BlueCross BlueShield Association

BlueDistinction® Specialty Care

Program Selection Criteria: 2023 Maternity Care

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Blue Cross Blue Shield Association is an association of independent Blue Cross and Blue Shield companies.

Document Overview

The Program Selection Criteria outlines the Quality, Business, and Cost of Care Selection Criteria and evaluation processes used to determine eligibility for the Blue Distinction® Centers (BDC) for Maternity Care program (this Program).

Sections of this document include:

1. Blue Distinction Centers for Maternity Care
2. Evaluation Process
3. Quality Evaluation
4. Quality Selection Criteria
5. Rationale For Required Selection Criteria
6. Quality Informational Measures
7. Business Selection Criteria
8. Cost of Care Selection Criteria
9. Cost of Care Evaluation
10. Appendix A: Obstetric Hemorrhage Patient Safety Bundle Elements
11. Appendix B: Severe Hypertension Patient Safety Bundle Elements
12. Appendix C: Safe Reduction of Primary Cesarean Births Patient Safety Bundle Elements

Blue Distinction Centers for Maternity Care

The BDC for Maternity Care program (Program) evaluates facilities (acute care hospitals, as well as children's hospitals) that offer maternity services for adult patients 18 years or older. This Program evaluates patient outcomes and additional measures collected in the 2023 Maternity Care Provider Survey. Designation as a BDC for Maternity Care differentiates facilities locally, as well as nationally, and includes two levels of designation:

- **Blue Distinction Centers (BDC):** Facilities recognized for their expertise in delivering specialty care.
- **Blue Distinction Centers+ (BDC+)**: Facilities recognized for their expertise and cost-efficiency in delivering specialty care.

Quality is key*: only those facilities that first meet nationally established quality measures for BDC will be considered for designation as a BDC+.*

Designations are awarded to individual facilities (i.e., unique bricks-and-mortar facilities with unique addresses). Any facility with multiple locations (different addresses) was evaluated separately for each location. Health systems and other groups of multiple facilities/clinics are not designated collectively.

Evaluation Process

Blue Distinction Specialty Care programs establish nationally consistent and continually evolving approaches to evaluating quality and value of care. The evaluation process include:

Quality

A nationally consistent approach to evaluating quality and safety by incorporating quality measures with meaningful impact, including care delivery system features and specific quality outcomes to which all can aspire.

Cost

A nationally consistent and objective approach for selecting BDC+ was used to address market and consumer demand for cost savings and affordable healthcare.

Access

Blue members' access to Blue Distinction Centers was considered to achieve the Program's overall goal of providing differentiated performance on Quality and, for the BDC+ designation, Cost of Care.

Data Sources

Objective data from the Provider Survey, Plan Survey, and National Blue Claims Dataset (Claims Data) information were used to evaluate and identify facilities that meet the Program's Selection Criteria. Table 1 below outlines the data sources used for evaluation of this Program.

Table 1: Data Sources

Selection Criteria Components	Data Source	Blue Distinction Centers (BDC)	Blue Distinction Centers+ (BDC+)
Quality	• Quality data supplied by applicant facility in the Provider Survey • Local Blue Plan Quality Criteria *(if applicable)*	✓	✓
Business	• Data supplied by Blue Plan in the Plan Survey • Review of Blue Brands Criteria • Local Blue Plan Business Criteria *(if applicable)*	✓	✓
Cost of Care	• Blue Health Plan Claims Data • Local Blue Plan Cost Criteria *(if applicable)*		✓

Quality Evaluation

Blue Distinction Specialty Care programs establish a nationally consistent approach to evaluating quality and safety by incorporating quality measures with meaningful impact. Selection Criteria continues to evolve through each evaluation cycle, consistent with medical advances and measurement in this specialty area. The measurement framework for this and other Blue Distinction programs were developed using the following guiding principles:

- Align with credible, transparent, nationally established measures with an emphasis on improved outcomes.
- Implement a nationally consistent evaluation approach.

- Include metrics that close clinical care gaps recognized as affecting longevity and quality of life and/or contributing to higher spend.
- Evolve the selection criteria, consistent with medical advances and objective measures demonstrating improved outcomes. by including elements of behavioral/mental health, virtual care, equity, and social determinants of health (where applicable).
- Apply a fair and equitable evaluation approach that identifies facilities that meaningfully differentiate the delivery of care.

Quality Measure Selection

Facilities were evaluated on quality measures developed through a process that included input from the medical community and quality measurement experts, and review of medical literature. This process also included an analysis of national quality and safety initiatives, and a thorough analysis of meaningful quality measures. Quality Selection Criteria includes general facility structure and process measures, and patient outcome measures specific to maternity care. The evaluation was based on facility responses to the Provider Survey for cases performed during the most recent 12 months prior to submitting the Provider Survey.

The selected measures are joined into the final aggregate scoring model for evaluating facilities. The goal of the program is to create a final aggregate model that provides differentiated performance on quality, while still providing Blue Member access to designated facilities in each of the top 100 MSAs for Maternity Care.

Furthermore, Quality Selection Criteria scoring was based on a 90% lower confidence limit (LCL) of the outcome measures, not on the actual point estimate (or rate) of the quality outcome measures. This benefits each facility by taking potential measurement error into account, based upon statistical confidence predictions. If a facility's LCL is equal to or below the threshold, then that facility's performance is the same or better than that threshold and that facility would meet the quality scoring threshold for that measure; but if a facility's LCL is above the threshold, that indicates that the facility performance is worse than that threshold and that facility will not meet the quality scoring threshold for that measure.

For accuracy, patient outcome measures were evaluated only if the analytic measure volume (measure denominator) reported was greater than or equal to 11. If the reported analytic measure volume was less than 11, then that patient outcome measure was not evaluated due to insufficient data.

Quality Selection Criteria

Quality Selection Criteria are outlined in Tables 2-4, below. Scoring of quality measures is based on both required and flexible measures.

- **Table 2** outlines **required quality measures**. The facility must meet **ALL** required measures.
- **Table 3** outlines **required patient outcome measures**. The facility must meet **ALL** required measures.
- **Table 4** outlines **flexible measures**. The facility must meet a specific number of measures within each of three flexible measure categories:

1) Patient Outcome measures: Must meet **1 of 3** measures.
2) Patient Safety Bundles measures: Must meet **2 of 3** measures, and
3) Structure and Process measures: Must meet **2 of 4** measures.

Required Quality Measures

Table 2: Quality Measures (Required)

<table>
<tr><th colspan="4">Table 2: Quality Selection Criteria: Required Measures
Facility must meet ALL measures</th></tr>
<tr><th>Measure Name</th><th>Data Source</th><th colspan="2">Selection Criteria Description</th></tr>
<tr><td>National Accreditation</td><td>Provider Survey Question #4</td><td colspan="2">The facility is fully accredited by at least one of the following national accreditation organizations:
The Joint Commission (TJC) (without provision or condition) in the Hospital Accreditation Program.
Healthcare Facilities Accreditation Program (HFAP) of the Accreditation Association for Hospital and Health Systems (AAHHS) and is an acute care hospital. www.hfap.org.
National Integrated Accreditation Program (NIAHO[SM])—Acute Care of DNV GL Healthcare.
Center for Improvement in Healthcare Quality (CIHQ) in the Hospital Accreditation Program.</td></tr>
<tr><td>Quality Improvement Program</td><td>Provider Survey Question #19</td><td colspan="2">Facility has an internal quality improvement program to assess maternity care.</td></tr>
<tr><td rowspan="2">Obstetric Hemorrhage</td><td>Provider Survey Question #21</td><td colspan="2">Facility uses a standardized, facility-wide, stage-based obstetric hemorrhage emergency management plan, with checklists and an escalation policy.</td></tr>
<tr><td>Provider Survey Question #22</td><td>Facility has implemented ALL the following elements of the Obstetric Hemorrhage Patient Safety Bundle:
Facility uses an evidence-based risk assessment tool for hemorrhage risk at defined stages of labor (prenatal, on admission, pre-birth, and on transition to postpartum care) for all patients.
Facility measures cumulative quantitative blood loss on all patients.
Facility performs active management of the 3rd stage of labor (department-wide protocol).
Facility completes multidisciplinary reviews for monitoring of outcomes and process metrics (at least) for OBH cases resulting in 4 or more units of blood products and/or SMM Indicator (as defined by CDC) by the facility's perinatal quality improvement (QI) committee.</td><td>OR

Facility has implemented at least 4 of the 6 bundle elements.

(Refer to Appendix A for a list of bundle elements)</td></tr>
</table>

Table 2: Quality Selection Criteria: Required Measures
Facility must meet ALL measures

Measure Name	Data Source	Selection Criteria Description	
Severe Hypertension in Pregnancy	Provider Survey Question #23	Facility uses standardized protocols (with checklists and escalation policies), which include a standardized response to maternal early warning signs, listening and investigating patient-reported and observed symptoms, **and** assessment of standard labs for the management of patients with severe hypertension or related symptoms, as well as obtaining appropriate consultation and maternal transport.	
	Provider Survey Question #24	Facility uses standardized protocols (with checklists and escalation policies) for management and treatment of severe hypertension, eclampsia, seizure prophylaxis, and magnesium overdosage, as well as postpartum presentation of severe hypertension/preeclampsia.	
	Provider Survey Question #25	Facility has implemented **ALL** the following elements of the Severe Hypertension in Pregnancy Patient Safety Bundle: • Facility has rapid access to standardized medications used for severe hypertension/eclampsia. • Facility ensures accurate measurement and assessment of blood pressure and initiates treatment with antihypertensive. medication(s) that are recommended to be administered ASAP (preferably within 60 minutes of verification). • Provides educational information, which includes specific to warning signs/ symptoms of severe hypertension/ preeclampsia.	**OR** Facility has implemented **4 or more of the 6** bundle elements. *(Refer to Appendix B for a list of bundle elements)*
Safe Reduction of Primary Cesarean Birth	Provider Survey Question #26	Facility has implemented **ALL** the following elements of the Safe Reduction of Primary Cesarean Birth Patient Safety Bundle: • Facility uses standardized methods in the assessment of the fetal heart rate status, including interpretation and documentation based on National Institute of Child Health and Human Development (NICHD) terminology, and encourages methods that promote freedom of movement. • Facility upholds standardized induction scheduling, to ensure proper selection and preparation of women undergoing induction of labor. • Facility utilizes standardized evidence-based labor algorithms, policies, and techniques, which allow for prompt recognition and treatment of labor dystocia. • Facility adopts policies that outline standardized management of Category II fetal heart rate patterns and uterine tachysystole.	**OR** Facility has implemented **5 or more of the 8** bundle elements. *(Refer to Appendix C for a list of bundle elements)*

Table 2: Quality Selection Criteria: Required Measures Facility must meet ALL measures		
Measure Name	**Data Source**	**Selection Criteria Description**
Demographic Data Collected	Provider Survey Question #34	Facility **collects** the demographic data of race, ethnicity and spoken language (REL) data preferred for healthcare during patient registration or during a hospital visit.
System for Documenting REL Data	Provider Survey Question #35	Facility has an established system to document obtain **self-reported** race, ethnicity, and primary language (REL) data directly from patients.
Drills for Serious Adverse Maternal Events	Provider Survey Question #43	Facility holds drills or simulations for adverse maternal events.
Frequency of Drills for Severe Adverse Maternal Events	Provider Survey Question #44	Facility holds drills or simulations AT LEAST **every 12 months, or more frequently.**
PQC Involvement	Provider Survey Question #47	Facility engages with its state Perinatal Quality Collaborative.
Prevention of Deep Vein Thrombosis (DVT)	Provider Survey Question #51	Facility routinely uses sequential compression devices (SCDs) for deep vein thrombosis (DVT) prevention on patients at high risk for DVT.
Doulas	Provider Survey Questions #53 and #54	Facility employs doulas and/or is supportive of participation by doulas in labor support.
Local Blue Plan Quality Criteria (if applicable)	Plan Survey	An individual Blue Plan, at its own independent discretion, may establish and apply local quality requirements as additional Selection Criteria for eligibility in a Blue Distinction Centers Program, for facilities located within its Service Area.

Patient Outcome Measures (Required)

Facilities also must meet patient outcome measures for Maternity Care procedures, as reported in the Provider Survey. Patient outcome measure evaluation requirements are outlined below in Table 3. For accuracy, a facility must present sufficient data to meet the minimum analytic measure volume (measure's denominator):

1) If the analytic measure volume is **greater than or equal to 11**, then then the patient outcome measure has 'Sufficient Data' for evaluation and the patient outcome measure will be evaluated.
2) If the analytic measure volume is **less than 11,** then the patient outcome measure has 'Insufficient Data' for evaluation, will not be evaluated, and the facility will not meet that measure.

Table 3. Patient Outcome Measures (Required)

Quality Selection Criteria: Patient Outcome Measures (Required) Facility must meet ALL measures		
Measure Name	**Data Source**	**Selection Criteria Description**
Analytic Measure Volume	Provider Survey Questions #12, #13 and #16	Facility's analytic measure volume is **greater than or equal to 11** for the following measures: • PC-01 Elective Delivery Denominator • PC-02 Cesarean Section Denominator • Episiotomy Denominator (Measure is evaluated in the Patient Outcome Measures Flexible criteria, outlined below in Table 4)
PC-01 **Elective Delivery**	Provider Survey Question #12	Rate of patients delivering newborns with >=37 and <39 weeks gestation completed lower confidence level (LCL) **must be less than or equal to 4.00%.**
PC-02 **Cesarean Section**	Provider Survey Question #13	Rate of Nulliparous Patients who delivered a live term singleton newborn in vertex presentation via cesarean section lower confidence level (LCL) **must be less than or equal to 24.00%**

Flexible Measures – Structure/ Process and Patient Outcome Measures

Required flexible measures are grouped into 3 categories, shown in Table 4:

- **Patient Outcomes Measures** Facility must meet **1 of 3** measures
- **Patient Safety Bundles Measures** Facility must meet **2 of 3** measures
- **Structure and Process Measures** Facility must meet **2 of 4** measures

Table 4: Flexible Measures

Quality Selection Criteria: Flexible Measures		
Measure Name	**Data Source**	**Selection Criteria Description**
Patient Outcome Measures Flexible Category: Must Meet 1 out of 3 Measures		
Episiotomy Rate	Provider Survey Question #16	Percent of women who received an episiotomy during a vaginal birth lower confidence limit (LCL) must **be less than or equal to 5.00%** Measure denominator must be at least 11 procedures for the measure to be evaluated, explained above in Table 2.
PSI 18 (Obstetrical Trauma with Instrument)	Provider Survey Question #17	Hospital discharges with third- and fourth-degree obstetric traumas with instrument-assisted vaginal deliveries lower confidence level (LCL) must be **less than or equal to 11.72% (AHRQ**).
PSI 19 (Obstetrical Trauma without Instrument)	Provider Survey Question #18	Hospital discharges with third- and fourth-degree obstetric traumas without instrument-assisted vaginal deliveries lower confidence level (LCL) must be **less than or equal to 1.75% (AHRQ).**
Patient Safety Bundles Measures Flexible Category: Must Meet 2 out of 3 Measures		
Care for Pregnant and Postpartum People with Substance Use Disorder	Provider Survey Question #27	Facility assesses all pregnant women for substance use disorders (SUDs), using validated screening tool(s) to identify drug and alcohol use; and incorporates a screening, brief intervention, and referral to treatment (SBIRT) approach, in the maternity care setting.

Quality Selection Criteria: Flexible Measures		
Measure Name	**Data Source**	**Selection Criteria Description**
Postpartum Discharge Transition	Provider Survey Question #29C	Facility screens all patients for Post-Partum Depression prior to discharge (using the Edinburgh Postnatal Depression Screen or another standardized tool) and establishes a system of support and follow-up within 30 days for those who screen positive.
Sepsis in Obstetrical Care	Provider Survey Question #30	Facility uses standardized protocols with checklists and escalation policies (including a standard response to maternal early warning signs, listening, investigating patient-reported and observed symptoms, and assessment of standard labs for the management of patients with symptoms of sepsis) and obtain critical care consult and transfers patients when necessary.
Structure and Process Measures Flexible Category: Must Meet 2 out of 4 Measures		
Frequency of Data Sharing	Provider Survey Question #20	Facility shares personal rates of maternal quality measures with OB providers **at least** annually.
Unconscious Bias Training	Provider Survey Question #42	Facility has implemented trauma-informed protocols and anti-racist training (unconscious bias/ respectful and equitable care) to address healthcare team member biases and stigmas.
Physicians at Drills/ Simulations	Provider Survey Question #45	Facility requires physicians (both privileged and hospital-based) who provide obstetric care at your facility to participate in serious maternal adverse event drills and/or simulations.
Ongoing Education and Training	Provider Survey Question #46	Facility requires ongoing (at least every 2 years) physician and nursing education/ training of fetal heart rate monitoring, obstetric hemorrhage management and severe hypertension in pregnancy management.

Rationale for Required Selection Criteria

The selection criteria chosen for the 2023 BDC Maternity Care Program places a renewed focus on the need for improved maternity services, in alignment with the BCBS National Health Equity Strategy and the goal of reducing racial disparities in maternal health by 50% in 5 years. Nationwide efforts have been put into place to address the maternal health crisis in the United States. Severe maternal morbidity, which includes unexpected complications in labor and delivery that result in significant short-term or long-term consequences to a women's[1] health, has been increasing and affects thousands of women in the United States each year. The selection criteria for the Maternity Care Program aligns with actionable approaches recommended by organizations such as the Department of Health and Human Services (HHS), American College of Obstetricians and Gynecologists (ACOG), Alliance for Innovation on Maternal Health (AIM), and the California Maternal Quality Care Collaborative (CMQCC), to enhance outcomes and reduce adverse events in maternal health care. The following categories offer background information and suggestions for improvement on each of the required selection criteria, where applicable.

[1] Throughout this document, the terms "mother,"" maternal,"" she" or "her" refer to a person who is pregnant, has given birth or is in the postpartum stage of pregnancy. We recognize that not all people who have been pregnant or given birth identify with these terms, and that all people deserve to receive safe, equitable healthcare.

Quality Improvement Program

Having a robust quality improvement (QI) program is instrumental to making positive changes at the facility and must be an organizational priority. Administrative support, staff involvement, and a multidisciplinary team are the backbone of effective quality improvement programs. Facility and provider engagement should include data collection, analysis, and data sharing to identify issues; focus on improvements when things go wrong; incorporate evidence-based practices and standardized protocols to close gaps in care for all mothers; and have a commitment to high reliability performance for ongoing quality improvement.[2]

Patient Safety Bundles

Patient safety bundles have been developed by maternal health experts, to provide guidance on the implementation and quality improvement efforts related to PREVENTABLE obstetric conditions that have a direct correlation to severe maternal morbidity and mortality. AIM Patient Safety Bundles are based on five (5) major components: Readiness; Recognition and Prevention; Response; Reporting and Systems Learning; and Respectful, Equitable, and Supportive Care. Following these evidence-based actions, with defined rationales, allows facilities to be prepared for adverse maternal complications and to improve maternal outcomes. Similarly, CMQCC has developed toolkits for several obstetric emergencies and disorders, which outline research and evidence-based practices that facilities can use to improve outcomes. Standardization of protocols and checklists, using evidence-based practices, are vital in reducing patient harm, thanks to consistency and reliability of a process that will apply to most patients.[3,4] Both AIM and CMQCC also provide suggestions and guidance for quality improvement projects specific to each topic.

Recently, AIM Patient Safety Bundles and CMQCC toolkits have begun to include actionable steps that facilities can take to provide more equitable maternal healthcare, as well as to address maternal mental health with the incorporation of trauma informed care. Traumatic birth experiences can come from any unexpected outcome – ranging from an unintended cesarean birth to obstetric complications, such as obstetric hemorrhage leading to hysterectomy. As self-harm resulting from mental health conditions has been determined to be one of the top causes of maternal mortality[5], maternity care providers should be educated on how to identify trauma and implement strategies to reduce the risk of re-traumatization, while providing care that offers patients a sense of safety[6]. AIM also released a new maternal mental health tool kit recently, which facilities should review and implement to prevent potential gaps in care, Perinatal Mental Health Conditions | AIM (saferbirth.org).

Although not part of the required selection criteria for the 2023 BDC Maternity Care Program, AIM Cardiac Conditions in Pregnancy Bundle may become required in future Maternity Care evaluation cycles. Facilities should take time to review the bundle and initiate implementation of a Cardiac Conditions screen and a **standardized protocol for managing maternal** cardiac conditions when they are identified. CMQCC has developed an algorithm

[2] BCBS National Health Equity Strategy: Maternal Health Compendium and Workbook, Blue Cross Blue Shield Association, April 2021

[3] Clinical guidelines and standardization of practice to improve outcomes. ACOG Committee Opinion No. 792. American College of Obstetricians and Gynecologists. Obstet Gynecol 2019;134: e122–5.

[4] The use and development of checklists in obstetrics and gynecology. Committee Opinion No. 680. American College of Obstetricians and Gynecologists. Obstet Gynecol 2016;128: e237–40

[5] Pregnancy-Related Deaths: Data from Maternal Mortality Review Committees in 36 US States, 2017–2019 | CDC

[6] Caring for patients who have experienced trauma. ACOG Committee Opinion No. 825. American College of Obstetricians and Gynecologists. Obstet Gynecol 2021;137: e94–9

for cardiovascular disease assessment in pregnant and postpartum women with recommendations for interventions and referrals, when necessary.[7]

Each of the required Patient Safety Bundles For Safer Birth | AIM are outlined below, with actionable items highlighted that facilities should consider implementing on a priority basis, if they are not in place already.

Obstetric Hemorrhage

In the event of obstetric hemorrhage, early recognition is essential to successfully manage the hemorrhage. This starts with using an evidence-based risk assessment tool upon admission to labor and delivery and upon admission to postpartum, at minimum. Quantifying blood loss is a simple process facilities can have in place to measure a mother's blood loss, before, during, and for up to 24 hours after birth, or when clinically indicated. Pregnancy doubles a woman's blood volume, allowing her to lose almost 1 liter of blood before she starts to show clinical signs and symptoms of hypovolemia. If obstetric hemorrhage is not recognized before that point, it is even more difficult to manage. Utilizing standardized protocols and emergency checklists with the actio n items identified in the Obstetric Hemorrhage patient safety bundle and toolkit will allow for effective management of the hemorrhage. A facility should consider reviewing any case of hemorrhage in which the patient receives 4 or more liters of blood products as part of their Quality Improvement program to determine opportunities for improvement and celebrate the successes noted.[8,9,10]

Severe Hypertension in Pregnancy

To recognize severe hypertension in pregnancy, facilities must first ensure that maternal care providers understand how to measure blood pressure correctly, being sure to consider the patient's physical position, recent drug or medication use, and psychosocial status. Not identifying these factors (or identifying them incorrectly) can lead inaccurate blood pressure assessment. Using standardized protocols and checklists with the action items in the Severe Hypertension in Pregnancy patient safety bundle and toolkit, the facility should treat any sustained blood pressure (≥160/≥110) quickly, regardless of the perceived reason for the severe range blood pressure. Timely treatment from the second severe range blood pressure to the administration of antihypertensive medication is data that would be beneficial for a facility to collect and then use to develop an appropriate performance improvement plan for, if necessary.[11,12, 13]

[7] Afshan B. Hameed, Christine H. Morton, and Allana Moore. Improving Health Care Response to Cardiovascular Disease in Pregnancy and Postpartum Developed under contract #11-10006 with the California Department of Public Health, Maternal, Child and Adolescent Health Division. Published by the California Department of Public Health, 2017, Cardiac Conditions in Obstetric Care | AIM (saferbirth.org)

[8] Lagrew D, McNulty J, Sakowski C, Cape V, McCormick E, Morton CH. Improving Health Care Response to Obstetric Hemorrhage, a California Maternal Quality Care Collaborative Toolkit, 2022

[9] Quantitative blood loss in obstetric hemorrhage. ACOG Committee Opinion No. 794. American College of Obstetricians and Gynecologists. Obstet Gynecol 2019;134: e150–6

[10] Obstetric Hemorrhage | AIM (saferbirth.org)

[11] Druzin M, Shields L, Peterson N, Sakowski C, Cape V, Morton C. Improving Health Care Response to Hypertensive Disorders of Pregnancy, a California Maternal Quality Care Collaborative Quality Improvement Toolkit, 2021

[12] Severe Hypertension | ACOG

[13] Severe Hypertension in Pregnancy | AIM (saferbirth.org)

Safe Reduction of Primary Cesarean Birth

Cesarean birth is necessary at times, for the mother and/or baby's safety. Unfortunately, cesarean births also occur frequently when they are not necessary, needlessly increasing a woman's risk of complications (such as hemorrhage and infection) and putting her at risk for complications (such as uterine abruption and placenta accreta spectrum in future pregnancies). Standardized induction protocols and labor admission processes/rules should be in place to decrease mothers' need for medical intervention to progress labor. As ACOG recommends, supporting natural labor progress, with actions such as intermittent fetal heart rate monitoring, ambulation, and frequent position changes, can improve a mother's chance at a successful vaginal birth.[14] When slow labor progress or fetal intolerance to labor is a concern, utilizing evidence-based algorithms from CMQCC can guide maternal care providers to accurately diagnose labor dystocia and manage category II fetal heart rate tracings.

Although not a requirement of the 2023 BDC Maternity Care Program, it is of interest to consider employment models for certain maternity care providers and their effect on maternal outcomes. Research has shown that facilities whose care model includes Obstetric Hospitalists, Certified Nurse Midwives and/or doulas have better outcomes, including lower cesarean birth rates, than those who use traditional employment models. These care models offer an alternative to on-call requirements, which may surpass 24 hours at a time, leading to exhaustion and a greater risk of medical error.[15] Utilizing obstetric hospitalists, CNMs, and/or doulas allows patients to receive care from provider(s) who are more available and can offer greater labor support and patience than one who needs to multitask office responsibilities, operative cases, and other laboring patients.

Facilities should review cases regularly for primary cesarean births and the causes attributed to them, comparing the care documented to evidence based practices outlined by AIM and CMQCC, while looking for trends and opportunities that may need to be addressed. Cesarean birth rates should be shared with the facility's providers to create awareness of the need for cesarean reduction and the leading contributors for potentially avoidable cesarean births.[16,17,18]

Care for Pregnant and Postpartum People with Substance Use Disorder Abuse

Screening every pregnant patient for substance abuse is the first step a facility can take to addressing substance use disorder (SUD). Screening (with a validated verbal assessment tool), then providing Brief Intervention and a Referral to Treatment (together, SBIRT) is an evidence-based tool that facilities can implement to identify patients with SUD and then provide the resources and interventions necessary to improve outcomes for both mother and infant. Management of SUD in pregnancy and postpartum can be challenging and requires collaboration with a multidisciplinary team of SUD specialists to care for the mother properly and to keep her safe, both during

[14] Approaches to limit intervention during labor and birth. ACOG Committee Opinion No. 766. American College of Obstetricians and Gynecologists. Obstet Gynecol 2019;133: e164–73

[15] The obstetric and gynecologic hospitalist. Committee Opinion No. 657. American College of Obstetricians and Gynecologists. Obstet Gynecol 2016;127: e81–5.

[16] Smith H, Peterson N, Lagrew D, Main E. 2016. Toolkit to Support Vaginal Birth and Reduce Primary Cesareans: A Quality Improvement Toolkit. Stanford, CA: California Maternal Quality Care Collaborative

[17] Safe prevention of the primary cesarean delivery. Obstetric Care Consensus No. 1. American College of Obstetricians and Gynecologists. Obstet Gynecol 2014; 123:693–711.

[18] Safe Reduction of Primary Cesarean Birth | AIM (saferbirth.org)

hospitalization and after discharge. Quality improvement topics may include ensuring that screening is completed on all mothers, with follow through using evidence-based guidelines when a positive screen is identified.[19,20,21]

Postpartum Discharge Transition

Discharge home after childbirth can be incredibly challenging for many families. Signs and symptoms of obstetric complications can often be dismissed while caring for a new human and coping with fatigue and postpartum mood changes. Facilities should develop guidelines for discharge teaching, with criteria for discharge to home and coordinated care for follow up visits. Screening for comorbidities and social determinant of health concerns, such as food insecurity and unstable housing, will allow maternity care providers to identify concerns and coordinate appropriate follow up care and resources for the patient. Discharge teaching of post birth warning signs for the most common obstetric complications, using tools such as a those developed by the Association of Women's Health, Obstetric and Neonatal Nurses (AWHONN)[22], should be available in multiple languages and written with health literacy in mind. Health education is essential in empowering mothers to speak up for themselves when they feel something is not right and these tools can have a direct impact on maternal mortality and morbidity in the postpartum period. Quality improvement plans might include assessing readmission rates for mothers who present to the Emergency Department and are readmitted to the facility within 30 days of discharge, to provide insight into trends of postpartum complications at your facility and to put a plan in place to reduce readmissions.[23,24,25]

Sepsis in Obstetrical Care

Facilities should have a maternity specific sepsis protocol in place. Maternity care providers must have a clear understanding of the difference in clinical features of sepsis between the pregnant and non-pregnant patient. Using evidence-based guidelines provided by organizations such as AIM and CMQCC will direct maternity care providers how to identify sepsis properly, based on laboratory values and risk factors specific to the pregnant or postpartum patient, and how to manage the patient's care if sepsis is diagnosed. CMQCC's toolkit offers algorithms that clinicians can use in their management of sepsis. Prompt recognition and initiation of treatment is necessary for improving outcomes. Any case of confirmed sepsis also should be reviewed by the facility to determine opportunities for improvement and to reduce the incidence of sepsis in the future.[26]

Demographic Data Collection

Collecting self-reported demographic data (race, ethnicity, spoken language) is the first step facilities can take to reduce racial disparities in healthcare. Facilities can use the data collected to stratify quality measures and make changes to policies, procedures, patient safety goals and quality improvement goals to address equity. An

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[19] Opioid use and opioid use disorder in pregnancy. Committee Opinion No. 711. American College of Obstetricians and Gynecologists. Obstet Gynecol 2017; 130: e81–94

[20] Crew E, Chowfla A, DuPlessis H, Lee H, Main E, McCormick E, Oldini C, Smith H, Robinson R, Waller C, Wong J. Mother and Baby Substance Exposure Toolkit. Stanford, CA: California Maternal Quality Care Collaborative and California Perinatal Quality Care Collaborative. 2020. Accessed from https://nastoolkit.org/.

[21] Care for Pregnant and Postpartum People with Substance Use Disorder | AIM (saferbirth.org)

[22] POST-BIRTH Warning Signs Education Program – AWHONN

[23] Optimizing postpartum care. ACOG Committee Opinion No. 736. American College of Obstetricians and Gynecologists. Obstet Gynecol 2018; 131: e140–50

[24] Stuebe, Alison M. MD, MSc; Kendig, Susan JD, WHNP-BC; Suplee, Patricia D. PhD, RNC-OB; D'Oria, Robyn MA, RNC. Consensus Bundle on Postpartum Care Basics: From Birth to the Comprehensive Postpartum Visit. Obstetrics & Gynecology 137(1): p 33-40, January 2021. | DOI: 10.1097/AOG.0000000000004206

[25] Importance of social determinants of health and cultural awareness in the delivery of reproductive health care. ACOG Committee Opinion No. 729. American College of Obstetricians and Gynecologists. Obstet Gynecol 2018; 131: e43–8

[26] Gibbs R, Bauer M, Olvera L, Sakowski C, Cape V, Main E. Improving Diagnosis and Treatment of Maternal Sepsis: A Quality Improvement Toolkit. Stanford, CA: California Maternal Quality Care Collaborative

intervention as simple as communicating in a patient's preferred language can increase trust, satisfaction and improve outcomes.[27]

Drills and Simulations for Adverse Maternal Events

Obstetric emergencies happen, and periodic drills and simulations improve the facility's response and outcomes when they do. Drills and simulations should follow established protocols and standardized interventions, using a strategy that emphasizes effective communication, such as TeamSTEPPS, and include a multidisciplinary team, requiring physicians, nurses, nursing assistants, and other care providers from all potentially involved departments (anesthesiology, blood bank, pharmacy etc.) to attend. Resources for drills and simulations can be found with the AIM Patient Safety Bundles and the CMQCC toolkits. Readiness is a core principle of patient safety bundles and preparing for obstetrical emergencies allows faster and improved response along, with improved patient outcomes by team members' knowledge of designated roles, access to emergency supplies, effective communication, and ongoing education and training.[28]

Perinatal Quality Collaborative Involvement

Perinatal Quality Collaboratives (PQC) consist of maternal and neonatal health experts that develop initiatives aimed at improving the quality of care for mothers and babies. PQCs assist facilities in implementing performance improvement plans consisting of evidence-based practices and data collection targeted at an identified gap in maternity care practices. Involvement with the applicable state's PQC provides each facility with not only the resources and expertise to be successful in improving outcomes, but also a community of support and encouragement to maintain a path to continuous improvement.[29]

Doulas

While hospital employed doulas may not be feasible everywhere, supporting their involvement during labor and delivery is. Doulas do not have formal obstetric training; they are trained, however, to provide emotional, physical, informational and resource support through pregnancy and into the postpartum period. Collaboration between all maternity care providers and doulas within a facility not only enhances the patient experience, but also has been shown to reduce cesarean birth rates and to lower incidences of maternal complications – which is why ACOG reports that continuous labor support by a doula is "one of the most effective tools to improve labor and delivery outcomes."[30] Doulas also reduce racial disparities in maternal care, by serving as patient advocates for minority groups – especially in the hospital setting, where mistrust of maternity care providers can exist. Doulas empower patients to make the best personal decision for themselves and their babies by helping them to understand and interpret what is happening to them in the hospital environment. Facilities are encouraged to assess their relationships with doulas and determine an action plan to incorporate doulas as valuable members of their maternity care team.[31]

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[27] Makoul G, Donohue R, England W, Gorley T. 2023 Experience Perspective. NRC Health. https://nrchealth.com/resources (Accessed 05/31/2023)

[28] Preparing for clinical emergencies in obstetrics and gynecology. Committee Opinion No. 590. American College of Obstetricians and Gynecologists. Obstet Gynecol 2014; 123:722–5

[29] Perinatal Quality Collaboratives | Perinatal | Reproductive Health | CDC

[30] Safe prevention of the primary cesarean delivery. Obstetric Care Consensus No. 1. American College of Obstetricians and Gynecologists. Obstet Gynecol 2014; 123:693–711

[31] Smith H, Peterson N, Lagrew D, Main E. 2016. Toolkit to Support Vaginal Birth and Reduce Primary Cesareans: A Quality Improvement Toolkit. Stanford, CA: California Maternal Quality Care Collaborative. pp 102-105

Unconscious Bias Training

Unconscious bias refers to attitudes and stereotypes held towards others that affect our understanding, actions, and decisions in an unconscious manner.[32] Reducing racial disparities is another way that facilities can improve maternal health outcomes. Research has proven that Black and Hispanic women experience higher rates of childbirth complications, regardless of age or geographic location.[33] Unconscious bias and lack of cultural humility and awareness can lead to unintended, but unequal treatment of patients from racial and ethnic minorities or from marginalized social groups.[34] Unconscious bias training helps maternity care providers to recognize their own biases and to understand how and why to deliver safe, equitable care to all patients. Standardization of protocols and processes also ensures that the same care is provided to every patient, every time.

Regardless of their designation eligibility status, all applicant facilities should use the 2023 Maternity Care Provider Survey results as a guide to improve care and to identify gaps in their Maternity Programs for which performance improvement plans may be necessary. The structure and process measures highlighted in the survey have all been correlated to improvements in maternal health outcomes and racial disparities. In the future, these elements and more will be required for designation. Our Program recommends that facilities look closely at their own maternity programs and develop a strategy for addressing the opportunities for improvement that they identify. As a next step, BCBSA will begin working closely with Blue Plans, as they encourage facilities to implement performance improvement activities that will enhance their maternity care programs and patient outcomes.

Quality Informational Measures

The informational measures outlined in Table 5 were included in the Provider Survey. These measures were not scored but used as an educational tool for quality improvement. These informational measures may become required Quality selection criteria, in future Program evaluation cycles.

Table 5: Informational Measures

Informational Measures Not Scored		
Measure Name	**Source**	**Selection Criteria Description**
The Joint Commission's (TJC) Perinatal Care Certification or Advanced Perinatal Care Certification	Provider Survey Question #5	Facility has either attained, not attained, is in process of attaining or is not in the process of attaining, TJC Perinatal Care Certification or Advanced Perinatal Care Certification.
Centers for Medicare and Medicaid Services' Birthing-Friendly Hospital Designation	Provider Survey Question #6	Facility participates in a structured state or national Perinatal Quality Improvement (QI) Collaborative and/or has implemented patient safety practices or bundles as part of these CMS Birthing Friendly Designation QI initiatives.
TJC/ American College of Obstetricians and Gynecologists (ACOG)	Provider Survey Question #7	Facility has attained, is in process of attaining, or is not in the process of attaining, a TJC/ACOG Levels of Care verification between I and IV.

[32] Quick Safety Issue 23: Implicit bias in health care, the Joint Commission.
[33] Racial Disparities in Maternal Health, Blue Cross Blue Shield Association Health of America Report, May 2021.
[34] Implicit bias in health care professionals: a systematic review, Chloë FitzGerald, Samia Hurst, BMC Med Ethics. 2017.

Informational Measures Not Scored		
Measure Name	**Source**	**Selection Criteria Description**
Levels of Care Verification Program		
Centers for Disease Control and Prevention's Levels of Care Assessment Tool (CDC LOCATe℠)	Provider Survey Question #8	Facility has attained, has not attained, or is not in the process of attaining a CDC LOCATe℠) Level of Care determination between Level I and Level IV.
PC-02 Cesarean Section for the past 24 months	Provider Survey Question #14	Facility reports PC-02 Cesarean Delivery rates for the most recent 24 months, if available.
PC-07 Severe Obstetric Complications	Provider Survey Question #15	Facility reports PC-07 Severe Obstetric Complications rate, if available.
Cardiac Conditions in Obstetric Care	Provider Survey Question #32 and #33	Facility has implemented a standard protocol (with checklists and escalation policies) for management of cardiac symptoms and conditions, which includes multidisciplinary consultation and maternal transport when necessary and has trained obstetric care providers to perform a basic Cardiac Conditions Screen.
Patient Perception of Care	Provider Survey Question #41	Facility collects information regarding patient perception of care (including, but not limited to the patient's perception of receiving unbiased, respectful healthcare).
Postpartum Contraception	Provider Survey Question #48	Facility provides postpartum women with access to placement of Long-Acting Reversible Contraceptives (LARCs) with-in 3 days of birth.
Post-Birth Warning Signs	Provider Survey Question #49	Facility has implemented the Association of Women's Health, Obstetric and Neonatal Nurses (AWHONN's) Post-Birth Warning Signs for patient discharge education.
Enhanced Recovery after Cesarean Surgery	Provider Survey Question #50	Facility has implemented Enhanced Recovery After Surgery (ERAS) protocols for cesarean birth patients.
Navigator/ Support Program	Provider Survey Question #52	Facility offers an Obstetric Nurse Navigator program (or similar program), which facilitates the mother's access to pregnancy education, self-care, and support systems (such as doulas).
Birthing Center	Provider Survey Question #55	Facility is affiliated with a birthing center, either attached to or detached from the facility.
Obstetric Hospitalists/ Laborists	Provider Survey Question #56	Facility employs obstetric hospitalists/ laborists.

Business Selection Criteria

The Business Selection Criteria consists of the following components:

- Facility Performs Services
- Facility Preferred Provider Organization (PPO) Participation;
- Blue Brands Criteria; and
- Local Blue Plan Business Criteria (if applicable)

A facility must meet **ALL** components listed below in Table 6 to meet the Business Selection Criteria for the Blue Distinction Centers for Maternity Care designation.

Table 6. Business Selection Criteria

Business Selection Criteria	
Facility Performs Services	Facility must perform maternity care services.
Facility PPO Participation	Facility must participate in the local Blue Plan's BlueCard® Preferred Provider Organization (PPO) network.
Blue Brands Criteria	Facility and its corporate family meet BCBSA criteria for avoiding conflicts with BCBSA logos and trademarks.
Local Blue Plan Business Criteria (if applicable)	An individual Blue Plan, at its own independent discretion, may establish and apply local business requirements as additional Selection Criteria for eligibility in a Blue Distinction Centers program, for providers located within its Service Area.

Note: Physician participation in the local Blue Plan's PPO Network is not part of the Selection Criteria and evaluation for the Program at this time but **will become a requirement in the next evaluation cycle**. Blue Cross Blue Shield and Local Blue Plans believe that all patients should be protected from surprise medical bills. We are strongly committed to working with policy makers, hospitals, and physicians on solutions to better protect consumers while preventing unintended costs and disruptions to the healthcare system.

Cost of Care Selection Criteria

In addition to meeting the Program's nationally established, objective Quality and Business Selection Criteria for BDC, facilities must meet **ALL** requirements of the following Cost of Care Selection Criteria in Table 7 to be considered eligible for the BDC+ designation.

Table 7. Cost of Care Selection Criteria

Cost of Care Selection Criteria Facility must meet ALL measures to be designated as BDC+	
Measure Name	**Selection Criteria Description**
Episode Volume	The facility has **greater than or equal to 5** matched episodes of cost data in both clinical categories: • Vaginal Delivery • Cesarean Delivery
Composite Cost Index	Composite Cost Index must be **less than or equal to** the established **threshold of 1.00**.

Cost of Care Selection Criteria Facility must meet ALL measures to be designated as BDC+	
Measure Name	**Selection Criteria Description**
Local Blue Plan Cost Criteria (If Applicable)	An individual Blue Plan, at its own independent discretion, may establish and apply local cost requirements as additional Selection Criteria for eligibility in a Blue Distinction Centers program, for facilities located within its Service Area.

Quality is key: Only those facilities that first meet nationally established quality and business measures for Blue Distinction Centers will be considered for designation as a Blue Distinction Center+.

Cost of Care Evaluation

Cost of care measures were designed to address market and consumer demand for cost savings and affordable healthcare. The Cost of Care Selection Criteria were used to provide a consistent and objective approach to identify BDC+ facilities. The inputs and methodology used in the cost of care evaluation are explained below.

Cost of Care Methodology Framework

The cost of care evaluation uses a consistent framework to define and adjust episodes, and to establish and compare the resulting cost measures.

Figure 1. Cost of Care Methodology Framework Illustration

Defining the Episodes

Cost of care evaluation was based on a nationally consistent analysis of Claims Data. To provide validity for comparisons, cost analytics for the BDC Maternity Care program focus on vaginal and cesarean deliveries.

Cost Data Sources

Each facility's cost of care is calculated using adjusted allowed amounts for specific maternity care episodes of care for actively enrolled Blue Members, derived from Blue Plans' PPO Claims data from National Data Warehouse from January 1, 2019, through August 31, 2022, paid through November 30, 2022, with episodes of care occurring between June 1, 2020, through May 31, 2022.

Clinical Category Identification Criteria

To provide validity for comparisons, cost analytics for the BDC Maternity Care program focus on vaginal and cesarean births. This section explains how Maternity Care episodes are characterized and identifies the subset of episodes included in the comparison analysis.

Maternity episodes are triggered by inpatient deliveries – either vaginal or cesarean, using the Blue Claims data. and by MS-DRGs (DRGs are assigned by Blue Health Intelligence® (BHI) to ensure consistency of approach) and are listed in Table 8.

Table 8. Maternity Care MS-DRG Trigger Codes

Trigger Category	Code Type	Code	Code Description
Vaginal Deliveries	MS-DRG	805	Vaginal Delivery without Sterilization and/or D&C with MCC
	MS-DRG	806	Vaginal Delivery without Sterilization and/or D&C with CC
	MS-DRG	807	Vaginal Delivery without Sterilization and/or D&C
Cesarean Deliveries	MS-DRG	786	Cesarean Section without Sterilization with MCC
	MS-DRG	787	Cesarean Section without Sterilization with CC
	MS-DRG	788	Cesarean Section without Sterilization

CC – Complications or Comorbidities
MCC – Major Complications or Comorbidities

Costs associated with long-acting contraceptive (LAC) and sterilization procedures (IUD, Implant, and Tubal Ligation) were flagged and excluded, using episode inclusion/exclusion criteria. This evaluation cycle used updated DRGs, which provided more specificity and meaningfully reduced the number of episodes flagged for exclusion. The majority of LAC and sterilization procedures were already removed from the beginning of the analysis because they were tied to sterilization-specific delivery DRGs (*i.e.,* 796, 797, 798, 783, 784, 785), which were excluded from the final trigger code list.

Member Exclusion Criteria

- Exclude age <18 or >64 years.
- Exclude discharge status Left Against Medical Advice (LAMA) or discontinued care.
- Exclude expired or expired in a medical facility
- Exclude when primary payer is not a Blue Plan

- Exclude members not continuously enrolled for the duration of the episode
- Exclude multiple birth (e.g., twins)
- Exclude gender equal to male or unknown
- Exclude if episode did not include both professional and facility claim.
- Exclude if episodes included claims for long-acting contraceptive (LAC) and/or sterilization procedures.

Clinical category costs are adjusted for the impact of significant patient co-morbidities, via risk adjustment methods. No other clinical exclusions are applied.

Episode Duration

Each delivery episode type has time windows before and after the episode trigger event (in-patient hospitalization for delivery) within which relevant services may be included. The trigger start date is the First Service Date from the facility header claim identified as the trigger claim. The episode window for maternity begins 280 days prior to date of admission of the index admission and ends 90 days following discharge from the index admission. Episodes are included in the analysis only if the member is continuously eligible for relevant (primarily PPO) BCBS benefits throughout the episode duration

Cost Components Included in Episode

After an episode was “triggered,” services must be linked to the episode in a comprehensive and consistent manner to ensure completeness and comparability of costs. Services and related costs were included if they were logically related to the episode – either vaginal delivery or cesarean delivery.

Table 9 below provides more detailed examples of professional services billed using the following routine obstetric services codes during the episode duration:

Table 9: Professional Services Billed for Routine Obstetric Service Codes

CPT	OB Maternity Service
59425	Antepartum care only; 4-6 visits
59426	Antepartum care only; 7 or more visits
59400	Routine OB care including antepartum, vaginal delivery, postpartum
59409	Vaginal delivery only
59410	Vaginal delivery only including postpartum care
59412	External cephalic version, with or without tocolysis; antepartum manipulation
59414	Delivery of placenta (separate procedure)
59510	Routine OB care including antepartum, cesarean, and postpartum
59514	Cesarean delivery only
59515	Cesarean delivery only; including postpartum care
59610	Routine obstetric care including antepartum, vaginal delivery and postpartum care, after previous cesarean
59612	Vaginal delivery only, after previous cesarean delivery (with or without episiotomy and/or forceps)
59614	Vaginal delivery only, after previous cesarean delivery; including postpartum care
59618	Routine obstetric care including antepartum care, cesarean delivery, and postpartum care, following attempted vaginal delivery after previous cesarean delivery

CPT	OB Maternity Service
59620	Cesarean delivery only, following attempted vaginal delivery after previous cesarean delivery;
59622	Cesarean delivery only, following attempted vaginal delivery after previous cesarean; including postpartum
59430	Postpartum care only (separate procedure)

Adjusting Episode Costs

Adjustments in episode costs are needed for both the validity and fairness of cost comparisons among facilities and included the following two types of adjustment:

- Factor adjustment – which adjusts for factors known to have a predictable impact on costs of care.
- Outlier management – which protects against rare, unpredictable high-cost and very low events that could have a dramatic impact on average costs for a facility.

Two types of factor adjustments are made commonly in health cost comparisons:

- Adjustments for predictable cost differences related to geography; and
- Adjustments for predictable cost differences due to risk; or, more specifically, due to differences in the clinical characteristics of patients and age that have a measurable and predictable impact on costs.

A geographic adjustment factor was applied to the episode cost, to account for geographic cost variations in delivering care. Adjustments made for predictable cost differences related to geography used the 2023 Geographic Adjustment Factors (GAFs) for 112 Geographic Practice Cost Index (GPCI) localities level, as defined by CMS.

Risk adjustment was used to adjust for variation in cost that may relate to differences in patient severity (with or without comorbidity), as well as case mix, using the following steps:

- Identified patient severity levels, using the MS-DRG risk stratification system.
- Three separate age-bands (18-34 years, 35-39 years, and 40+ years) were created for better risk assessment within each broad clinical category. As a result, there will be a total of nine sub-categories to calculate nine risk adjustment factors under both vaginal and cesarean deliveries.
- Managed outliers through winsorization within risk bands. Outliers were identified in each risk band as those values for which geographically adjusted costs were the top 2 percent and bottom 2 percent of episode costs. Outlying cost values were truncated to these points, to preserve their considerations in calculating the overall episode cost estimate while moderating their influence.

Calculated Risk Adjustment Factor

The mean of the geographically adjusted, winsorized episode costs for each clinical category/risk level combination at the national level is the expected cost for that clinical category/risk level combination. The national expected cost for each clinical category/risk level combination is divided by the national mean cost for the clinical category, to calculate the Risk Ratio for each clinical category/risk level combination. The Risk Adjustment Factor (which is the inverse of the Risk Ratio) is multiplied by each facility's geographically adjusted and winsorized facility episode

costs for each clinical category/risk level combination to normalize for risk, resulting in a final episode cost that is both geographically adjusted, and risk adjusted.

Minimum Case Volume Requirement

For reliability, a minimum of 5 episodes are needed in each clinical category to be included in the cost calculation of at the facility level. For maternity, this means that a facility must have 5 vaginal delivery episodes and 5 cesarean delivery episodes to meet minimum case volume.

Establishing the Cost Measure

Each episode was attributed to the facility where the primary procedure/surgery occurred, based on trigger events that occurred at that facility for each of the two clinical categories: vaginal delivery and cesarean delivery. Each facility has a separate calculation for the Clinical Category Facility Cost (CCFC) based on the median value of the adjusted episode costs. Confidence intervals (90 percent) were calculated around each Clinical Category Facility Cost (CCFC) measure; the Upper Confidence Limit (UCL) of the measure was divided by the National Median Episode Cost to become the Clinical Category Facility Cost Index (CCFCI). The combined cost index of the median UCL was rounded down to the nearest 0.025 to give facilities the benefit of the doubt and to avoid situations where a facility narrowly missed BDC+ eligibility by an immaterial margin. The rounded median UCL was the measure used for cost scoring. For reliability, a minimum of five procedures was required within a clinical category for the data to be included in the calculation of a Composite Facility Cost Index (CompFCI) for a facility.

Using each of the Clinical Category Facility Cost Index values, an overall Composite Facility Cost Index (CompFCI) was calculated for the facility. Each Clinical Category Cost Index was weighted by that facility's own volume and facility costs to calculate a composite measure of cost called the Composite Facility Cost Index.
Composite Facility Cost Indices (CompFCI) for each facility, calculated using the UCL of individual clinical category facility cost indices (CCFI), were then compared to the cost threshold set by BCBSA. A facility was selected for BDC+ designation if the CompFCI was lower than or equal to the cost threshold set by BCBSA, demonstrating that the expected composite facility cost index was lower than or equal to the cost threshold cost index**.**

Questions

Contact your local Blue Plan with any questions.

Blue Distinction Centers (BDC) met overall quality measures for patient safety and outcomes, developed with input from the medical community. A Local Blue Plan may require additional criteria for facilities located in its own service area; for details, contact your Local Blue Plan. Blue Distinction Centers+ (BDC+) also met cost measures that address consumers' need for affordable healthcare. Each facility's cost of care is evaluated using data from its Local Blue Plan. Facilities in CA, ID, NY, PA, and WA may lie in two Local Blue Plans' areas, resulting in two evaluations for cost of care; and their own Local Blue Plans decide whether one or both cost of care evaluation(s) must meet BDC+ national criteria. National criteria for BDC and BDC+ are displayed on www.bcbs.com. Individual outcomes may vary. For details on a facility's in-network status or your own policy's coverage, contact your Local Blue Plan and ask your facility before making an appointment. Neither Blue Cross and Blue Shield Association nor any Blue Plans are responsible for non-covered charges or other losses or damages resulting from Blue Distinction or other provider finder information or care received from Blue Distinction or other providers.

Appendix A: Obstetric Hemorrhage Patient Safety Bundle Elements

Obstetric Hemorrhage Patient Safety Bundle Elements
1. Uses an evidence-based risk assessment tool for hemorrhage risk at defined stages of labor (prenatal, on admission, pre-birth, and on transition to postpartum care) for all patients.
2. Measures cumulative **quantitative** blood loss on all patients.
3. Performs active management of the 3rd stage of labor (department-wide protocol).
4. Completes multidisciplinary reviews for monitoring of outcomes and process metrics (at least) for obstetric hemorrhage (OBH) cases resulting in 4 or more units of blood products and/or Severe Maternal Morbidity (SMM) Indicator (as defined by Centers for Disease Control and Prevention) in perinatal quality improvement (QI) committee.
5. Provides trauma informed support program for patients, their identified support network, and staff for all significant hemorrhages.
6. Provides educational information, which includes (at least) warning signs/symptoms of obstetric hemorrhage and who to contact with medical/mental health concerns about the patient.

Appendix B: Severe Hypertension Patient Safety Bundle Elements

Severe Hypertension Patient Safety Bundle Elements
1. Facility has rapid access to standardized medications used for severe hypertension/eclampsia.
2. Facility ensures accurate measurement and assessment of blood pressure for every pregnant and postpartum patient, including: (1) notification of OB Provider if systolic BP ≥ 160 or diastolic BP ≥110 for two measurements within 15 minutes; and (2) after the second elevated measurement, initiates treatment with antihypertensive medication(s) that are recommended to be administered ASAP (preferably within 60 minutes of verification).
3. Performs multidisciplinary reviews for monitoring of outcomes and process metrics, which include (at least) required reviews by the perinatal quality improvement (QI) committee for appropriate and timely treatment of severe range blood pressure and/or Severe Maternal Morbidity (SMM) Indicator (as defined by Centers for Disease Control and Prevention).
4. Provides trauma informed support program for patients, their identified support network, and staff for all serious complications of severe hypertension.
5. Provides educational information, which includes (at least) warning signs/ symptoms of severe hypertension/ preeclampsia, and who to contact with medical/ mental health concerns about the patient
6. Initiates postpartum follow-up visits to occur within 3 days of discharge for individuals whose pregnancy was complicated by hypertensive disorders.

Appendix C: Safe Reduction of Primary Cesarean Births Patient Safety Bundle Elements

Safe Reduction of Primary Cesarean Births Patient Safety Bundle Elements
1. Implements standardized admission criteria, triage management, education, and support for women presenting in spontaneous labor.
2. Offers standardized techniques of pain management, comfort measures, and labor support methods that promote labor progress and prevent dysfunctional labor.
3. Uses standardized methods in the assessment of the fetal heart rate status, including interpretation and documentation based on National Institute of Child Health and Human Development (NICHD) terminology, and encourages methods that promote freedom of movement.
4. Upholds standardized induction scheduling, to ensure proper selection and preparation of women undergoing induction of labor.
5. Utilizes standardized evidence-based labor algorithms, policies, and techniques, which allow for prompt recognition and treatment of labor dystocia.
6. Adopts policies that outline standardized management of Category II Fetal Heart Rate patterns and uterine tachysystole.
7. Monitors primary cesarean delivery rates (using both a sample of cases [as determined by the facility] and individual physician cases) for compliance with standardized evidence-based algorithms for labor dystocia and management of Category II Fetal Heart Rate patterns to discuss in perinatal quality improvement (QI) committee.
8. Provides trauma informed support for patients, their identified support network, and staff if necessary for patients impacted by primary cesarean deliveries.