairer and more efficient health care system.

5) Cost-effectiveness will guide decision-making. Cost-effective services and technologies are considered to be:
   - at least as effective and less costly than alternatives.
   - more effective and more costly than alternatives, but resultant patient outcomes justify additional expenditure.
   - less effective and less costly than alternatives, but resultant patient outcomes from the use of more expensive alternatives *do not* justify additional expenditures.

PPAG and DHS Process

6) The process is transparent and public.

7) Recommendations made by PPAG are subject to HSAC approval. DHS will communicate with PPAG regarding final decisions on all recommendations.

8) Recommendations must be practical and feasible, and coverage policy should be equivalent across all delivery systems.

Membership

The Perinatal Practices Advisory Group will have representation from the following categories:

- Obstetrician
- OB Unit Manager
- Nurse Midwife
- OB Nurse
- Neonatologist
- Anesthesiologist
- Perinatologist
- Hospital Administrator
- Family Practice Physician
- March of Dimes
- Rural Health Systems
- DHS Medical Director (ex officio)

Terms and Compensation

A) This ad-hoc work group will expire when it has completed its analysis.

B) There will be no compensation to the members of PPAG.

Responsibilities

A) Attend all meetings. If a member misses two meetings without good reason, the DHS will discuss this with the member and consider appointment of a new member.

B) Bring concerns of the community to the attention of the Chair, DHS Medical Director, and DHS staff.

C) Take part in discussions.

D) Actual conflict of interest or the appearance of conflict of interest may exist in certain situations. Members should disclose, orally in a HSAC meeting, whenever actual conflict or the perception of conflict of interest occurs. Members will then refrain from the participation in discussion of and voting on motions pertaining to the matter.

Members and guest presenters will also be required to sign a conflict of interest disclosure statement.

E) Review the HSAC agenda and information before meetings and prepare comments or questions.

F) Review and make recommendations on proposals presented by the department related to clinical issues, evidence based practice guidelines, legislation and other DHS policies in accordance with the guiding principles stated above.

Contact Information

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Appendix D: State Perinatal Initiatives (Draft Analysis)

	Organization	Organization Mission	Projects, Initiatives and Activities
AL	Alabama State Perinatal Advisory Council	The purpose of Alabama's Perinatal Program is to develop strategies that will reduce infant morbidity and decrease infant mortality	• Focused on infant health
AZ	Arizona Perinatal Trust P: (520) 421-9880	The Arizona Perinatal Trust was created to be an independent source of energy and resources to focus efforts on the continuing improvement of the health of Arizona's mothers and babies.	• Voluntary certification of hospitals A quality improvement process that matches hospital capabilities and capacity to established guidelines through hospital self-assessment and peer professional site visits. • Annual perinatal data profile of member hospitals • Professional perinatal education
CA	California Perinatal Quality Care Collaborative Barbara Murphy, RN MSN Executive Director P: (650) 723-5763 P: (650) 721-6540 barbar@standford.edu	To develop a collaborative network of public and private, obstetric and neonatal providers, insurers, public health professionals and business groups to support a system for benchmarking and performance improvement activities for perinatal care.	• 126 member hospitals • CPQCC Activities o Risk adjusted perinatal system o Comprehensive strategy for benchmarking and data-driven quality improvement activities o Topic specific training and toolkits o Research best practices and continuous reassessment of performance improvements • CPQCC Perinatal Data System o Data management system that facilitates identification of perinatal improvement targets and monitors public health effects of planned interventions, systems changes, care behavior modification. • CPQCC Data Center o Integrated, statewide databases coordinated with state databases • Perinatal Quality Improvement Panel o Analyzes CPQCC data and reviews current, relevant literature o Defines indicators and benchmarks o Recommends quality improvement objectives o Provides models for performance improvement
CO	Colorado Perinatal Care Council Jan Goldbeg P: (303) 692-2422 jan@coloradoperinatalcarecouncil.com	A volunteer, non-profit advisory group whose members represent a variety of professions, hospital and organizations with an expertise or interest in perinatal care. Its major focus is the coordination and improvement of perinatal care services in Colorado.	• Established by the Governor and the Colorado Department of Health in 1975 to provide broad-based leadership in planning and coordinating statewide perinatal health care delivery. • Primary objective: to advise the Colorado Department of Public Health and Environment regarding guidelines of the delivery of perinatal care, geographic distribution of care, utilization of services and the need for additional services. • Voluntary perinatal hospital self

			assessment To establish a consistent set of minimum expectations for each level of perinatal services, and recognize the capabilities, commitment and resources of institutions that are beyond the minimum expectation for their level of perinatal services. • Consumer education • Activities related to medical, legal, legislative and ethical issues in perinatal care.
CT	Connecticut Perinatal Health Advisory Committee		• Perinatal Health Plan for Connecticut 2005-2009
DE	Delaware Healthy Mother and Infant Consortium	The Delaware Healthy Mother and Infant Consortium is established to help ensure the effective implementation of recommendations set forth by the Infant Mortality Task Force.	• DHMIC is established by Delaware code and reports to the governor • Is a successor to the Delaware Perinatal Board • Focus is on reducing infant mortality
GA	Georgia Perinatal Association	Georgia Perinatal Association is a multi-disciplinary organization concerned with health care issues that improve pregnancy and infant outcomes. Our membership works to promote perinatal health through education collaboration and influence of state public policy.	• Not affiliated with the state, but part of their mission is to influence state policy • Focused on infant mortality and newborn health
	Governor's Council on Maternal and Infant Health in Georgia Council on Maternal and Infant Health P: (404) 657-3152 gcmih@dhr.ga.gov	To courageously advocate for optimal reproductive and infant health in Georgia, serving as a sought after authority on the State's health system and outcomes. Vision: To use its influence to help build an equitable system of high quality care. This system will address the diverse and multifaceted needs of Georgians in order to promote reproductive health. The Council's ultimate success will be realized when informed citizens consistently demonstrate healthy lifestyle choices perpetuating the best pregnancy outcomes and child health.	• State insurance reform (legislation to require group dependent health insurance policies to cover infants from birth) • Access o State-wide health care referral line o Newborn Follow-Up Care o Teen Pregnancy and Family Planning • Education o Back-to-Sleep Campaign • Recommended Guidelines for Perinatal Care to the Georgia Department of Community Health o Recommendations were incorporated into law • Public Dialogues o To gain information from local communities about issues affecting maternal and infant health o Open to the public National Survey of Maternal and Infant Health Councils
ID	Idaho Perinatal Project	The primary purpose of the Idaho Perinatal Project is to reduce maternal and infant morbidity and mortality and	• Focused on infant health

	P: (208) 381-4174 jacobssa@slrmc.org	to improve pregnancy outcomes throughout the state of Idaho.	
IL	Illinois Department of Public Health – Perinatal Advisory Committee and Perinatal Program	A comprehensive statewide system of services created to provide the best opportunity for optimal care throughout pregnancy, early infancy and to improve the health outcomes of women and infants in Illinois.	• Makes recommendations and leads a regional network of 10 perinatal centers • Each perinatal center is a university affiliated hospital. • Activities include quality monitoring and professional education programs • Most recent meeting minuets April 2009 Perinatal Advisory Committee Meeting • Services are targeted to pregnant women with high risk conditions and newborns requiring neonatal intensive care
IN	Indiana Perinatal Network P: (866) 338-0825 ipn@indianaperinatal.org Information about IPN from the Indiana Department of Health: http://www.in.gov/isdh/21052.htm	To lead Indiana to improve the health of all mothers and babies.	• Convenes and maintains state perinatal advisory boards o Representatives from all perinatal constituencies including county health departments and payers o Subcommittees of advisory board issue consensus documents, hold statewide conferences and implement pilot projects. • Education to consumers • Professional education • Legislation and Advocacy o Newborn Hearing Screening o Family Planning Waiver o Prenatal Substance Abuse
IA	Iowa Statewide Perinatal Care Program Stephanie Trusty, BSN Iowa Dept of Public Health P: (515) 281-4731	The Statewide Perinatal Care Program provides professional training, development of standards/guidelines of care, consultation to regional and primary providers and evaluation of the quality of care delivered to reduce the mortality and morbidity of infants.	• Contracts with University of Iowa Hospitals and Clinics • Focused on Infant Health
KS	Perinatal Association of Kansas	The Perinatal Association of Kansas (PAK) promotes the health and well being of mothers and infants enriching families, communities and our world. Every mother deserves a healthy and safe pregnancy; and every baby deserves to be born healthy and into a safe and	• Nonprofit organization that is not affiliated with the State of Kansas

		nurturing home.	
KY	Kentucky Perinatal Association P: 502-655-0424 kyperinatal@aol.com	To mission statement listed	• Nonprofit organization that is not affiliated with the State of Kentucky
MD	Maryland Perinatal Collaborative William F. Minogue, MD Executive Director P: (410)-540-9210 wminogue@marylandpatientsafety.org	To create perinatal units that deliver care safely and reliably with zero preventable adverse outcomes by various proven methods. To reduce infant harm through the implementation and integration of systems improvements and team behaviors into maternal-fetal care.	• 28 hospitals participate in sharing information, consensus building and evaluation surrounding the development of change concepts that are implemented by hospitals to improve quality of care. • A planning group and an expert panel select topics and lead workshops with participants to identify change concepts. • Standardization of EFM language • Training in team coordination and teamwork behaviors • Complete documentation and availability of prenatal records • Improve staff-performance during high risk events • Elective induction and augmentation bundles • Credentialing of core competencies • Establish didactic on vacuum extraction • Implement daily huddles
MI	Michigan		• In January 2009 the state convened three expert groups to develop recommendations for a regional perinatal system. The three groups were obstetrics, neonatology and pediatrics • Michigan Perinatal Level of Care Guidelines
NH VT	Northern New England Perinatal Council Dr. Michele R. Lauria P: (603)-653-9306 michele.r.lauria@hitchcock.org	To improve perinatal health throughout Northern New England through • developing regional quality improvement parameters • outcome review • external peer review • health care benchmarking • developing best practice guidelines • providing a forum for interaction and collaboration of hospitals • Perinatal education	• Member states are Vermont and New Hampshire • VBAC Project to increase availability and safety of VBAC o Consent Form for VBAC o VBAC Guidelines o Patient Ed- Birth choices after C/S • Emergency C/S Hospital Tool Kit To improve local emergency C/S delivery process o Emergency C/S simulation tool o Emergency C/S guidelines o Emergency C/S surgical tray o Global process overview and process mapping • Multi-State Web Based Delivery Registry To provide data for quality assurance and

			quality improvement projects o collect consistent and complete data across region o patient-level reporting on antepartum, delivery, nursing, pediatric and birth certificates
NJ	Southern New Jersey Perinatal Cooperative P: (856) 665-6000	To preventing preterm births and improving the health of pregnant women, infants, and children in South Jersey.	• state-licensed, non-profit, maternal-child health consortium serving the seven southernmost counties of New Jersey • Began as a demonstration project in 1981 by the New Jersey Department of Health and Senior Services • Collaborates with health department and hospital networks
NY	New York State Perinatal Association	New York State Perinatal Association (NYSPA) is a state-wide alliance of health and human service professionals and consumers concerned with perinatal health issues from preconception through early childhood. NYSPA advocates for optimal perinatal care and parenting and promotes education and research, influences state priorities and encourages a multi-cultural and multi-disciplinary approach to maternal and child health.	• Advises state government through representation on various executive and legislative bodies
NC	North Carolina Perinatal Health Committee		• Regionalization of Perinatal Care • Perinatal Outreach Program o Training and technical assistance to health care practitioner o Focus on improving quality of care in preterm birth prevention (17P and 39 week imitative) • Reducing Recurring Preterm Birth 17P initiative • Case management services for low-income mothers • Nurse-Family Partnership o Evidence based program that provides nurse home visits to low-income first time mothers beginning before 28 weeks of pregnancy and ending 2 years after birth.
	Perinatal Quality Collaborative North Carolina	To collaborate with organizations, agencies and individuals to make North Carolina the best place to be born.	• 29 members • Initiatives to Eliminate Elective Deliveries Under 39 weeks Gestation o Retrospective data collection of C/S and inductions performed between 36-38 weeks o Learning Labs to educate hospital members about the evidence surrounding elective deliveries before 39 weeks and assist hospitals develop action plans to eliminate elective deliveries before 39 weeks.

	North Carolina Perinatal Association	The North Carolina Perinatal Association: "A Coalition of Healthy Mothers and Healthy Babies" was formed in 1985 as a non-profit organization. The purpose of this organization is to improve perinatal health for childbearing families throughout the state. The North Carolina Perinatal Association provides leadership, education, and advocacy for healthy mothers and healthy infants. Through the use of state, regional, and local resources, and a multidisciplinary approach, the North Carolina Perinatal Association continues to promote the health and well being of families.	• Focused on infant health
OH	Ohio Perinatal Quality Collaborative Barbara Rose, RN, MPH Program Director P: (513) 636-2554 Barbara.Rose@cchmc.org OPQC@cchmc.org	Through collaborative use of improvement science methods, reduce preterm births and improve outcomes of preterm newborns in Ohio as quickly as possible.	• Mainly focused on reducing infant mortality • Developed neonatal and obstetric toolkits containing data sharing agreement, decision matrix for choosing clinical topics, delivery brochures. • Partners with State of Ohio, March of Dimes, National Initiative for Children's Healthcare Quality, CMS, American Academy of Pediatrics, ACOG • Also partners with perinatal collaboratives in the following states: AR, CA, IL, MA, NC, NY, TN, WI, NJ
OK	Central Oklahoma Perinatal Coalition		• Not affiliated with State of Oklahoma
PA	Pennsylvania Perinatal Partnership Liz Werthan P: 215-985-6268 liz@paperinatal.org	The Mission of the PPP is to improve women's and children's health outcomes in Pennsylvania through education, advocacy, and collaboration.	• Membership includes representatives from county health departments, city health departments, state department of health, department of public welfare and other state or local administrations. • Focused on perinatal depression and fetal alcohol spectrum disorder
SC	South Carolina Perinatal Association	The South Carolina Perinatal Association is a multidisciplinary group of health care providers and consumers dedicated to improving the health status	• Not affiliated with the State of South Carolina • Focused on infant health

		of women, infants and children by: promoting education initiatives, influencing public policy, fostering delivery of optimal family centered care and providing leadership	
TN	Tennessee Initiative for Perinatal Quality Care TIPQC Main Office P: (615) 343-8536 TIPQC.office@TIPQC.org	To improve health outcomes for mothers and infants in Tennessee by engaging key stakeholders in a perinatal quality collaborative that will identify opportunities to optimize birth outcomes and implement data-driven provider and community-based performance improvement initiatives.	• Statewide perinatal database • Statewide quality improvement initiatives to reduce mortality and morbidity associated with premature birth and low-birth weight • Promote system changes by provider organizations to increase use of evidence-based clinical practices for obstetric and NICU patients. • No elective deliveries before 39 weeks project
VT	Vermont Oxford Network VON Main Office P: (802) 865-4814 mail@vtoxford.org	To improve the quality and safety of medical care for newborn infants and their families through a coordinated program of research, education and quality improvement projects.	• High risk newborn database • Evidence based quality improvement collaborative for neonatology
WA	Washington State Perinatal Advisory Committee Bat-Sheva Stein, RN, MSN P: (360) 236 3582 Bat-Sheva.Stein@doh.wa.gov	This statewide perinatal advisory committee was formed by the WA Department of Health to identify and prioritize statewide perinatal concerns, identify need and make recommendations through specific work groups to address perinatal issues, provide consultation and recommend prioritized solutions to WA Dept. of Health.	• Cesarean Reimbursement Rate Changes • Perinatal Level of Care Guidelines • Key Indicators of Perinatal Health for Washington Residents • Perinatal Regional Network o State and federal funds to contract with geographically strategic healthcare institutions to coordinate and implement QI projects to decrease poor pregnancy outcomes for Medicaid clients. Cost Control in Obstetrics 2009 Fact Sheet from Washington Department of Social and Health Services
WV	West Virginia Perinatal Partnership Nancy Tolliver, Project Director nancytolliver@wvperinatal.org (304) 342-8237	A statewide partnership of health care professionals and public and private organizations working to improve perinatal health in West Virginia • Encourage new laws that promote better health for pregnant women • Create opportunities for perinatal professionals to share their expertise with each other	• Hospital guidelines and self assessment • Maternal risk assessment tools • Maternal Screening Act Requires development and use of a standardized tool to alert OB providers of the need for further evaluation and assessment of high-risk pregnant women • Telemedicine to bring consultative expertise rural areas • Blueprint to Improve West Virginia Perinatal Health

WI	Wisconsin Association for Perinatal Care and the Perinatal Foundation WAPC Statewide Office P: (608) 417-6060 wapc@perinatalweb.org	Our mission is to improve perinatal outcomes by: • Leading collaborative efforts that promote, develop, and coordinate systems of perinatal care in Wisconsin • Providing and supporting professional educational programs that focus on the continuum of perinatal care • Valuing and engaging the talented and diverse community of perinatal health care advocates • Increasing public awareness of perinatal health	• Fetal monitoring recommendations • Education materials for providers and consumers to support a reduction in cesarean births • Participation in Cesarean Reduction Workgroup • Promote evidence-based strategies to decrease disparities in perinatal outcomes • Affiliated with Wisconsin Department of Human Services, the University of Wisconsin, various professional organizations • Professional education publication on perinatal issues

Appendix E: PPAG Membership

Ad-Hoc Perinatal Practices Advisory Group (PPAG) to the Health Services Advisory Council (HSAC)

Members

Name	Role(s)	Organization(s)
Janette Strathy, MD	Obstetrician – MMA Legislative Committee, MNACOG Legislative Committee	Park Nicollet Medical Center
Katherine Simon, CNM, MS	Clinic Owner, Nurse Midwife	North Metro Midwives, PA
Kathleen Macken, MD	Medical Director	United Family Medicine Residency Program and Peter J. King Family Health Center
Kathryn Zuspan, MD	Anesthesiologist, Trustee-Perinatal Resources Inc., Board Member – Society of Obstetric Anesthesia and Perinatology	Valley Anesthesiology Consultants
Kitty Haight	Performance Improvement Consultant	Allina Hospitals and Clinics
Linda Chapeau	Director of Medical Services	South Country Health Alliance
Mark Bergeron, MD, MPH	Neonatologist	Associates in Newborn Medicine , PA, St. Paul Childrens Hospital
Marianne Keuhn	State Director of Programs and Public Affairs	March of Dimes
Mary Goering, NP	Clinical Nurse Specialist at the BirthPlace at United Hospital, Co-lead of the Allina Pregnancy Care Council	United Hospital, Allina
Mary Rossi, CNM	Nurse Midwife	MNSCU – Mankato, School of Nursing
Maureen Beaverson, RN, BSN, MA	Group Director – Maternity Care Services	HealthEast (alternate for Ritu Syal)
Ritu Syal, MD	Obstetrician – Co-chair of HealthEast OB Clinical Council	HealthEast
Stan Davis, MD	Obstetrician – Medical Quality Consultant	Fairview
Thomas Satre, MD	Family Physician – St. Cloud	Mid-Minnesota Family Medicine Center
Virginia Lupo, MD	Perinatologist – Head of OBGYN at HCMC	Hennepin County Medical Center

Minnesota Department of Human Services

Name	Role(s)	Organization(s)
Jeff Schiff, MD, MBA	Medical Director, Health Care Programs	MN Department of Human Services
Trudy Ohnsorg, MPH	Staff to Health Services Advisory Council (HSAC)	MN Department of Human Services