Aetna Better Health of Florida

Maternity Health Program – Reducing C-Section Rates

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Agenda

Maternity Health Program – Reducing C-Section Rates

- Mode of delivery
- Rates increasing worldwide
- Reducing cesarean delivery
- C-section checklist
- Obstetrical (OB) Care Management Program
- Doulas

Primary audience of this guideline

- obstetricians, midwives, nurses, general medical practitioners, hospitals

Caesarean section as a mode of delivery

Caesarean section is a surgical procedure that can effectively prevent maternal and newborn mortality when used for medically indicated reasons.

- There is no evidence showing the benefits of caesarean delivery for women or infants who do not require the procedure.
- As with any surgery, caesarean sections are associated with short- and long-term risk which can extend many years beyond the current delivery and affect the health of the woman, her child, and future pregnancies.
- These risks are higher in women with limited access to comprehensive obstetric care.

Every effort should be made to provide caesarean sections to women that truly require the procedure

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Cesarean Section Deliveries

In the United States, there has been a tremendous surge in elective primary Cesarean section deliveries.

Approximately one in three births happen by C-section, a rate that has risen dramatically over the past few decades.

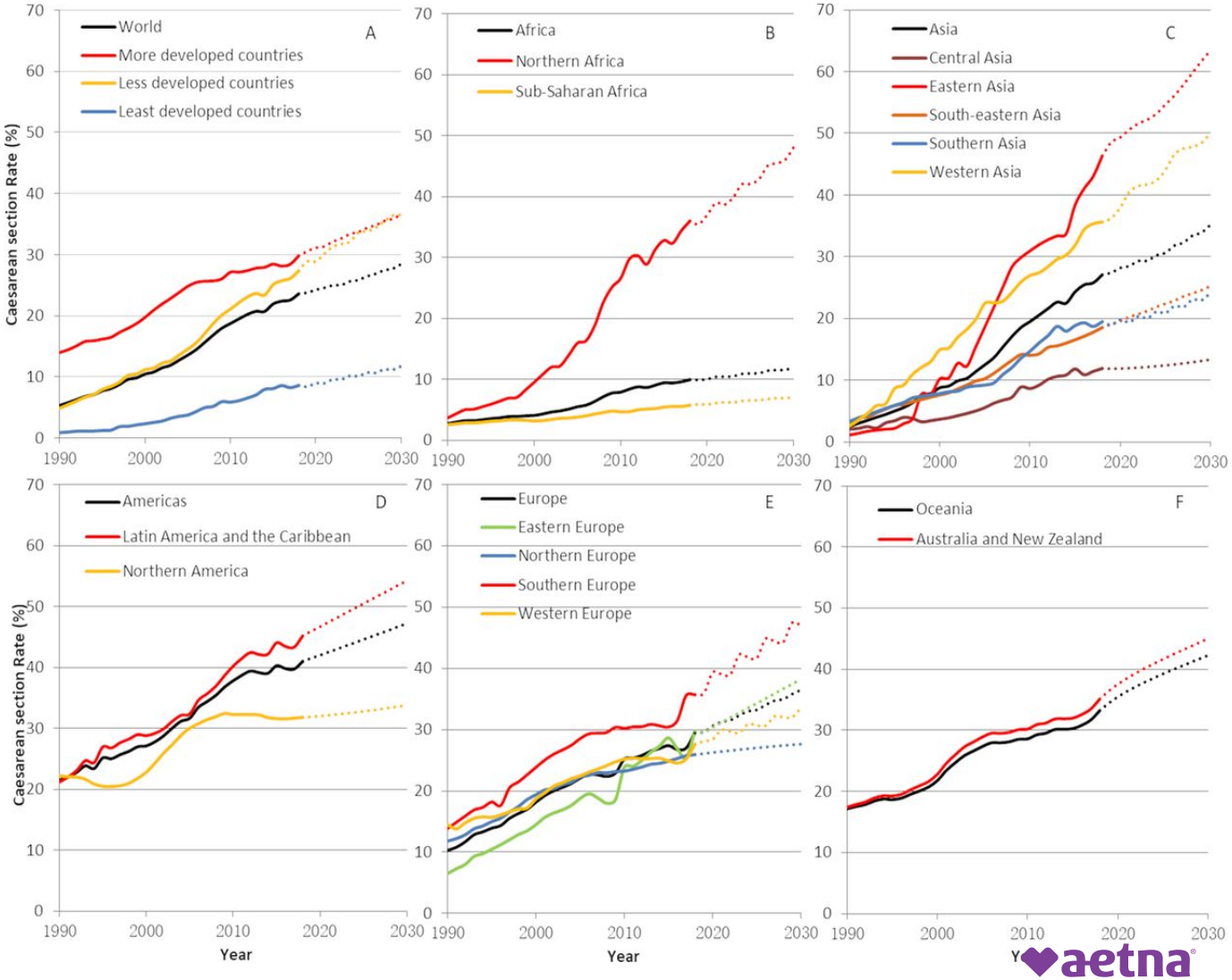
Aetna Better Health of Florida (ABHFL) encourages safe deliveries and seeks to reduce the number of unnecessary primary cesarean sections, thereby improving maternal and infant health outcomes.

How can cesarean delivery rates be reduced?

ABHFL understands a wide scope of evidence-based methods are necessary to reduce cesarean delivery rates. Rates can vary by hospital systems, hospitals, practices, and patient preference.

Cesarean Section Rates Increasing Worldwide

- The optimal caesarean section rate is unknown, but it varies between facilities because of differences in the obstetric populations attended.
- Over the last decades birth by caesarean section has increased in a sustainable and continuous manner to unprecedented levels worldwide
- Governments and clinicians have expressed concern about the rise in the numbers of caesarean section births and the potential negative consequences for maternal and infant health.
- Target Goal <23.6% (Healthy people 2030 goal)



Reducing Cesarean Deliveries

As an obstetrics provider, you should recognize the following as ways to reduce unnecessary Cesarean deliveries:

- Suspected fetal macrosomia is not an indication for cesarean delivery unless EFW is >5000gm in non-diabetics and 4500g in diabetics.
- Cervical-ripening methods should be used when inducing women with an unfavorable cervix.
- For a breech presenting fetus, offer external cephalic version whenever possible and appropriate.
- Before diagnosing a failed induction — when maternal/fetal status allows — consider a longer duration in the latent phase with augmentation.
- Counsel women with vertex presenting twin to attempt vaginal delivery. Evidence shows when the first twin is cephalic presentation, outcomes are not improved by cesarean delivery.
- For women with a history of the herpes simplex virus, administer acyclovir at or beyond 36 weeks gestation for viral suppression, even in the absence of outbreak, to reduce cesarean delivery due to an active outbreak.
- Use of a C-section checklist to confirm all viable options to prevent Cesarean section have been considered prior to operating. https://www.aetnabetterhealth.com/content/dam/aetna/medicaid/florida/provider/pdf/abhfl_08_2021_c_section_provider_bulletin.pdf
- Before diagnosing arrest of labor, allow two hours of pushing in multiparous women and at least three hours in nulliparous women. A longer duration may be appropriate on an individual basis.
- Effective use of Doula's continuous one-on-one support during labor and delivery, is one of the most effective resources in reducing cesarean delivery rates
- Ongoing education of the benefits of vaginal birth and risk of Cesarean section throughout pregnancy is key to reducing unwarranted C-section rates

C-section checklist

Pre-Cesarean Huddle Form

The intent of this form is to define criteria for arrest of dilatation, failed induction and interventions for NRFHT's as defined by the FPQC. It is also meant to explore safe options to prevent cesarean sections in an interdisciplinary setting on the OB unit.

Huddle should occur when a c/s is being considered due to arrest, failed IOL or NRFHT's. Huddles can occur for other reasons as deemed necessary by the providing team.

- **Date and time of huddle-** _____
- **G's and P's and Gestational age-** _____ **Current room** _____
- **ROM time** _____ **Last Cervical Exam** _____
- **Attendees- list names**

  Attending physician* required _____

  Safety Nurse &/or Charge Nurse* 1 required _____

  Bedside provider (CNM/Resident) *1 required _____

  Primary RN (if available) _____

  Anesthesia (if available) _____

- **Reason for huddle- (circle all that apply)**

  C/S being considered ☐ NRFHT ☐ Arrest of Dilatation/Labor Dystocia ☐ Maternal Condition ☐ Failed IOL ☐
  Other _____

- **FHT agreed upon interpretation*at the time of huddle*-** Baseline _____ Variability _____

  Decels present (circle all that apply) - Early ☐ Variable ☐ Late ☐ Prolonged ☐

  Accels present- ☐ Yes / No ☐ Category of tracing- 1 ☐ 2 ☐ 3 ☐

- **Interventions done thus far (circle all that apply)** - *Reposition ☐ *IVF bolus for hypotension ☐ *O2 ☐ *Terbutaline ☐

  *Decrease Pitocin ☐ *Stop Pitocin ☐ *Amnioinfusion for variable decels ☐ *Remove Cervidil ☐

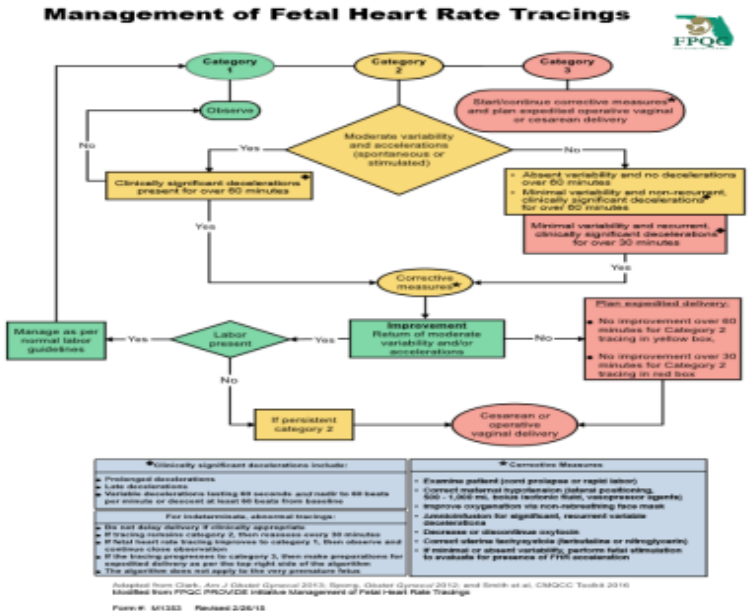
  *Remove balloon/Cook ☐ *Vaginal exam/VAS to elicit fetal response for minimal variability ☐

- **Birth Outcome:** _____

  See back of page for Labor Dystocia, Failed IOL and Management of FHR Algorithm.

- **Labor Dystocia criteria-**
  - Less than 6cm – not in labor, does not meet these criteria (cannot call c/s due to Arrest if less than 6 cm, active labor has not been achieved, consider giving more time)
  - 6 cm - 9.5 cm dilated- was there at least 4 hours with adequate uterine activity or at least 6 hours with inadequate uterine activity and with oxytocin? If no, does not meet criteria for arrest- consider giving more time.
  - If 10cm- Primigravida- was there at least 3 hours or more in second stage- 4 hours with an epidural? If not, does not meet criteria for arrest, consider giving more time. Multiparous- was there at least 2 hours or more in the second stage (without an epidural)?

- **Failed IOL Criteria** –
  - If <6cm dilated, were there at least 12 hours of oxytocin after rupture of membranes?
  - If 6-10cm dilated, was there at least 4h with adequate uterine activity or at least 6h with inadequate uterine activity and with oxytocin?
  - If completely dilated, was there 3h or more of active pushing (4h with epidural)?



Reference:

Spong, C.Y., Berghella, V., Wenstrom, K.D., Mercer, B.M., and Saade, G.R. Preventing the First Cesarean Delivery: Summary of a Joint Eunice Kennedy Shriver National Institute of Child Health and Human Development, Society for Maternal-Fetal Medicine, and American College of Obstetricians and Gynecologists Workshop. Obstet Gynecol. 2012 November; 120 (5): 1181-1193.

Reducing Cesarean Deliveries

More than half of cesarean deliveries are founded on abnormal labor and abnormal or indeterminate fetal heart rate (FHR) tracings.

The variation in rates of nulliparous, term, singleton and vertex cesarean births suggest that clinical practice patterns influence the number of cesarean deliveries done.

Below are the most common indications in order of occurrence are:

- Labor dystocia
- Abnormal or indeterminate (formerly non-reassuring) FHR tracing
- Fetal malpresentation
- Multiple gestations
- Suspected fetal macrosomia

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Obstetrical (OB) Care Management Program

An obstetrical nurse works with Obstetricians and Perinatologists to help coordinate services during pregnancy for members with high-risk conditions.

The care manager also monitors the mother and newborn progress through the sixth week postpartum follow-up visit.

Call Member Services at 1-800-441-5501 and ask to speak to someone on our Care Management team to enroll a patient.

Members can choose to join or leave the program at any time.

Managed Medicaid Expanded Benefits- Doulas

Doulas- are trained professionals who provide continuous physical, emotional and informational support to a mother before, during and shortly after childbirth to help her achieve the healthiest, most satisfying experience possible.

Doula Services are expanded benefits provided to the member fee of charge.

Service	Description	Coverage/Limitations	Prior Authorization
Doula Services	Home visits for care before baby is born, care after baby is born, and newborn visit by Doula	No limit for pregnant female members 14 to 55 years of age	Yes

Credentialing is not required if the Doula is not a registered nurse/midwife or has a masters level certification.

Prior Authorization is required for Doula Services.

Approved Doula Service Codes and Diagnosis

Codes	Modifier	Description
S9442		Birthing classes, non-physician provider, per session
S9443		Lactation classes, non-physician provider, per session
S9444		Parenting classes, non-physician provider, per session
S9445		Prenatal education (patient education non classified, non-physician)
S9445	TS	Postpartum education (patient education non classified, non-physician)
S9446		Prenatal patient education, not otherwise classified, non-physician provider, group, per session
S9446	TS	Postpartum patient education, not otherwise classified, non-physician provider, group, per session
59400	XU	Routine obstetric care including antepartum care, vaginal delivery (with or without episiotomy, and/or forceps) and postpartum care
59409	XU	Doula support for vaginal delivery only
59510	XU	Standard doula benefit with support at cesarean delivery; Global code: routine obstetric care including antepartum care, C-section delivery, and postpartum
59514	XU	Doula support during Cesarean delivery only. 1 per delivery
59610	XU	Standard doula benefit with support at VBAC delivery; Routine obstetric care including antepartum care, vaginal delivery (with or without episiotomy, and/or forceps) and postpartum care, after previous cesarean delivery Codes Used
59612	XU	Doula support for VBAC delivery only, with or without episiotomy and/or forceps
59618	XU	Routine obstetric care including antepartum care, vaginal delivery (with or without episiotomy, and/or forceps) and postpartum care, after failed attempt at vaginal delivery after cesarean.
59620	XU	Doula support for Cesarean delivery only, following attempted vaginal delivery after previous cesarean delivery

Additional Resources

- Publications and services of the American Congress of Obstetricians and Gynecologists (ACOG)
- American College of Obstetricians and Gynecologists. (2014). “Safe prevention of primary cesarean delivery.”


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