Collaborating to Improve Birth Outcomes in New Jersey: **A CHCS Project Spotlight**

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Nationwide, preterm births and low birth weight babies exact a heavy toll: In 2001, hospital charges for low birth weight babies and premature deliveries averaged $75,000 per child, compared to $1,300 for newborns without complications.[1]

In New Jersey, statistics tell a similar tale. In 2003, the state's Department of Health and Senior Services reported that infant mortality rates were six times higher among women who received no prenatal care than among women who received early and proper care.

In 2006, the five Medicaid managed care health plans in New Jersey began collaborating to identify high-risk pregnancies and improve birth outcomes in Camden, New Brunswick, and Trenton. AmeriChoice of NJ, AMERIGROUP NJ, Health Net, Horizon NJ Health and University Health Plans were joined by the state Medicaid program and the New Jersey Maternal and Child Health Consortium in the pilot initiative, officially known as the *New Jersey Collaborative to Improve Birth Outcomes and Health Status of Children*. The Center for Health Care Strategies (CHCS) spearheaded the effort with funding from Children's Futures and the Robert Wood Johnson Foundation.

Working Collaboratively to Standardize Quality Improvement

The five health plans involved in the Collaborative have a unique history of working successfully together on other quality improvement efforts. Past collaborative successes include a multi-agency project that nearly doubled the lead screening rate of Medicaid-enrolled children under age 2 from 25 to 45 percent. The goals of this Collaborative, which included senior health plan medical and dental officers, quality improvement specialists, statistical and data personnel and nurse care managers, were to develop a standard prenatal risk assessment form (PRA) and a central data repository to collect the assessment information.

"Our idea behind the PRA was ambitious-yet simple: one form, one page, one fax number," said Anju Sikka, MD, medical director at Health Net. By having all five Medicaid health plans use the same form and collect the same information, the Collaborative aimed to:

- Simplify and standardize the process of flagging high-risk pregnancies no matter what health plan a woman was enrolled in;
- Ease the burden on providers by having them complete the same short form for each high-risk patient; and
- Begin to build a database to analyze trends in the state.

The *ultimate* goal of the Collaborative was to increase the identification of high-risk pregnancies and proactively intervene with appropriate care and education earlier to prevent poor birth outcomes.

This **Project Spotlight** profiles the experiences of the CHCS initiative, *New Jersey Collaborative to Improve Birth Outcomes and Health Status of Children*. CHCS spearheaded the effort with funding from Children's Futures and the Robert Wood Johnson Foundation. For more information, please contact Sheree Neese-Todd at (609) 528-8400 or **sneesetodd@chcs.org**.

[1] March of Dimes Perinatal Data Center, "Hospital Charges for Prematurity - 2001 Data."August 2003.

Designing the PRA

The standardized PRA collects information on pregnancy risk factors, current medical conditions, and social risk factors, and includes the *4P's Plus*©, which screen for recent and past alcohol, tobacco and other drug use by the patient, her parents and her partner.

What is the *4P's Plus*©?

The *4P's Plus* is a tool that health care providers can use to screen pregnant patients for substance use during pregnancy. The questions include:

PARENTS. Did either of your parents have any problems with alcohol or drugs?

PARTNER. Does your partner have a problem with drugs or alcohol?

PAST. Have you ever drunk beer, wine or liquor?

PREGNANCY. In the month before you knew you were pregnant, how many cigarettes did you smoke? In the month before you knew you were pregnant, how much wine/beer/liquor did you drink?

*SOURCE: **The 4P's Plus**© was developed and tested by Ira Chasnoff, MD and colleagues at the Children's Research Triangle, Chicago, Illinois.*

The PRA is a starting point: It flags high-risk pregnancies. Approaches to address high-risk pregnancy vary from plan to plan. "We knew if we successfully identified one high risk case and saved that child from the neonatal unit, and all that entails, than the hard work would be worth it," explained Dr. Sikka. "We would effectively make a huge difference in that child's life and save the family and society a huge burden."

Designing the PRA was an iterative process. The workgroup reached consensus on a single form and providers began using it in December 2006. In September 2007, the Collaborative expanded the form based upon feedback from obstetrics providers and the health plan case managers. As new information is identified, keeping the PRA form to one page as a manageable and efficient document is an ongoing challenge.

The PRA screening tool also reminds health care providers to examine the pregnant women's teeth and gums, inquire about overall oral health, and refer women with periodontal disease or other oral health problems to local dentists for care. Several studies have shown that severe periodontal disease, because it is a chronic infection, may be associated with preterm birth and low birth weight. Other studies have shown a possible link between periodontal disease and pre-eclampsia, which can threaten the health of both mother and baby.

Educating Providers: Getting Buy-In for the PRA

To introduce the PRA and encourage providers to embrace it, the medical directors, quality improvement directors, health plan staff, and community advocates provided in-office academic detailing sessions. They were encouraged by the providers' initial response to the PRA. "When I returned to the hospital for an academic detailing session, I got tremendous positive feedback from physicians and nurses about the PRA," said Dr. Sikka. "It was literally applauded."

The NJ Collaborative conducted a qualitative survey of health plans and obstetrical providers in March 2007 to gauge their satisfaction with the PRA. Overall satisfaction with the universal PRA was extremely positive and suggestions for improvements were incorporated into a new version of the form to further increase buy-in.

The state Medicaid agency provided incentives for health plans and providers to use the PRA. If the health plans adopted the PRA, it would fulfill one quality improvement credit toward their contract compliance. In addition, New Jersey requires obstetrical providers to ask pregnant women about their history of depression. By using the PRA, that question is asked and documented. For the providers, the completed PRA serves as the authorization form for payment for providing prenatal care.

A Central Data Repository

Family Health Initiatives (FHI), a subsidiary of the Southern New Jersey Perinatal Cooperative, led the effort to create and manage the central data repository. Twelve sites in Camden, New Brunswick, and Trenton-including physicians' offices and clinics-fax the forms to FHI. Daily, FHI sends an encrypted report to the health plans, which includes an Excel spreadsheet and a file that provides an easy-to-read graphic of PRA responses. The Collaborative sought to create a scannable form, so that the assessment data could be quickly and easily incorporated into the database.

"Creating one central data repository for information related to high-risk pregnant women served by Medicaid was a significant accomplishment and will allow for ongoing trend analysis," noted Sheree Neese-Todd, a program officer at the Center for Health Care Strategies.

This effort has provided a remarkable picture of high-risk pregnancies in the three pilot cities and is expected to produce outcomes data in the future. During the first nine months of the program 3,699 pregnant women were identified. The data reveals the following about women and their prenatal risk in the three urban areas:

- 40% Hispanic, 36% African American, 13% Caucasian, and 3% Asian;
- Caucasian and Hispanic women (50% and 52% respectively) were more likely than African American women (41%) to enter care during the first trimester;
- About 45% of all screened women were uninsured;
- Among the 55% of women who were insured, 34% were enrolled in the traditional Medicaid program, and 22% were covered by NJ FamilyCare, the state's SCHIP program; and
- Less than 20% of women reported visiting a dentist in the past year.

Key Lessons from the Improving Birth Outcomes Collaborative

Following are some of the major lessons learned by the Collaborative:

- **Include all relevant stakeholders**. Make sure all the parties who should be involved are included from the start and have a formal voice in the process.
- **Keep the clinical and administrative processes simple**. The PRA should have mostly "yes" or "no" responses. Ask for only the most critical information and stay to one page. For example, the data from the first prenatal visit is critical information for HEDIS measures.
- **Communicate benefits to get stakeholder buy-in**. Use information from the central data repository to inform state policy discussions and garner support for the data collecting effort. Helping providers realize the benefits, e.g., reduced paperwork/streamlined processes of a universal screening tool will help ensure they are using the form.
- **Collaboration takes time**. The logistics of involving multiple, statewide stakeholders and the state government in a managed care plan based-initiative can be daunting. The mediation of a common agenda and commitments are time intensive, particularly in the early stages of collaborative development.

Moving Forward

Ultimately, New Jersey hopes to take the PRA form statewide and convert the data collection process to a web-based system, with a fax version available for practices as needed. New Jersey Medicaid is investing $100,000 to support the statewide expansion and the health plans will also contribute resources. A business arrangement between the health plans and FHI is under development.

The Collaborative's effort to get high-risk pregnant women the care and services they need will get another boost from the state Medicaid agency in Fall 2007. Based in part on the suggestions raised by the Collaborative, county Medicaid offices will initiate an expedited enrollment process for pregnant women through presumptive eligibility. For high-risk pregnant women this will help get them enrolled more quickly into a Medicaid managed care plan and give them access to prenatal care and care management earlier in their pregnancies.

New Jersey's success in bringing together the health plans and creating the PRA provides a model for improving birth outcomes in Medicaid managed care programs. It has sparked interest in New York to consider a similar initiative. The New York State Office of Managed Care is reviewing the New Jersey PRA as they design a prenatal risk assessment program. The challenge? Other states will have to adapt this prototype to reflect their own environments with the knowledge that adopting a standardized form offers tremendous potential for streamlining practice paperwork and identifying commonalities among the state's high-risk pregnant beneficiaries.