CHCS

Center for
Health Care Strategies, Inc.

Toward Improving Birth Outcomes

TOOLKIT

Best Clinical and Administrative Practices for Medicaid Health Plans

CHCS Center for Health Care Strategies, Inc.

Toward Improving Birth Outcomes

A Best Clinical and Administrative Practices Toolkit for Medicaid Health Plans

About the Center for Health Care Strategies

The Center for Health Care Strategies is a nonprofit, policy resource center that promotes better health care services for low-income and special needs populations. We achieve this objective through providing grants and "real world" training and technical assistance to managed care organizations, purchasers of publicly-financed health care, and consumer groups. Our projects aim to achieve five quality goals: improving access to care, improving preventive care services, promoting clinical quality, preventing unnecessary hospitalizations and institutionalizations, and building organizational capacity.

Author
Margaret L. Oehlmann, MPH
Center for Health Care Strategies

Contributors
Alison L. Croke, MHA
Lorie Martin
Center for Health Care Strategies

Susanne Salem-Schatz, ScD
Health Care Quality Consultant

Editors
Richard J. Baron, MD, FACP
Healthier Babies, Healthier Futures, Inc.

Patricia J. Barta, MPH
Karen L. Brodsky, MHS
Seth Klukoff
Center for Health Care Strategies

Design
Nancy Biddle
Biddle Design

For additional copies
Additional copies can be downloaded or ordered online at www.chcs.org, or by calling 609.895.8101.

Toward Improving Birth Outcomes

A Best Clinical and Administrative Practices Toolkit for Medicaid Health Plans

October 2001

Table Of Contents

Acknowledgements

The Center for Health Care Strategies would like to thank the many people who assisted in the production of this toolkit. The following played vital roles in helping us to create the Best Clinical and Administrative Practices (BCAP) initiative: Peter Fox of PDF Incorporated; Foster Gesten, MD, of the New York State Department of Health; Harry Gill, MD; Catherine Halverson; Robert Master, MD, of Neighborhood Health Plan; Donald Umlah of the Health Services Advisory Group; and Victoria Wicks.

Acknowledgements are extended to Georgie Mazzarone, Cheryl Norvell, and Allicia Turner, who assisted with the production of materials for the *Toward Improving Birth Outcomes* workgroup; Marsha Gold, PhD and Jessica Mittler of Mathematica Policy Research, Inc. for a comprehensive evaluation of the BCAP initiative; and to Doriane Miller, MD, Michael Rothman, and Sara Thier of The Robert Wood Johnson Foundation and Stephen A. Somers, PhD, of the Center for Health Care Strategies, for their advice along the way.

Special thanks are offered to the members of the *Toward Improving Birth Outcomes* workgroup for their patience and generosity during the production of this toolkit. Your efforts to improve health care for Medicaid and State Children's Health Insurance Program beneficiaries are inspirational to us all.

Preface

Best Clinical and Administrative Practices (BCAP) is a five-year, $3.8 million initiative of the Center for Health Care Strategies (CHCS) to improve the quality and cost effectiveness of care provided by health plans serving Medicaid and State Children's Health Insurance Program (SCHIP)* enrollees. BCAP is convening leaders from health plans across the country to develop and replicate best practice models in managed care. The program is funded under a major grant from The Robert Wood Johnson Foundation.

To develop BCAP and clarify the challenges facing Medicaid health plans, CHCS conducted interviews with medical directors and senior quality management staff from plans in 10 states. The interviews revealed that serving Medicaid beneficiaries in managed care often is more challenging than serving Medicare or commercial members. Reasons for this include:

- Unlike Medicare, there are no national purchasing standards for Medicaid, and regulatory environments vary greatly by state.
- Medicaid health plans experience higher member turnover than Medicare or commercial health plans. As many as 10 to 15 percent of Medicaid members disenroll from health plans each month.[1]
- Medicaid members are far less likely than commercial or Medicare members to have stable housing, a reliable mailing address, a telephone, or a long-term relationship with a health care provider.[2]

Because of these obstacles, interventions that are successful in Medicare or commercial populations may not work as well within Medicaid. Health plans need creative strategies for addressing these clinical and administrative barriers. CHCS created BCAP to respond to these needs.

BCAP targets key areas for quality improvement, including birth outcomes, preventive care services for children, achieving better care for asthma, and adults and children with special health needs. For each topic, BCAP convenes a workgroup of eight to 15 health plan medical directors. Each workgroup makes a 21-month commitment to develop and pilot best practice models. These best practice models are shared with health plans nationwide through workshops and toolkits.

The first BCAP workgroup focused on *Toward Improving Birth Outcomes*. Pregnancy is one of the primary categories for Medicaid eligibility and deliveries account for almost 50 percent of Medicaid inpatient discharges.[3] Thus, assuring that pregnant women on Medicaid receive proper prenatal care is a priority for health plans both in terms of serving members well and improving health plan finances. It is our goal to share the experiences of BCAP to advance the quality of care and increase the number of healthy births among your enrollees.

* Activities in this toolkit relate to both Medicaid and State Children's Health Insurance Program enrollees. To simplify text, Medicaid is used throughout the toolkit to represent both populations.

[1] Health Care Financing Administration. *The Evolution of the Oregon Health Plan: First Interim Report*. Springfield, VA. National Technical Information Service, 1999.

[2] Brodsky K., Baron, R.J. "A 'Best Practices' Strategy to Improve Quality in Medicaid Managed Care Plans." *Journal of Urban Health*, December 2000. 77(4): 593.

[3] *National Medical Results for Selected 2000 HEDIS and HEDIS/CAHPS Measures*. Measure: Inpatient Utilization-General Hospital/Acute Care. National Committee for Quality Assurance. www.ncqa.org.

How Will This Toolkit Benefit Your Health Plan?

This toolkit offers a structured approach for addressing quality improvement and a collection of "lessons learned" by a diverse group of health plans serving Medicaid members. Whether your health plan intends to develop a new prenatal program or your plan is seeking to improve an existing program, this toolkit offers practical, realistic approaches that can help you:

- Review common barriers that Medicaid plans face in improving birth outcomes.
- Develop strategies to overcome these barriers.
- Review clinical and administrative strategies that other health plans have implemented.
- Measure incremental and long-term change.

Currently, there is little available literature identifying specific programs that are successful in improving birth outcomes. However, most health plan leaders agree that it is important to develop such programs because:

- Pregnancy is an eligibility category for Medicaid, hence making it one of the most frequent diagnoses in the Medicaid population.
- Delivery claims and high-cost neonatal expenses consume a large portion of most Medicaid health plan budgets.
- Women covered under Medicaid are more likely to experience poor birth outcomes than women with commercial insurance.
- State Medicaid officials often target prenatal care as a quality improvement project.
- It is the right thing to do.

How this Toolkit is Organized

The toolkit begins with a brief discussion of the process improvement model used in BCAP. It then presents the "typology for improvement" developed for the *Toward Improving Birth Outcomes* workgroup, followed by a separate chapter for each typology category. For each typology category, an inventory of change strategies is listed, followed by case studies of innovative pilot projects. The last chapter outlines effective communication tactics to facilitate change. Finally, the Appendices provide sample tools from BCAP workgroup health plans and other relevant materials.

How this Toolkit was Developed

The contents of this Toolkit reflect the experiences of the *Toward Improving Birth Outcomes* workgroup, a group of 11 health plans that collaborated to develop and pilot best practices for improving birth outcomes in their enrollee populations. At an initial meeting, the medical directors gathered to review current research, share their own successes and challenges in improving birth outcomes, and brainstorm ideas for successful improvement initiatives. After the first meeting, each medical director committed to piloting a series of small-scale quality improvement projects within his or her health plan, examples of which are highlighted throughout this toolkit.

Over the following nine months, health plans met two more times, bringing additional staff members into the initiative for a team approach. Plans with common pilot project initiatives worked together to discuss common barriers and share strategies for overcoming these barriers.

The health plans in the *Toward Improving Birth Outcomes* workgroup continue to refine their BCAP-related quality improvement strategies and actively participate in the "BCAP Network," a growing collaboration of health plans joined by the common goal of furthering the quality and cost-efficiencies of Medicaid managed care.

Toward Improving Birth Outcomes Workgroup Health Plans

Health Plan	Location	Medical Director Participant	Number of Medicaid Members*
Arkansas Foundation for Medical Care	Arkansas	William Golden, MD	196,000
CareSource Health Plan	Ohio	Ron Suprenant, MD	140,000
Colorado *Access*	Colorado	Virginia Gurley, MD	53,000
Coventry Health Care	Delaware	Jaime Rivera, MD	45,000
Harmony Health Plan	Illinois	Henry Hollander, MD	40,000
Health Partners of Philadelphia	Pennsylvania	Sharad Mansukani, MD	120,000
LA Care Health Plan	California	Helen DuPlessis, MD	600,000
Monroe Plan for Medical Care	New York	Joseph Stankaitis, MD	34,000
Neighborhood Health Plan	Massachusetts	Paul Mendis, MD	100,000
Sentara Healthcare	Virginia	David Levin, MD	71,000
The Bronx Health Plan	New York	Richard Younge, MD	54,000
Total Medicaid Membership			***1,453,000***

* Plan estimates as of September 2001.

Measuring for Success: A Process Improvement Strategy

How to Approach Process Improvement

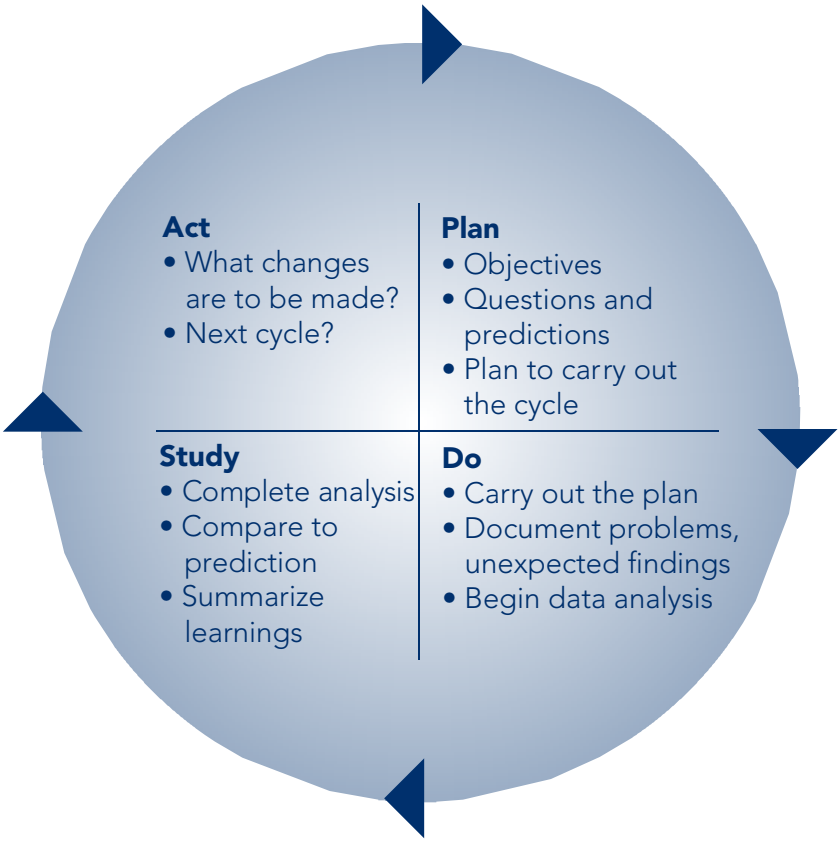
Sustained improvement requires fundamental change in the care-delivery system.[4] Plans are encouraged to test changes for long-term viability using a structured model for improvement. Such models provide guidance and focus for health plans implementing change. They also create a common language and approach that facilitates communication and shared learning within the health plan.

A Brief Guide to The Model for Improvement

There are numerous improvement models used in the managed care industry. All offer a systematic guide for identifying problems and making changes. The Model for Improvement[5] used by the *Toward Improving Birth Outcomes* workgroup identifies aim, measure, and change strategies by asking three questions:

AIM	What are we trying to accomplish?
MEASURE	How will we know that a change is an improvement?
CHANGE	What changes can we make that will result in improvement?

These questions are followed by the use of learning cycles to plan and test changes in systems and processes. These are referred to as P-D-S-A (Plan-Do-Study-Act) cycles. The P-D-S-A cycles guide improvement teams through a systematic analysis and improvement process.



[4] Headrick L., Katcher W., Neuhauser D., McEachern E. "Continuous Quality Improvement and Knowledge for Improvement Applied to Asthma Health Care." *Joint Commission Journal on Quality Improvement*. 1994; 20:562-568.

[5] Langley G., Nolan K., Nolan T., Norman C., Provost L. *The Improvement Guide: A Practical Approach to Enhancing Organizational Performance*. San Francisco. Jossey-Bass, 1996.

Step 1: Creating Your Aim Statement

An Aim Statement recognizes a deficiency in an important process or performance measure. It provides a clear goal for your plan's quality improvement team. An effective Aim Statement is clear and specific, and sets "stretch" goals (numerical targets that are a real reach).

Principles of an Effective Aim Statement

- Write clearly.
- Use specifics.
- Set direction.
- Set numerical goals.
- Set "stretch" or ambitious goals.

Examples of Aim Statements

"Identify pregnant members during their first trimester for 80 percent of all pregnancies."

"Successfully complete 90 percent of all attempts to contact pregnant members."

Step 2: Creating Measures for Improvement

Establishing a "culture of measurement" within health plans is critical to providing quality, cost-effective care. Most health plans have quality improvement departments responsible for creating initiatives to improve the health care and satisfaction of their enrolled members. Where these initiatives often fall short, however, is in measuring the effectiveness of the implemented approach or improvement. The Health Plan Employer Data and Information Set (HEDIS)[6] guidelines establish outcomes by which health plans measure improvement, but these measures are collected at lengthy intervals and are mainly useful for analyzing long-term trends.

Measurement for improvement differs substantially from judgment-based measurement in clinical research.[7] In the BCAP process, health plans are encouraged to establish realistic goals with a "stretch" component – make the goals obtainable, but enough of a reach to be challenging. Process measures, which track incremental improvements, are an effective way to measure progress on these goals.

Process measures are designed to tell you whether your change is having the expected impact, and in some cases, can highlight the cause of unexpected results. These measures provide short-term feedback to evaluate ongoing improvement efforts. Process measures should be a direct reflection of the Aim Statement.

Creating Process Measures

- Seek usefulness, not perfection.
- Use small, repeated samples.
- Measure over time and over a wide range of conditions.
- Include quantitative and qualitative measures.

Linking Measures to Aims

Aim	Measure
"Ninety percent of Health Risk Assessment (HRA) forms returned by providers within 14 days of the first prenatal visit."	▶ # of HRAs returned within 14 days / # of first prenatal visits

[6] HEDIS is a registered trademark of the National Committee for Quality Assurance (NCQA).

[7] Solberg L.I., Mosser G., McDonald S. "The Three Faces of Performance Measurement: Improvement, Accountability, and Research." *The Joint Commission Journal on Quality Improvement*. 1997. 23:135-147.

Step 3: Identifying, Planning, and Testing a Change

This Toolkit inventories the change strategies tested by the plans in the *Toward Improving Birth Outcomes* workgroup. They selected strategies based on the needs of their own organizations. As you review these, consider which Aim Statements most closely reflect those of your own organization. Then review the strategies and barriers listed to determine which are best suited for your health plan. Test selected changes on a small scale, review measures, make adjustments, and measure again. Repeat the cycle until you are satisfied with the results.

As you plan to test a change, specify the "who, what, where, and when," so that all project staff know their roles clearly. Careful planning will foster successful implementation. Be sure to plan for appropriate **training** and **communication** when you "go live" with the change. Use an "Improvement Documentation Form" (Appendix A) to help with planning the change.

Why Test a Change?

- Document magnitude of expected improvement.
- Opportunity for "failure" without having an impact on performance.
- Evaluate "side effects" of change.
- Learn how to adapt the change to your local setting.
- Minimize resistance on full implementation.

Key Principles for Testing a Change

- Start small.
- Use volunteers.
- Don't worry about full buy-in.
- Plan multiple cycles to test and adapt change.

The improvement strategies documented in this Toolkit are not "one-size-fits-all." Running testing cycles before full implementation offers a safe way to try something new and make modifications, while minimizing resource use and impact on the organization.

Measuring in Common: Highlighting Trends Over Time

Health plans participating in the *Toward Improving Birth Outcomes* workgroup agreed to collect a set of "shared" measures to reflect the progress of the initiative on a broader scale. The shared measures included HEDIS measures as well as new measures that the workgroup developed. The purpose of collecting shared measures is to document improvement and to show how each plan is improving from its own baseline. Shared measures provide a common metric for health plans in the BCAP workgroup to track progress.

What Shared Measures **Are Not**

Market variations, carve-outs, population differences, physician practice patterns, and plan design may vary significantly among health plans. Shared measures are not intended for comparisons of health plan performance, but rather to highlight improvement trends within each health plan.

Collecting Shared Measures

We encourage you to identify a number of key measures within Table 1 on page 10 that will allow you to track the overall success of your improvement initiative, in addition to measuring the effects of individual changes within typology categories. The measures are useful for documenting improvements to compare to your baseline levels.

Table 1: Shared Measures to Improve Birth Outcomes

Measure	Measurement Formula	Type of Measure
Identification by Trimester	# of pregnant members identified in first trimester / # of members delivered	Process Measure
Health Risk Assessment Rate	# of completed Health Risk Assessments / # of women identified as pregnant	Process Measure
Contact Rate	# of women contacted / # of women for whom contact was attempted	Process Measure
Rate of Check-Ups After Delivery	# of postnatal care visits between 21 and 56 days / # of women continuously enrolled with live births	Process Measure
Low Birth Weight Rate	All live births below 2,500 grams / All births in the plan	Outcome Measure
Very Low Birth Weight Rate	All live births below 1,500 grams / All births in the plan	Outcome Measure
Prenatal Visit Rate	Average number of prenatal visits per delivery.	Process Measure
Gestational Age	Average from birth certificate data.	Outcome Measure
HEDIS Measures		
Births and Average Length of Stay – Newborns	Newborns per 1,000 female member months, newborn discharges per 1,000 member months, days per 1,000 member months, and average length of stay for newborns.	Process Measure
Check-Ups After Delivery	The percentage of enrolled women who delivered (a) live birth(s) during the measurement year who were continuously enrolled 56 days after delivery, with no breaks in enrollment, who had a postpartum visit on or between 21 days and 56 days after delivery.	Process Measure
Frequency of Ongoing Prenatal Care	The percentage of pregnant Medicaid-enrolled women who received <21%, 21%-40%, 41%-60%, 61%-80% or ≥ 81% of the expected number of prenatal visits.	Process Measure
Discharges and Average Length of Stay – Maternity Care	Discharges per 1,000 member months, days per 1,000 member months, and average length of stay for females.	Process Measure
Weeks of Pregnancy at Time of Enrollment in Health Plan	The percentage of all enrolled women who delivered a live birth during the measurement year by the weeks of pregnancy at the time of their enrollment in the health plan, according to the following categories: • Prior to pregnancy. • During the first 12 weeks of pregnancy. • During the 13th-27th weeks of pregnancy. • The 28th week of pregnancy or after.	Process Measure

A Typology for Improvement

CHCS developed a "Typology for Improvement" to classify health plans' activities in designing quality initiatives. The four-step classification system addresses barriers commonly faced by health plans serving pregnant women on Medicaid. The model was developed based on interviews with health plan medical directors and quality improvement directors in 10 states. It offers a template for approaching quality initiatives that can be customized for a variety of clinical quality improvement projects.

Typology Category	Description
Identification	How do you identify the relevant population?
Stratification	How do you assign risk within that population?
Outreach	How do you reach the target population?
Intervention	What works to improve outcomes?

Applying the Typology Toward Improving Birth Outcomes

Identification Early identification of pregnant women is the first step toward improving birth outcomes. Action items to improve identification include:

- Examining the current tools the health plan uses to identify pregnant women.
- Analyzing when the health plan becomes aware of the pregnancy. (Many plans rely upon analysis of claims data, which often tells them about pregnancy only after delivery.)

Health plans that invest in efforts to identify women early in pregnancy are in a better position to offer case management or support services to women most at risk of a poor birth outcome.

Stratification Once the health plan has identified its population of pregnant women, how does it determine which members are most at risk of having poor birth outcomes? Risk factors include:

- History of a prior poor birth outcome.
- Short intervals between pregnancies.
- Maternal age.
- Drug use.
- Mental illness.
- Physical abuse.
- Smoking.
- A history of certain chronic illnesses, e.g., diabetes and epilepsy.

- **Outreach** Ongoing outreach efforts are critical to ensure that members have access to appropriate services and adhere to prenatal care guidelines. Health plans must evaluate:

  - How does the health plan reach its pregnant members?
  - Does the health plan make regular calls to members? Does the plan have a home visiting program, or a community presence?
  - Once pregnant women are contacted, does the health plan offer incentives to encourage ongoing prenatal care?

- **Intervention** Once the health plan has identified a pregnant woman, determined her level of risk, reached out to her, and encouraged her to complete her prenatal care regimen, what interventions does the plan actually offer her and her health care provider that suit her needs? Questions to consider include:

  - What programs are available to pregnant members who present with particular risk factors?
  - Are these programs cost effective?
  - Do members use the service?
  - Can the plan document improvements in health outcomes as a result of these programs?

While this typology is useful for organizing tactics into a systematic strategy, there also can be overlap between typology categories. A successful effort to improve identification, for example, can promote activities in stratification, outreach, and intervention. This toolkit is meant as a guide to help organize ideas, but is also designed to allow flexibility for creative planning and design of new initiatives.

Identification

How and when does the health plan find out if a member is pregnant?

By identifying pregnant women earlier, health plans can address risk factors through outreach and intervention strategies. Health plans seek to increase the number of women who are identified at a point when the health plan can have an impact on birth outcomes. If a health plan only finds out about pregnant members by paying delivery claims, there is nothing the health plan can do to intervene and influence early prenatal care.

A variety of sources are used by many health plans to identify pregnant women. Examples of common sources of data and the pitfalls of using these data are listed in Table 2. BCAP workgroup participants found that to increase identification of women earlier in their pregnancies, they typically needed to go beyond these traditional sources and develop alternative strategies for identification.

Table 2: Common Sources of Data for Identification

Source of Data	Common Barriers
Provider Reporting	Inconsistent and untimely.
Member Reporting	Intermittent at best.
Lab Data Analysis	Multiple lab contracts means data are scattered; confidentiality barriers in releasing lab results.
Pharmacy Data	Frequently dependent on a subcontractor; access to useful and timely reports may be unreliable.
Claims Data	Find out after member has delivered.
Enrollment Brokers	Untimely reporting.

Strategies to Identify Pregnant Women

To overcome these barriers, health plans in the *Toward Improving Birth Outcomes* workgroup developed multifaceted identification strategies that combined traditional strategies listed above with some of the more creative techniques outlined below.

Provider Reporting

- Meet with high-volume obstetric providers to enhance relationship between plan and providers, to review the importance of complete prenatal registration forms, and to develop workable reporting procedures.
- Offer or enhance provider incentives to submit a standardized prenatal notification form. (For example, health plan will reimburse the provider only if pregnancy identification forms are submitted within one week of the initial prenatal visit.)
- Revise provider reimbursement of pregnancy from case rates to fee-for-service.
- Collaborate with other plans in your region to develop a common reporting process.

Member Reporting

- Revise health plan's main voicemail to include the greeting, "press one if you are pregnant." Members who "press one" are routed to a pregnancy case management unit.
- Insert a tear-off sheet in the member handbook for members to complete and return to the plan if they are pregnant. Additional tear-off sheets can be used to provide information on available prenatal services.
- Create an "Are you pregnant?" poster to display around the health plan's service area encouraging women to call and notify the health plan if pregnant.
- Educate other health plan departments about the importance of identifying pregnant women early. Develop clear methods for sharing information about pregnant women with a maternity case manager. Other departments that have ongoing member communications could include: a Special Needs Unit, Member Services, Utilization Management, Community Relations, and Marketing/Communications.
- Add a question about pregnancy status to any welcome calls made to new members by member services. Evaluate additional ways to encourage new enrollees to contact the health plan if they are pregnant.
- Offer incentives to members who notify the health plan early in pregnancy (e.g., store gift certificates, T-shirts).

Identification through Lab Data

- Analyze lab data to identify women who have received an initial prenatal profile (workgroup health plans found this data source more effective than initial pregnancy test codes).

Identification through Claims Data

- Use pharmacy data systems to identify members who fill prenatal vitamin prescriptions.
- Evaluate computer systems to ensure that all systems that capture obstetrical information can be coordinated.

Identification through Enrollment Data

- Work with state to "fast track" Medicaid eligibility for new pregnant members.
- Work with enrollment broker to receive enrollment forms earlier.

Health Plan Case Studies

Harmony Health Plan: A Multi-Faceted Identification Approach

BACKGROUND: Harmony Health Plan, a non-profit plan based in Northeast Illinois with 40,000 Medicaid members, found that while its providers may know which members are pregnant, this information was either not shared with the health plan or the plan did not have a systematic way of evaluating sources of identification.

AIM: Increase identification by 25 percent.

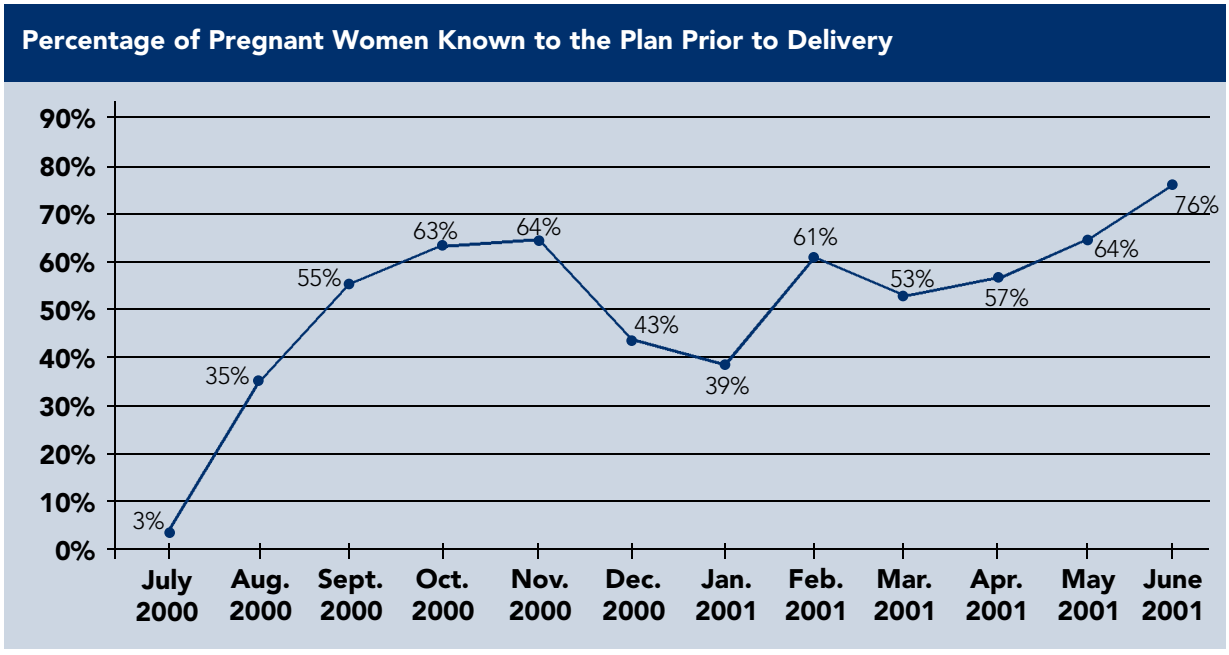
MEASURE: $\frac{\text{\# of pregnant women known to the plan prior to delivery}}{\text{\# of pregnancy delivery claims}}$

CHANGE:

1. **Analyzed state's claims data tapes for pregnancy codes** – Identified members who either self-reported or reported pregnancy through their physician by supplying their "estimated date of confinement."
2. **Provider incentives** – Offered monetary incentive of $25 to office managers to complete obstetrical forms. (Harmony originally targeted the incentive to the providers, but found the strategy more successful with office managers.)
3. **Analyze pharmacy data** – Identified prenatal vitamin prescriptions and compared this list to women known to be pregnant through other sources. Those not known to be pregnant previously were contacted by telephone.

RESULTS/LESSONS LEARNED: Through the changes implemented under BCAP, Harmony increased its identification rate from three percent in July 2000 to 76 percent in June 2001 (Figure 1).

Figure 1: Identification Success Over One Year for Harmony Health Plan



LA Care Health Plan: A Creative Use of Lab Data to Identify Pregnant Women

BACKGROUND: LA Care Health Plan is a non-profit "super" HMO representing seven health plan partners in Los Angeles County. LA Care Health Plan has 600,000 Medicaid enrollees. LA Care found that contacting pregnant women identified through initial pregnancy test results made some members uncomfortable. The plan was therefore seeking alternative identification methods.

AIM: Increase identification of pregnant members to 80 percent within four weeks of enrollment or during the first trimester by analysis of specific lab data.

MEASURE: $\frac{\text{\# of women identified using lab data analysis}}{\text{\# live births for the calendar year in question}}$

CHANGE: LA Care Health Plan identified women using lab data analysis of the initial obstetrical panel (CPT code 80055). This test is different from the initial pregnancy test (ß-HCG) because it tests the mother for blood type, Rh status, rubella immunity, complete blood count, and syphilis.

RESULTS/LESSONS LEARNED: This is a creative way to identify women who are pregnant because it decreases the risks associated with use of pregnancy test data (contacting women who plan to terminate pregnancies) or prenatal vitamins (contacting women who are not yet pregnant or who are nursing). LA Care Health Plan found in a preliminary review of lab data that it could identify 90 percent of pregnancies this way.

CareSource: Provider Incentives to Encourage Early Notification of Pregnancy

BACKGROUND: CareSource is a non-profit, Medicaid-only health plan serving 140,000 members in Ohio. In its BCAP project, CareSource chose to focus on improving its providers' poor rate of pregnancy notification.

AIM: Increase the receipt of the Prenatal Risk Assessment Form (Appendix B) from providers from 10 percent to 35 percent.

MEASURE: $\frac{\text{\# of deliveries for which a complete risk assessment form was received}}{\text{\# of deliveries}}$

CHANGE: CareSource changed its provider reimbursement for submitting Prenatal Risk Assessment Forms. Previously, the health plan offered $10 for these forms and reimbursed only one form per pregnancy. There was no clear policy and the plan often received batches of forms (usually incomplete) after members delivered. The health plan revised its policy, and now pays $10 for each risk assessment form, up to a maximum of three per pregnancy (one in each trimester). For the incentive to be paid, the form must be completely filled out and received within two weeks of the corresponding prenatal visit.

RESULTS/LESSONS LEARNED: With this new incentive, the number of forms CareSource received increased from 10 to 25 percent. This increase has reached a plateau, and the health plan is seeking new ways to improve submission of the risk assessment forms.

Sentara Healthcare: Statewide Collaboration to Reduce Eligibility Waiting Period for Pregnant Women

BACKGROUND: Sentara Healthcare is a for-profit integrated delivery system in Virginia with 71,000 Medicaid enrollees. The waiting period for Medicaid enrollment in Virginia was 60 days. If this waiting period was decreased, pregnant members could be identified faster, and it would increase the chance that the health plan could use meaningful interventions where appropriate.

AIM: Increase identification early in pregnancy for all pregnant members by decreasing waiting period for program entry by 100 percent (zero day waiting period).

MEASURE: $\frac{\text{Existing waiting period – new waiting period}}{\text{Existing waiting period}}$

CHANGE: Sentara Healthcare joined a statewide multi-health plan group to negotiate with the Commonwealth of Virginia to reduce the eligibility waiting period for enrollment.

RESULTS/LESSONS LEARNED: This negotiation was successful in decreasing the waiting period from 60 days to 30 days (50 percent change). The change went into effect 11/1/00. Virginia Medicaid believed that Centers for Medicare and Medicaid Services (CMS) policy prevents completely eliminating the waiting period, but the state is now working with its health plans to research whether there is flexibility within this policy.

Health Plan Action Steps for Identification

My health plan's challenges:

1. _____
_____
_____
_____

2. _____
_____
_____
_____

3. _____
_____
_____
_____

Aim:

Develop an Aim Statement that focuses on increasing the number of women identified earlier in pregnancy. For example: *Increase the number of women identified as pregnant in their first trimester from 10 percent to 40 percent*.

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Measure:

Assess your plan's ability to measure your Aim Statement. Avoid outcome measures (e.g., decrease in low birth weight) and develop measures that link directly to your Aim Statement. Measure this for the initial time period and on an ongoing basis. For example:

$$\frac{\textit{number of pregnant women identified in the first trimester}}{\textit{total number of delivery claims}}$$

Change:

Evaluate current methods of identification and change strategies that will effectively fulfill your Aim Statement. To help you brainstorm, review the change strategies included in this chapter.

Next Steps:

Include staffing issues, funding, timeframes, etc.

Stratification

How can a plan obtain and use health risk information about pregnant members?

Stratification is the process by which a plan determines which subpopulations of pregnant women require more extensive services. How does the health plan determine which members are at risk for poor birth outcomes? How does the plan know which women could benefit from enhanced services available in the community or through the health plan? Health risk assessments are commonly used to identify risk factors that could negatively affect either the mother's or the baby's health. Health risk assessments also can be focused to only capture "modifiable" risks for which the plan may already have programs in place (e.g., smoking cessation, diabetes or asthma management).

While health risk assessments are performed on individual members, stratification can assess the risk of a plan's entire pregnant population. Aggregate data collected from multiple health risk assessments can be analyzed to look for patterns and to determine which risk factors present with the greatest frequency and which members require immediate attention. Samples of health risk assessment tools are included in Appendices B and D.

Common Techniques to Assess Risk and Stratify Populations:

- Identify specific risk factors (e.g., mental illness, drug use, smoking, chronic illness).
- Classify the member's level of risk as high, moderate, or low.
- Determine which risk factors are modifiable (e.g., smoking, homelessness, uncontrolled diabetes).

Common Pitfalls in Risk Assessments:

- Different providers use different risk assessment tools, making it hard to compare results.
- Health plans in the same service area use different risk assessment tools, making it difficult for providers to participate.
- Risk assessment techniques used by health plans and providers may not capture relevant risk information (e.g., if homelessness is an important, modifiable risk factor, does the risk assessment tool capture it?).
- Once members are stratified by risk, how does the health plan determine which risk group will benefit most from a health plan intervention?

Strategies to Improve Member Stratification

Perform Health Risk Assessments:

- Provide an online or voice-activated risk assessment to members who visit the health plan website or who call the plan.
- Contract with the state's enrollment broker to perform initial assessment at the time of enrollment.
- Perform prenatal chart reviews to identify pregnant women with potential risk factors and contact them for further follow up.
- Conduct member calls and home visits to known pregnant members.

Improve the Number of Risk Assessments Received:

- Standardize health risk assessment tools across health plan departments (e.g., member services, case management).
- Standardize health risk assessment tools across health plan providers.
- Standardize health risk assessment tools across health plans.
- Offer provider incentives for timely submission of health risk assessment forms.
- Use enrollment broker to administer health risk assessments.

Maximize the Data in the Health Risk Assessment:

- Designate one department within the health plan for health risk assessment information collection and distribution.
- Establish a process to evaluate health risk assessments received and determine appropriate follow up.
- Develop a decision tool to highlight members with modifiable risk factors.

Health Plan Case Studies

Coventry Health Care of Delaware: Early Stratification of Risk Allows Health Plan to Focus Resources More Efficiently

BACKGROUND: Coventry Health Care of Delaware is a for-profit health plan with 45,000 Medicaid enrollees.

AIM: Increase the number of health risk assessments completed by new enrollees by 80 percent to facilitate early identification of pregnancies and associated co-morbidities.

MEASURE: $\frac{\text{\# of health risk assessments on new pregnant members received by the plan}}{\text{\# of new pregnant members in the health plan}}$

CHANGE: Coventry worked with other Delaware-based health plans, the state Medicaid agency, and the state's enrollment vendor to have the enrollment vendor complete health risk assessment forms at the time of enrollment. Forms are then forwarded to the health plan.

RESULTS/LESSONS LEARNED: Prior to this change, Coventry had a response rate of less than 10 percent for health risk assessments. Under BCAP, Coventry successfully raised this response rate to close to 100 percent. In addition, Coventry often receives the health risk assessment form from the enrollment broker before the member has become eligible for health plan benefits.

Arkansas Foundation for Medical Care: Analysis of Birth Weights by County Yields Results

BACKGROUND: Arkansas Foundation for Medical Care (AFMC) contracts with the State of Arkansas to provide quality improvement services to Medicaid beneficiaries in the state primary care case management program. Lessons learned by AFMC apply not only to primary care case management programs but also to any health plan serving the majority of Medicaid members within a defined geographic area.

AIM: Locate counties with greatest incidence of low birth weight (<2,500 g) and very low birth weight (<1,500 g) babies.

MEASURES: $\frac{\text{\# of babies born in a given county weighing <2,500 g}}{\text{\# of babies born in a given county}}$

$\frac{\text{\# of babies born in a given county weighing <1,500 g}}{\text{\# of babies born in a given county}}$

CHANGE: Using Arkansas Department of Health birth certificate data, AFMC produced a statewide map of birth weights by county (see Appendix C).

RESULTS/LESSONS LEARNED: These maps identified counties with the highest incidence of low and very low birth weight deliveries. In addition, this effort highlighted service areas within the state that had not previously been considered as key areas to focus limited resources. In addition, AFMC analyzed a random sample of medical records to identify inconsistencies with American Medical Association or American College of Obstetricians and Gynecologists guidelines, in order to develop quality improvement activities. AFMC will target three counties and use four counties as control groups.

Neighborhood Health Plan of Massachusetts: A Regional Collaboration to Enhance Provider Reporting

BACKGROUND: Neighborhood Health Plan of Massachusetts is a non-profit, community health center-based plan with 100,000 Medicaid enrollees.

AIM: Increase submission of completed obstetric risk assessment forms by 20 percent from current baseline.

MEASURE: $\frac{\text{\# of completed obstetric risk assessment forms in 2002}}{\text{\# of deliveries in 2002}}$

CHANGE: Neighborhood Health Plan of Massachusetts collaborated with other health plans in Massachusetts to develop a universal obstetrical Health Risk Assessment tool. The health plans agreed on the key elements to include in the tool and agreed to accept only this form from providers. As in many markets, providers in Massachusetts belong to multiple health plan networks and find the unique paperwork required by each health plan an administrative burden. By collaborating on this initiative, the health plans in Massachusetts hope to encourage more providers to submit health risk assessments when there is a universal form in place. A copy of this form is included in Appendix D.

RESULTS/LESSONS LEARNED: This form will be implemented statewide in early 2002.

Health Plan Action Steps for Stratification

My health plan's challenges:

1. _____
_____
_____
_____

2. _____
_____
_____
_____

3. _____
_____
_____
_____

Aim:

Develop an Aim Statement that focuses on increasing the number of women appropriately stratified by the health plan. For example: *Increase the number of women identified as pregnant who receive health risk assessments in the first trimester from 25 percent to 75 percent.*

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Measure:

Assess your plan's ability to measure your Aim Statement. Avoid outcome measures (e.g., increase in gestational age) and develop measures that link directly to your Aim Statement. Measure this for the initial time period and on an ongoing basis. For example:

$$\frac{\textit{number of pregnant women who receive health risk assessments in the first trimester}}{\textit{total number of women identified as pregnant in their first trimester}}$$

Change:

Evaluate current methods of stratification and change strategies that will most effectively fulfill your Aim Statement. To help you brainstorm, review the change strategies included in this chapter.

Next Steps:

Include staffing issues, funding, timeframes, etc.

Outreach

How can a plan reach and deliver services to pregnant members if they do not seek care?

After members have been identified and stratified by risk level, health plans need effective ways to contact members and encourage their use of appropriate health services. Outreach to the Medicaid population is particularly challenging for the following reasons:

- Members move more frequently than commercial enrollees, and addresses provided by the state and/or kept by the health plan are frequently out of date.
- Members may distrust health plan efforts to assist them.
- Members may feel "I'm not sick, I'm just pregnant" and turn down prenatal care outreach efforts.
- Cultural, linguistic, and literacy barriers need to be considered and addressed creatively.

Health plan activities that are often used to reach out to pregnant members and some barriers to their success are listed in Table 3.

Table 3: Common Outreach Strategies

Strategy	Barriers
Telephone Calls to Members	Phone numbers for Medicaid enrollees are often inaccurate. In some markets, many low-income households do not have a phone line.
Mailings to Promote Prenatal Programs	Medicaid members tend to move more frequently than commercial enrollees. Mailing addresses are frequently out of date. Literacy issues also should be considered.
Home Visits by Case Workers or Community Outreach Workers	Home visitors may find it difficult to find members and, once found, may not have success convincing them to come in for services. Plans may have problems recruiting staff willing to conduct visits to inner city or remote rural areas.
Mobile Vans/Community Presence	Need to determine how many of health plan's enrollees will benefit from this service.

Successful health plan outreach efforts identify what members need or value. Health plans might link outreach services to risk factors identified in the health plan's stratification efforts. If a member consistently misses her prenatal appointments, a review of her health risk assessment may reveal that she has inadequate access to transportation. An outreach program designed to help members with social service needs (e.g., housing, transportation, child care) may be more effective in stabilizing a pregnant woman's risk factors than focusing solely on clinical care improvements.

Strategies to Improve Outreach to Pregnant Women
✓ Employ outreach workers, either professional or lay.
✓ Conduct home visits by professional caseworkers.
✓ Send member newsletters regularly.
✓ Conduct outbound calling. • Pilot after-hours and weekend calling. • Track contacts made on an ongoing basis. • If not there after repeated attempts or if no telephone: - Leave message detailing a callback protocol to an 800 number. - Follow up by mail.
✓ Provide a free voice mailbox that pregnant women can use to receive messages.
✓ Provide pregnant women with a cellular phone that has the health plan's and obstetric provider's telephone numbers locked-in.
✓ Offer free phone cards.
✓ Conduct community health fairs.
✓ Conduct outreach at common gathering sites such as food stamp offices or at local grocery stores.
✓ Conduct Internet outreach.

Health Plan Case Studies

Colorado *Access*: A Multi-Faceted Action Plan to Address Outreach

BACKGROUND: Colorado *Access*, a non-profit health center-affiliated plan, with 53,000 Medicaid members, is based in Denver and serves approximately half the counties in Colorado.

AIMS:

1. Establish at least one new health education activity for pregnant members by December 2001.
2. Increase number of referrals to external community resources by 10 percent. External community resources include Women, Infant, & Children (WIC) programs and Prenatal Plus, the state-funded carve-out program for women on Medicaid with high-risk pregnancies.

MEASURES: $\frac{\text{\# of newsletters mailed to identified pregnant enrollees}}{\text{\# of deliveries for the year}}$

$\frac{\text{\# of community service referrals}}{\text{\# of pregnant women identified as high-risk}}$

CHANGES: Colorado *Access* undertook the following activities:

1. Developed the *Special Delivery* newsletter (English and Spanish) as a pilot project for members highlighting importance of good health habits during pregnancy and promoting a prenatal phone line (see Appendix E).
2. Marketed Prenatal Plus, a state funded carve-out program for high-risk pregnancies, offering eye glasses, dental care, lodging services, and mental health and substance abuse care.
3. Collaborated with providers and community agencies to facilitate community service referrals and enhance provider capacity.
4. Formed a Prenatal Market Expansion Work Group to address systems and eligibility issues.

RESULTS/LESSONS LEARNED: In this pilot project, Colorado *Access* used its prenatal vitamin report as the primary means of identifying pregnant women to receive the *Special Delivery* newsletter. In 2000, 15.6 percent (515/3,300) of pregnant members received the newsletter. For the first two quarters of 2001, 18 percent (440/2,455) of pregnant members received the newsletter. There was only a two percent return rate for undeliverable newsletters. Ten percent of newsletter recipients have called into the prenatal phone line for further information. Callers are given a menu to select from when using the prenatal phone line, including case management and resource information and referral.

The main challenge to increasing the number of women who receive the *Special Delivery* newsletter is the difficulty in identifying pregnant women early. While 100 percent of the women identified through the prenatal vitamin report received the newsletter, this report by itself does not capture all pregnant women. To improve identification, Colorado *Access* revised its reimbursement policies to enforce existing service authorization policies. A universal service request form has been developed and must be submitted before services will be reimbursed. There are several pregnancy-related questions on this form, which will be used to identify pregnant members for newsletter receipt as well as for preliminary stratification.

Results on the referral component of the outreach strategy will be available in Spring 2002.

The Bronx Health Plan: Post-Partum Initiative Builds Relationships with New Mothers

BACKGROUND: The Bronx Health Plan, a community health center-affiliated health plan in New York City, has 54,000 Medicaid members. In its efforts to improve outreach to pregnant women, The Bronx Health Plan has focused its resources on a post-partum initiative. Post-partum visits give The Bronx Health Plan providers an opportunity to review family-planning options with their members to increase the intervals between pregnancies.

AIM: Contact 50 percent of high-risk pregnant members by phone or mail to increase the number of women who keep post-partum appointments.

MEASURES:

$$\frac{\text{\# of women reminded to keep post-partum visit}}{\text{\# of women who delivered}}$$

$$\frac{\text{\# of women who scheduled post-partum visits}}{\text{\# of women scheduled for a post-partum visit}}$$

$$\frac{\text{\# of women who kept post-partum visits}}{\text{\# of women reminded to keep post-partum visit}}$$

$$\frac{\text{\# of women who kept post-partum visits}}{\text{\# of women who delivered}}$$

CHANGE: Member Services now contacts new mothers prior to delivery discharge to gather demographic information and facilitate post-partum visits. If the post-partum visit is kept within the prescribed timeframe, the member is given a $25 gift certificate to Giftcertificates.com, an online gift certificate company that offers recipients choices from more than 500 stores.

RESULTS/LESSONS LEARNED: The Bronx Health Plan began this initiative just a few weeks after the BCAP workgroup had its initial meeting. Table 4 compares their most recent results with their baseline measures. Between September 2000 and August 2001, The Bronx Health Plan saw an almost three-fold increase in the number of women who kept post-partum appointments.

Table 4: Results from The Bronx Health Plan Post-Partum Initiative

Measure	Baseline Time Period April-September 2000	Most Recent Period January-August 2001
% of women contacted to keep post-partum visit	23.8% (55/231)	54.0% (191/354)
% of women contacted who scheduled post-partum visit	89.1% (49/55)	79.1% (151/191)
% of women contacted who kept post-partum visit	49.1% (27/55)	56.5% (108/191)
% of women who delivered that kept post-partum visit	11.6% (27/231)	30.5% (108/354)

Health Partners: A Unique Way to Track Outreach Efforts

BACKGROUND: Health Partners of Philadelphia, a non-profit health plan in Southeastern Pennsylvania, has 120,000 Medicaid members.

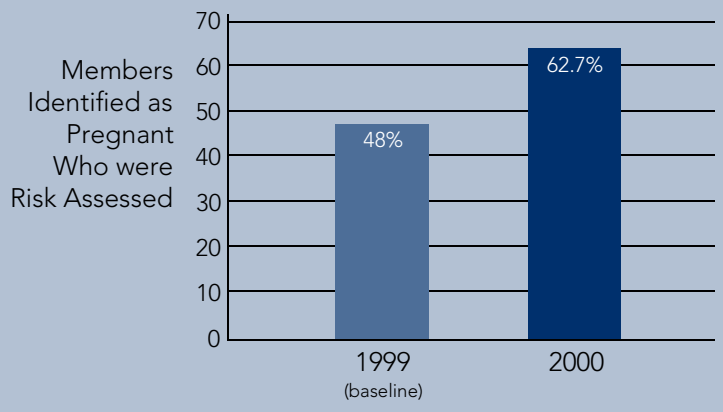
AIM: Increase the percentage of women risk assessed through the Health Partners prenatal program to 55 percent.

MEASURE: $\frac{\text{\# of members risk assessed}}{\text{\# of members identified as pregnant}}$

CHANGE: Health Partners of Philadelphia developed an algorithm to contact newly identified pregnant women. The algorithm identifies various risk factors and then recommends outreach strategies based on each risk factor. Once a pregnant woman is identified through various sources (e.g., providers, inter-departmental referral, the state enrollment broker, pharmacy data), the case is referred to the disease management unit. Members are then classified based on information known at the time of referral. If the disease management unit has an accurate phone number and a completed health risk assessment form from Healthier Babies, Healthier Futures, Inc. (a consortium of health plans in Southeastern Pennsylvania that tracks pregnancy and birth outcome data across health plans (see Appendix F)), then the member is contacted. Different outreach strategies are used depending on the woman's risk classification. If the phone number is inaccurate or if risk assessment information is unavailable, a different set of outreach strategies are employed. A copy of the algorithm is included in Appendix G.

RESULTS/LESSONS LEARNED:

Health Partners Outreach Results



Health Plan Action Steps for Outreach

My health plan's challenges:

1. _____
_____
_____
_____

2. _____
_____
_____
_____

3. _____
_____
_____
_____

Aim:

Develop an Aim Statement that focuses on increasing the number of pregnant women the health plan contacts to make aware of health plan services. For example: *Increase the number of high-risk pregnant women who receive outreach services from the health plan by 10 percent in one year.*

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Measure:

Assess your plan's ability to measure your Aim Statement. Avoid outcome measures (e.g., decrease in C-section rates) and develop measures that link directly to your Aim Statement. Measure this for the initial time period and on an ongoing basis. For example:

$$\frac{\textit{number of high-risk pregnant women who receive outreach services}}{\textit{total number of women stratified as high-risk}}$$

Change:

Evaluate current outreach methods and evaluate change strategies that will most effectively fulfill your Aim Statement. To help you brainstorm, an inventory of change strategies is included in this chapter.

Next Steps:

Include staffing issues, funding, timeframes, etc.

Intervention

What activities can be implemented to respond to member risk factors and improve the potential for healthier newborns?

What *works* to improve outcomes? Unfortunately, we cannot look to the medical literature for a clear answer to this question. Yet, clearly there are unexplained and well-documented disparities in birth outcomes. In New York State, for example, the low birth weight rate for the commercial managed care population is 4.6 percent, while for Medicaid enrollees in managed care it is nine percent.[8] This is an unacceptably disparate outcome and the commercial rate should be regarded as an outcome benchmark for the Medicaid population.

An operating assumption of all plans in the *Toward Improving Birth Outcomes* workgroup is that there **are** interventions that can make a difference, and they probably focus more on "social" risk factor modification than on classic "medical" risk treatment. While this chapter provides examples of some interventions tried by the BCAP plans, many of the activities undertaken in identification, stratification, and outreach also naturally resulted in increased intervention with pregnant members. (For example, The Bronx Health Plan's post-partum initiative was organized as an outreach activity, but resulted in pregnant women having better compliance with post-partum visits).

Health plan activities that are frequently used to treat women with high-risk pregnancies and some barriers to their success are listed in Table 5.

Table 5: Typical Interventions Offered by Health Plans

Intervention	Barriers to Serving Medicaid Enrollees
Early Entry into Prenatal Care	A portion of the Medicaid population may not see pregnancy as a condition needing medical care and may only seek care in the last months of pregnancy.
Case Management	Medicaid beneficiaries may have psychosocial or situational needs (e.g., homelessness) that are not addressed by standard case management programs.
Behavioral Health Coordination	Co-morbidities (e.g., maternal depression) can affect whether prenatal care is sought early in pregnancy. Coordination is complex if behavioral health services are carved out of the health plan's contract.
Smoking Cessation Programs	As one expert puts it, "pregnant women don't refer well." Plans who do offer off-site smoking cessation counseling often report limited participation by pregnant women. The role of nicotine replacement or buproprion treatment in pregnancy is controversial. (See Appendix H for information on smoking cessation interventions during pregnancy).

[8] Bubniak P. and Franco S. "A Report on Managed Care Performance." Bureau of Quality Management and Outcomes Research, New York State Department of Health, 2001. www.health.state.ny.us.

Strategies for Interventions with Pregnant Women
✓ Help members access available state-funded or social services such as WIC, welfare benefits, homeless programs, or March of Dimes programs.
✓ Create a resource directory of community support services on disk or on-line; if necessary, hire a resource specialist.
✓ Educate physicians about available "wrap around" enhanced services.
✓ Provide nutritional supplements to teens and underweight women, who tend to have a higher incidence of pre-term babies.
✓ Include vitamins with folic acid in standard member welcome packages.
✓ Work with obstetricians to provide appointments within three days of initial contact by a pregnant member.
✓ Target interventions to post-partum women to assist in family planning and increase the interval between pregnancies.
✓ Promote the use of multi-vitamins and folic acid as a standard pharmacy benefit for pregnant women or for all women of childbearing age in health plan.
✓ Provide social support programs for pregnant women that convene in-person or via a pregnancy hotline.
✓ Offer incentives to members who complete prenatal and post-partum care.

Health Plan Case Studies

Monroe Plan for Medical Care: Better Care for Pregnant Members with Behavioral Health Needs

BACKGROUND: Monroe Plan for Medical Care is a non-profit Independent Practice Association based in Rochester, New York, with 34,000 Medicaid enrollees. In a retrospective review of its prenatal registration forms, Monroe Plan found that almost 20 percent of the forms identified mental health or chemical dependency (MH/CD) issues.

AIM: Assure that 100 percent of pregnant women identified with MH/CD issues receive appropriate follow-up services through the Monroe Plan Behavioral Health Unit.

MEASURE:

$$\frac{\text{\# of pregnant women with MH/CD issues whose needs are appropriately addressed by health plan}}{\text{\# of pregnant women identified with MH/CD issues by the prenatal registration form}}$$

CHANGE: Monroe Plan developed a formal review process in which relevant prenatal registration forms are reviewed by medical and mental health staff. The program was launched in November 2000.

RESULTS/LESSONS LEARNED: The baseline measure for this program indicated that in November 1999, seven women were identified as having MH/CD needs, but the health plan did not follow up on these assessments. After implementation of this initiative, the plan found that in the first quarter of 2001, 53 women were identified and contacted by the health plan. Of these 53 women:

- Twenty are in chemical dependency therapy.
- Eight are pending chemical dependency therapy.
- Seven have opted out of chemical dependency therapy.
- Twenty-one are receiving mental health therapy.
- Thirteen are pending mental health therapy.
- One refused mental health therapy.

In the second quarter of 2001, 12 women were identified as having mental health or chemical dependency issues; all 12 women have been contacted and only one declined therapy. Monroe Plan also is tracking the longer-term treatment outcomes of these women.

LA Care Health Plan: Revive Successful Fee-for-Service Program to Provide Prenatal Care within Managed Care

BACKGROUND: LA Care Health Plan is a non-profit "super" HMO representing seven health plan partners in Los Angeles County. LA Care Health Plan has 600,000 Medicaid enrollees. The Comprehensive Prenatal Services Program (CPSP) was developed by the state fee-for-service Medicaid program in California to provide appropriate obstetrical care and supplemental services such as health education, nutrition, and social services to pregnant women. However, the decision not to require obstetric providers in the Medicaid managed care program to be CPSP providers and the elimination of additional reimbursement for CPSP supplemental services undermined the availability of these services for LA Care beneficiaries.

AIM: Provide comprehensive prenatal services, including nutrition education/assessment, health education, and social service intervention, to 50 percent of women with risk factors for poor pregnancy outcomes in a defined geographic area.

MEASURE: $\frac{\text{\# of high-risk women receiving CPSP services in a defined geographic region}}{\text{\# of women assessed as high-risk in a defined geographic region}}$

CHANGE: Develop a pilot project establishing regional CPSP supplemental services teams in a defined geographic area. Publicize availability of these teams to prenatal providers and members in the catchment area.

RESULTS/LESSONS LEARNED: LA Care surveyed its providers to determine which ones were still CPSP certified. Few CPSP certified providers remain in LA Care's network and limited, if any, CPSP services are provided to LA Care members. LA Care established an advisory committee to facilitate further project development and performed a geo-mapping analysis of remaining CPSP providers in the LA Care network to determine the best pilot site/region. To date, they have not been able to move this project forward within LA Care due to significant staffing issues and budgetary concerns. However, in its original exploration of the project, LA Care established a relationship with Community Outreach for Prevention and Education (COPE), a community organization in Venice, CA. Based on LA Care's project plan, COPE developed a similar project on a smaller scale. COPE has since contracted with five different hospital systems to provide CPSP services and is interested in working with LA Care to expand the program countywide.

Harmony Health Plan: Folic Acid Supplements Sent to Members

BACKGROUND: Harmony Health Plan is a non-profit plan based in Northeast Illinois with 40,000 Medicaid members. Each month, Harmony Health Plan sends a letter to all member families with a choice of several packages they can receive as a benefit under their health plan membership. "Harmony +10" packages are then sent the following month and include items such as: skin lotions, Tylenol, thermometers, baby powder, sun screen (seasonal), and Band-Aids.

AIM: Encourage 100 percent of plan members who are women of child-bearing age to take folic acid. The ultimate goal is to reduce the frequency of neural-tube defects in member pregnancies.

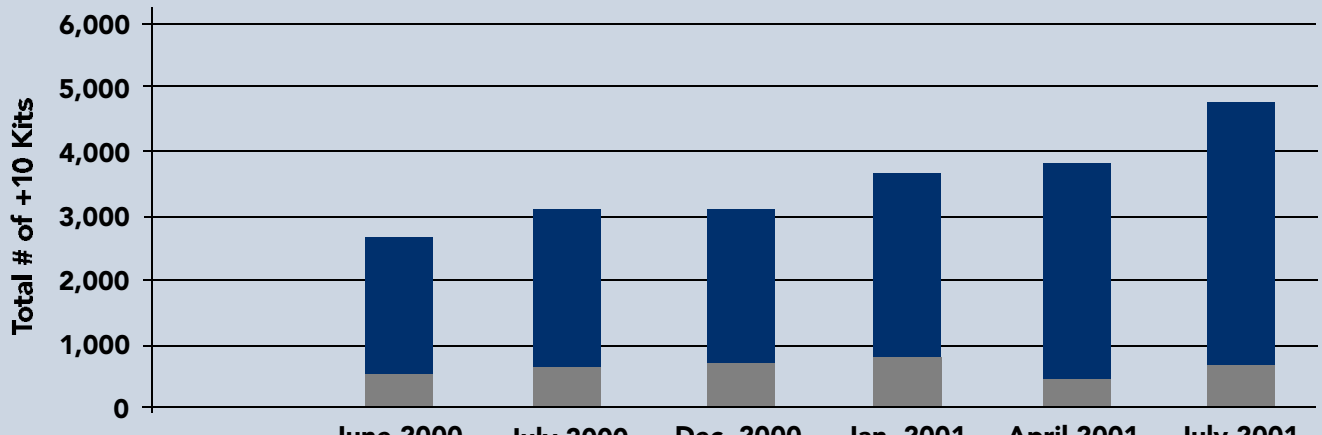
MEASURE: $\frac{\text{\# of women who choose "Harmony +10" package with folic acid}}{\text{\# of women of child-bearing age}}$

CHANGE: The "Harmony +10" program offers several "kits" of different products worth up to $10 each month per family. Once a quarter, folic acid is added to one of the available kits to encourage use by women of childbearing age.

RESULTS/LESSONS LEARNED: Harmony Health Plan offers folic acid kits periodically throughout the year. Figure 2 illustrates that between 10 to 25 percent of members select "Harmony +10" folic acid kits each time it is offered. Harmony is pleased with the success of this new program. The variation in response rate depends on what other packages were offered during the month and whether those items were more attractive than this kit. (Harmony finds that baby thermometers are a popular item.)

Figure 2: Harmony Health Plan of Illinois Folic Acid Intervention

"Harmony +10" Member Benefit Package



	June 2000	July 2000	Dec. 2000	Jan. 2001	April 2001	July 2001
+10 Folic Acid Kits	527	581	690	832	451	676
+10 Kits (Non-Folic Acid)	2,190	2,533	2,423	2,852	3,325	4,114
% of Total Kits	19.30%	18.60%	22.10%	22.50%	11.90%	14.10%

Monroe Plan for Medical Care: Smoking Cessation Program for Pregnant Members

BACKGROUND: Monroe Plan for Medical Care is a non-profit Independent Practice Association based in Rochester, New York, with 34,000 Medicaid enrollees. In 1999, a review of the Monroe Plan perinatal database revealed that approximately 43 percent of the plan's pregnant members were smokers. The health plan decided to develop a pilot program to provide smoking cessation services for pregnant women.

AIM: Decrease smoking in pregnant women at pilot site by 20 percent.

MEASURE: $\frac{\text{\# of women at pilot site who stop smoking by the end of pregnancy}}{\text{\# of women identified as smokers by the prenatal registration form}}$

CHANGE: The Monroe Plan engaged the services of a smoking cessation physician specialist to provide a smoking cessation program one day per week at one of the high-volume obstetric sites for the Monroe Plan.

RESULTS/LESSONS LEARNED: This approach to smoking cessation among pregnant women was unsuccessful. Recent turnover in the pilot health center, as well as lack of provider education about the importance of such a program, contributed to this failure. However, the health plan intends to continue its attempts by compensating obstetricians for counseling pregnant members on smoking cessation techniques.

Health Plan Action Steps for Intervention

My health plan's challenges:

1. _____
_____
_____
_____

2. _____
_____
_____
_____

3. _____
_____
_____
_____

Aim:

Develop an Aim Statement that focuses on increasing the number of pregnant women who receive intervention services. For example: *Increase the number of high-risk pregnant women who receive mental health/chemical dependency services from the health plan by 15 percent in one year.*

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Measure:

Assess your plan's ability to measure your Aim Statement. Avoid outcome measures (e.g., decrease in number of babies born with fetal alcohol syndrome) and develop measures that link directly to your Aim Statement. Measure this for the initial time period and on an ongoing basis. For example:

$$\frac{\textit{number of pregnant women receiving mental health/chemical dependency services at the end of the year}}{\textit{number of pregnant women who received these services at the beginning of the year}}$$

Change:

Evaluate current interventions for women with mental health/chemical dependency needs and change strategies that will most effectively fulfill your Aim Statement. To help you brainstorm, review the change strategies included in this chapter.

Next Steps:

Include staffing issues, funding, timeframes, etc.

Communicate to Create Change

Without effective communication, internal and external, even the best quality improvement ideas will falter moving from theory to reality. Good communications strategy can solidify buy-in within your organization and, externally, can facilitate collaboration with states, enhance support from providers and their staffs, and increase understanding by and compliance from enrollees.

Good communications strategy is largely common sense: Whom do I need to reach to make this initiative as successful as possible? What does the target audience(s) need to know? How do I reach the audience(s)? Successful communications hinges on committing time at the onset of a project to answer these questions and outline a consistent strategy to deliver your message.

Identify Your Audiences

The first step in developing a communications strategy is to define your audience. Internal audiences are essential to building organizational support for your project. Think beyond the team working on your quality improvement project. You might ask, "Whose cooperation do I ultimately need to keep this project moving?" It might be information services contacts whom you rely on for data extraction, front-office staff who answer calls and direct enrollees to case managers, and/or a senior executive whose approval you need for additional staffing support.

Keep your plan's marketing/communications staff aware of your activities. Their support and knowledge of your activities is vital to promoting your accomplishments in established communications vehicles, including internal and/or external plan newsletters, press releases, and media outlets.

Potential Audience

Internal:
- Health Plan CEO
- Information Services
- Claims Department
- Quality Improvement
- Marketing/Communications
- Member Services

External:
- Members
- Providers
- State health purchasers
- Other health plans
- Consumer organizations
- Media

External audiences include anyone outside your plan whose cooperation is necessary to achieve pilot program goals as well as anyone who would be interested in the successful outcome of the initiative. For example, clear communication with providers and their office staff is critical in successfully identifying members, assessing risk, and implementing interventions. Outreach activities for members require communications tactics geared specifically toward their specific needs and desires.

State Medicaid/SCHIP contacts should not be overlooked as an audience. Keeping states aware of plan quality initiatives and accomplishments will go far in building collaborative partnerships toward a common goal of quality care for Medicaid beneficiaries.

Colorado *Access* Recognition Letter

Merely taking the time to send a letter can be a stepping-stone to building partnerships and garnering support from key external audiences. After Colorado *Access* participated in the BCAP *Toward Improving Birth Outcomes* workgroup, the plan informed the state's Medicaid director of its accomplishments under BCAP. Shortly thereafter, the state Medicaid director sent a letter to Colorado *Access*' Chief Executive Officer, lauding their quality improvement effort.

Define Your Messages

Once you identify audiences to reach, the next step is crafting a compelling message to reinforce at every opportunity. In most cases, you will start with your overall Aim Statement linked to your quality initiative and reframe it slightly for each audience depending on their perspective. Internally, you may use the same message with different gradations based on your audience. To help revise the message for each audience, answer the following: *Why do they care?* and/or *How will it help them?* The message should be simple and easy to remember, for example:

- **Internal** – ***Increase identification of ABC Health Plan pregnant members in the first trimester by 25 percent in 2001.*** This is important for ABC Health Plan because it will potentially lead to an increase in healthier births and cost savings for high-risk pregnancies.
- **Providers** – ***Submit obstetrical health risk assessment forms for members in the first trimester and receive a $50 incentive.*** This is important for providers because reimbursement will increase and patients will receive more coordinated care.
- **Members** – ***Positive pregnancy test? Visit your doctor now to keep you and your baby healthy.*** This is important for a pregnant member because she increases her chance for a healthier birth.
- **State** – ***ABC Health Plan is working to improve birth outcomes by identifying members earlier in their pregnancies.*** This is important for the state because pregnant members will ultimately receive higher quality, more responsive, and more cost-effective care.

Use Communications Tools Creatively

Effective communications need not break the budget, or require intensive time commitment. A successful communications strategy could entail tactics as simple as distributing a clearly written e-mail status report on a monthly basis to important internal contacts. Posting graphics in a public location showing ongoing results of your project provides recognition for team members and can build support and enthusiasm throughout the organization. The key to employing communications tools effectively is consistent use, reinforcement, and gearing tools for specific audiences. *Your communications strategy will guide the specific tools or tactics that you use.*

Samples of communications tools include:

- Letters, memos.
- Quarterly internal updates.
- Quality improvement status meetings.
- Quality improvement e-mail updates.
- Newsletters (print or e-mail).
- Web site.
- Posters, flyers.
- Standardized presentation.
- Press releases.
- List-servs.

Measure Effectiveness of Communications

Measure the effectiveness of your communications strategy to determine what works and does not work for your target audiences. Define the desired response of your communication up front (e.g., consistent use of a new form, cooperation with a new procedure, referrals, etc.). Then, when you review overall outcomes of your quality initiative, devote time to examine how your communications strategy met the overall goal of the project. If the target audience did not respond appropriately, you may want to rethink your communications strategy to reach them more effectively.

Thinking "Beyond the Box" to Communicate with Providers

Americaid Community Care of Illinois, a participant in CHCS' BCAP workgroup on *Improving Preventive Care Services for Children*, developed a strategy to communicate with providers to work toward increasing HEDIS scores for well-child visits by 10 percent between 2000 and 2001. These strategies also can be used with obstetric providers. Communications tactics include:

- One-on-one meetings with the 20 highest-volume physician offices.
- Quarterly "Quality Care Forums" – breakfast meetings with physicians and office staff.
- "Outstanding Physician Award," which honored eight physicians who scored 99 to 100 percent on the 2000 annual medical records audit. Americaid pursued local media recognition for the physicians who received the award.

Appendices A-J

Appendix A

Toward Improving Birth Outcomes
Improvement Documentation Form

PLAN NAME: _____

Category: ❑ Identification ❑ Stratification ❑ Outreach ❑ Intervention

Aim Statement:	
Measure(s):	_____
Change:	

Implementation Plan:

Who:	
What:	
When:	
Training:	
Communication:	
Troubleshooting:	

Appendix B

careSource

PRENATAL RISK ASSESSMENT FORM

(Please print or type)

Patient/Member Name:	Physician Name:	Expected date of delivery (EDD): (mo/day/yr)
Member ID #:	Physician Telephone:	Please circle diagnostic code for this assessment: **V22** **V23**
Patient Address:	Provider Number:	Please circle trimester of pregnancy: **1st** **2nd** **3rd**
Patient Telephone:	Please complete and mail to **One Dayton Centre, 1 S. Main St., Dayton, OH, 45402** or fax to **(937) 224-3388**. Forms must be received within 4 weeks of date of service.	

At Risk of Preterm Birth

Please check all that apply. If at least one factor is checked, patient is at risk of preterm birth – V23.8

Obstetrical History

- ☐ 1. Abortion, 1st or 2nd trimester, spontaneous or therapeutic
- ☐ 2. Cone biopsy
- ☐ 3. DES exposure
- ☐ 4. Eclampsia or severe pre-eclampsia
- ☐ 5. Incompetent cervix
- ☐ 6. Low birth weight, less than 2500 g
- ☐ 7. Preterm delivery/labor

Current Pregnancy

- ☐ 8. Abdominal surgery
- ☐ 9. Age, less than 19 or more than 35 years
- ☐ 10. Anemia, less than 11 hgb or less than 33% hct
- ☐ 11. Anemia, Sickle Cell or other hemoglobinopathy
- ☐ 12. Asthma, on medication
- ☐ 13. Bleeding, if significant after 12 weeks
- ☐ 14. Cervix dilated, more than 1.5 cm before 29 weeks
- ☐ 15. Cervix effaced, less than 1 cm before 29 weeks
- ☐ 16. Chronic bronchitis
- ☐ 17. Diabetes, insulin dependent
- ☐ 18. Domestic violence
- ☐ 19. Drug or alcohol abuse
- ☐ 20. Eclampsia or pre-eclampsia
- ☐ 21. Heart disease
- ☐ 22. Hypertension, on medication
- ☐ 23. Irritable uterus
- ☐ 24. Late initial visit, after 14 weeks of pregnancy
- ☐ 25. Malignancy or leukemia
- ☐ 26. Missed prenatal appointments
- ☐ 27. Multiple gestation
- ☐ 28. Oligohydramnios
- ☐ 29. Placenta previa, 3rd trimester
- ☐ 30. Pneumonia
- ☐ 31. Polyhydramnios
- ☐ 32. Poor nutrition
- ☐ 33. Prenatal care noncompliance, most recent pregnancy
- ☐ 34. Preterm labor
- ☐ 35. PROM, confirmed
- ☐ 36. Kidney disease, UTI (urinary tract infections)
- ☐ 37. Smoking
- ☐ 38. Trauma
- ☐ 39. Underweight
- ☐ 40. Uterine anomaly or fibroids
- ☐ 41. Weight loss
- ☐ 42. Other (please specify):

At Risk of Poor Pregnancy Outcome

Please check all that apply. If at least one factor is checked, patient is at risk of poor pregnancy outcome – V23.9

Obstetrical History

- ☐ 43. Congenital anomaly, major
- ☐ 44. Infant death - stillborn, neonatal, post-neonatal

Current Pregnancy

- ☐ 45. Anesthesia-related allergies
- ☐ 46. Deep venous thrombosis
- ☐ 47. Diabetes, gestational, diet-controlled
- ☐ 48. Drug or alcohol abuse
- ☐ 49. Epilepsy or on anticonvulsant
- ☐ 50. Familial genetic disorder, confirmed
- ☐ 51. Grand multipara, more than 5 of 20 weeks or more
- ☐ 52. Group B Streptococcal disease
- ☐ 53. Height, less than 5 feet
- ☐ 54. Hepatitis or chronic liver disease
- ☐ 55. HIV/ARC/AIDS
- ☐ 56. Illiteracy or language barrier
- ☐ 57. Isoimmunization associated with fetal disease
- ☐ 58. Mental retardation
- ☐ 59. Obesity, more than 20% weight for height
- ☐ 60. Prior C-section
- ☐ 61. Psychosis, within past 5 years
- ☐ 62. Recent delivery, less than 1 year
- ☐ 63. Rubella exposure with rising titer
- ☐ 64. Sexually transmitted disease, any
- ☐ 65. Thyroid disease, confirmed
- ☐ 66. Tuberculosis, active
- ☐ 67. Other (please specify):

Physician's Signature:	**Date:**

Appendix C

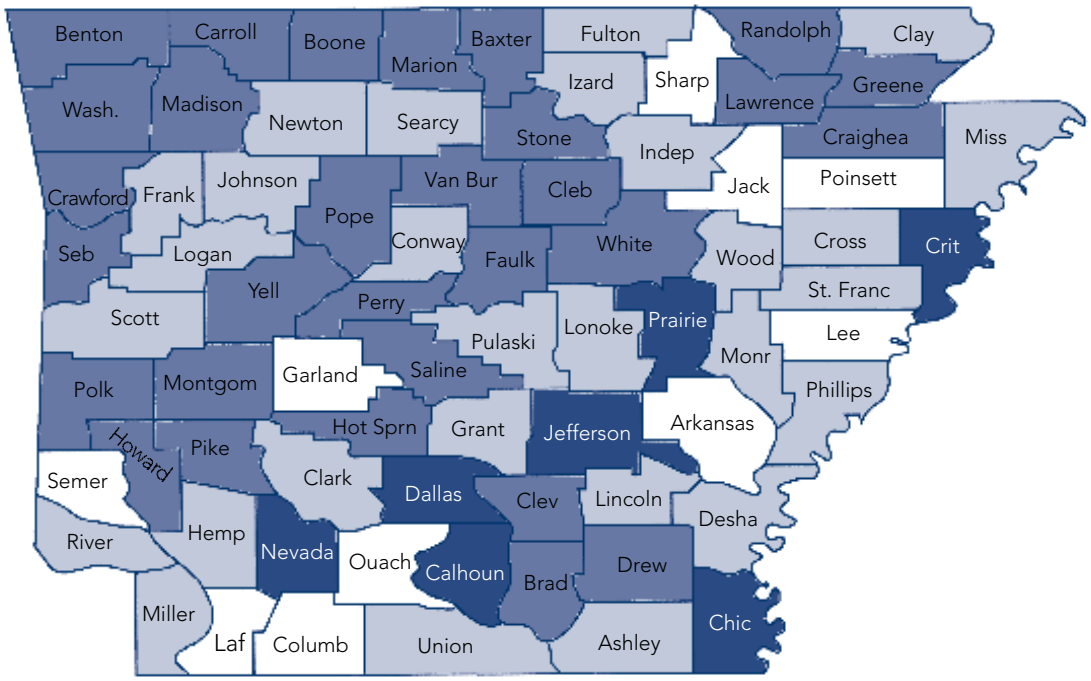
Arkansas Foundation for Medical Care Analysis of Low Birth Weights by County

Percent of deliveries that were under or equal to 2,500 grams – 1997 and 1998, n=6,303

Total deliveries – 73,281

Rate

- rate < 8%
- 8% ≤ rate < 10%
- 10% ≤ rate < 12%
- 12% ≤ rate < 16%



Source: Arkansas Department of Health

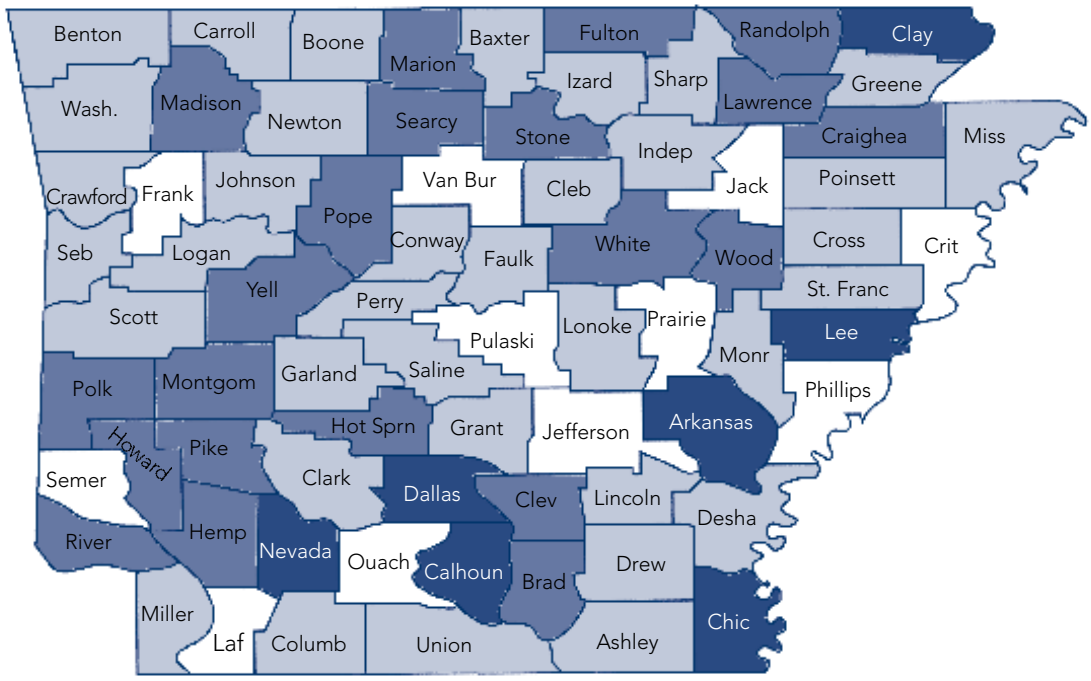
Arkansas Foundation for Medical Care Analysis of Very Low Birth Weights by County

Percent of deliveries that were under or equal to 1,500 grams – 1997 and 1998, n=1,148

Total deliveries – 73,281

Rate

- rate < 1%
- 1% ≤ rate < 2%
- 2% ≤ rate < 3%
- rate ≥ 3%



Source: Arkansas Department of Health

Appendix D

Massachusetts Health Quality Partners Obstetrical Risk Assessment Form

Name _____ Health Plan & Subscriber ID#_____
Last First Middle

Address _____
street Apt.# City State zip

Phone: Home_____ Work:_____ Date of Birth: _____

Obstetrical Clinician's Name:_____ OB Provider ID#_____

Obstetrical Provider's Phone#_____ Fax: _____ EDC:___/___/___

Planned Hospital for Delivery: _____ 1st Prenatal Visit Date: ___/___/___

Race: White ❑ Black ❑ Asian/Pacific Islander ❑ American Indian ❑ Other ❑ Ethnicity: Hispanic ❑ Non Hispanic ❑

Language spoken at home_____ Needs translatiion help Y ❑ N ❑ Support System Y ❑ N ❑

Behavioral Risks

Smoking Status

Smokes regularly now, about the same as prior to pregnancy. Y ❑ N ❑

Smokes regularly now but less than prior to the pregnancy. Y ❑ N ❑

Smokes every once and a while. Y ❑ N ❑

Quit smoking since becoming pregnant. Y ❑ N ❑

Wasn't smoking when became pregnant and doesn't smoke now. Y ❑ N ❑

Substance Abuse

Is the patient currently using alcohol? ..... Y ❑ N ❑

Is the patient currently street drugs? ..... Y ❑ N ❑

In the month prior to pregnancy:

How many drinks did the patient consume in one week? _____

On how many occasions did the patient have more than 3 drinks? _____

On how many occasions did the patient have any drugs? _____

Occupational Demands Sedentary ❑ Active ❑ Hours spent standing_____

Psychosocial Assessment completed Y ❑ N ❑

Psychosocial risk factors identified: (please circle) 1. frequent moves 2. care access 3. hungry 4. education 5. safe 6. violence 7. stress 8. pregnancy planning

Obstetrical High Risk/ Pre-Term Labor Assessment

Gravida_____ Full Term_____ Pre-term_____ Abs_____ Living _____ Height:_____ Weight:_____

Previous C/S? Y ❑ N ❑ VBAC discussed ❑ VBAC planned ❑ VBAC refused ❑ VBAC medically inappropriate ❑

Risk Factors: Past OB/GYN History Including Past Pregnancies **Initial Screen date** ___/___/___

Pre-term labor with previous pregnancy (less than 37 weeks) ..... Y ❑ N ❑

Pre-term delivery with previous pregnancy (less than 37 weeks) ..... Y ❑ N ❑

Diagnosis associated with pre-term delivery (narrative)_____

Incompetent cervix Y ❑ N ❑ Cerclage with previous pregnancy Y ❑ N ❑

DES Exposure ..... Y ❑ N ❑

Two or more 2nd trimester abortions ..... Y ❑ N ❑

Delivery within the past 12 months ..... Y ❑ N ❑

Prior cone biopsy Y ❑ N ❑ Known uterine anomalies Y ❑ N ❑

Uterine fibroids Y ❑ N ❑ Myomectomy Y ❑ N ❑

Risk Factors: Current Pregnancy **26-28 weeks screening date** ___/___/___

ART this pregnancy Y ❑ N ❑ Gonadotropin Y ❑ N ❑ Clomophine Y ❑ N ❑

Multiple gestations Y ❑ N ❑ Fetal reduction Y ❑ N ❑

Presence of Bacterial Vaginosis this pregnancy Y ❑ N ❑ Treatment for BV Y ❑ N ❑

Bleeding after 12 weeks this pregnancy ..... Y ❑ N ❑

Pre-term labor this pregnancy Y ❑ N ❑ Cervical changes Y ❑ N ❑ Cerclage Y ❑ N ❑

Placenta previa beyond 26 weeks, this pregnancy ..... Y ❑ N ❑

Polyhydramnios this pregnancy ..... Y ❑ N ❑

Pregnancy Induced Hypertension this pregnancy ..... Y ❑ N ❑

Gestational diabetes this pregnancy ..... Y ❑ N ❑

Other Risk Factors current or past pregnancy (narrative)_____

I hereby authorize the Provider indicated herein to release the information on on this from to the named Health Plan

Signature of Member Date Signature of Provider Date

Please fax this form to the appropriate office based on patient's health insurance (see information printed on back) Updated 2/16/01

Appendix E

Colorado *Access* Special Delivery Newsletter

THE FIRST EDITION

Welcome!

Congratulations on your new pregnancy! It must be a very exciting time in your life. For many of you, pregnancy is one of the only times you will have regular contact with the healthcare system. For first-time moms, everything about pregnancy is new, exciting, and a little scary. Even experienced mothers have lots of questions during their pregnancy. It is never too early to help you and your baby have a healthy pregnancy. Eating well, getting lots of sleep and getting early and ongoing prenatal care are a few ways you can make a difference.

As your health plan, we can help you access the best health care services. Our Prenatal Services will help you have a healthy pregnancy. This newsletter will help you understand your benefits, and the health care system. One of the best ways to do this is to take responsibility for your health. The first step is definitely the hardest, but you've already done it! If you are reading the First Edition of *Special Delivery*, you have obtained healthcare coverage and started prenatal care. Great Job!

Selecting Your Health Care Providers

All members of Colorado *Access* have an obstetrician or other health care provider during pregnancy. It is very important for you to schedule regular visits for routine prenatal care and women's health care services during this time. As a pregnant member of Colorado *Access*, you can select any prenatal care provider in the Colorado *Access* network without a referral.

For more information on choosing your prenatal care provider from the Colorado *Access* network, contact Member Services at 1-866-833-5717, prompt 2, and *ask about direct access to OB/GYN care.*

Benefits for Obstetrical Care

Colorado *Access* is a health plan that provides health coverage for pregnant women enrolled in Medicaid and Child Health Plan Plus. Benefits for pregnant members include all routine prenatal care, laboratory tests, emergency observations, home health care services and hospital stays for you and your baby. Diagnostic ultrasounds are also a covered benefit. Other testing is available for our high-risk members! Your prenatal care provider decides on treatments and needed services for care during your pregnancy. Nurses and doctors may review some services to make sure your health care needs are being met. Co-payment for services may be required for Child Health Plan Plus members.

If you have questions about benefits and covered services, please refer to your Member Handbook or call our Member Services Department at 1-866-833-5717, press 2.

QUESTIONS about your pregnancy?
Write them down and ask your health care provider at your next prenatal appointment.

About Colorado *Access*

Colorado *Access* is a private, nonprofit health plan serving the medical and behavioral health needs of more than 130,000 of Colorado's medically underserved residents. Colorado *Access* was founded in 1994 by the Children's Hospital, Colorado Community Managed Care Network, Denver Health, University of Colorado Hospital, and University Physicians, Inc.

We provide medical services as well as health education and preventive health care services.

Preventive Health Programs

- Childhood immunizations
- Well-child check-ups
- Vision services
- Flu shots
- Mammograms
- Cervical cancer screening

Perinatal Program

- Care coordination services for high risk moms and babies
- Health education materials
- Member outreach
- *Access* Baby Care Program

Asthma & Diabetes Programs

- Health education materials
- Care Coordination Services
- Medical Supplies (for example, glucometers, spacers, nebulizers, etc.)
- Prescription benefits

Look for a new edition of *Special Delivery* in the mail

If you have had an unexpected termination of pregnancy or got this newsletter by mistake, please call Mary Gomez Chambers at 1-866-833-5717, press 6.

FREE Prenatal Vitamins

Prenatal Vitamins are FREE for Medicaid members. Simply, ask your prenatal care provider for a prescription.

Then, take it to your local pharmacist along with your Colorado *Access* Medicaid card. If you are a Medicaid member and have had difficulty getting your prenatal vitamins, please call Pharmacy Services at 1-866-833-5717, press 3.

Choosing the Ideal Health Plan

Once you receive Medicaid, you should contact Health*Colorado*, the enrollment broker for the State, to choose a health plan. Colorado *Access* is one of your choices. If a health plan is not chosen within sixty-five days, Health*Colorado* will choose one for you. This process is repeated every six months. After being enrolled in a health plan for six months. You can call the enrollment broker at 1-888-367-6557 to change your health plan.

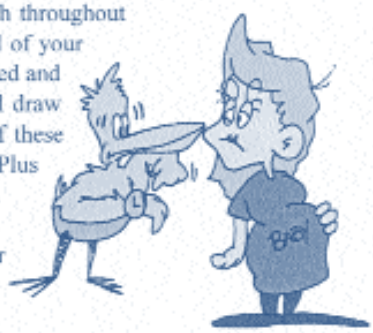
Colorado *Access*, the State's largest Medicaid health plan is a great choice for pregnant members.

"Our network of doctors and specialist are trained to care for high-risk moms and babies."

Importance of Early & Ongoing Prenatal Care

Prenatal Care is the medical care you receive while you are pregnant. Most health care providers believe prenatal care is the key to a healthy pregnancy and healthy baby.

Prenatal care begins with a visit to your health care provider when you first think you are pregnant. You will continue to have prenatal visits every month throughout your pregnancy and more often as your due date draws near. At all of your prenatal visits, you will be weighed, have your blood pressure checked and your urine tested. At your first visit, your health care provider will draw your blood to be tested and will prescribe prenatal vitamins. All of these services are free benefits from Colorado *Access*. Child Health Plan Plus members may have a small co-pay for prescriptions and office visits.



If you have questions about prenatal care, appointment availability or prenatal vitamins, call the Colorado *Access* Medical Management Department at 1-866-833-8717, press 1, and *ask to speak to someone in Prenatal or Pharmacy Services.*

How Smoking Affects Your Baby

Smoking is known to harm your baby's health and is associated with miscarriage, premature birth and low infant birth weight. Every cigarette you smoke prevents your unborn baby from getting food and oxygen *(see picture)*.

If you are interested in getting more information on quitting smoking or the effects of smoking during pregnancy, please contact your health care provider or Colorado *Access* Medical Management Department at 1-866-833-5717, press 1. *Ask to speak to someone in Prenatal Services.*

Source: Center for Disease Control

Gaining Weight?

GREAT!! Weight gain during pregnancy ensures adequate birth weight for your baby. Where does the weight go?

Baby	7-8 pounds
Placenta	1-2 pounds
Amniotic Fluid	2 pounds
Uterus	2 pounds
Blood Volume	3-4 pounds
Fluid, fat, breast tissue	10 pounds

All of these changes are normal and associated with healthy changes during pregnancy.

Appendix F

Healthier Babies, Healthier Futures, Inc.: A Regional Collaborative of Medicaid Plans to Improve Identification and Stratification of Pregnant Women

When Pennsylvania announced plans to create the HealthChoices program of mandatory Medicaid managed care in Philadelphia and four surrounding counties, Health Partners – one of four plans operating under HealthChoices – saw an opportunity to coordinate and standardize an approach to prenatal data collection. Among the four plans, there are 15,000 deliveries and more than 100,000 prenatal visits annually.

Health Partners worked with the other three plans to develop Healthier Babies, Healthier Futures, Inc., a non-profit corporation built on a stakeholder governance model. Healthier Babies, Healthier Futures, Inc. was made possible through financial support from the Center for Health Care Strategies and The Robert Wood Johnson Foundation. All plans agreed to forego previous risk assessment approaches (three different forms, various telephone protocols) and use one standard written form (the Universal Prenatal Encounter Form, or UPEF). Healthier Babies, Healthier Futures, Inc. receives all the forms and enters them into a relational database that each plan can access for clinical information about its pregnant members. These data are then linked to the electronic birth certificate database maintained by the Pennsylvania Department of Health. Through a coordinated provider communications strategy, prenatal care providers were educated to complete a UPEF each time any pregnant member receives services.

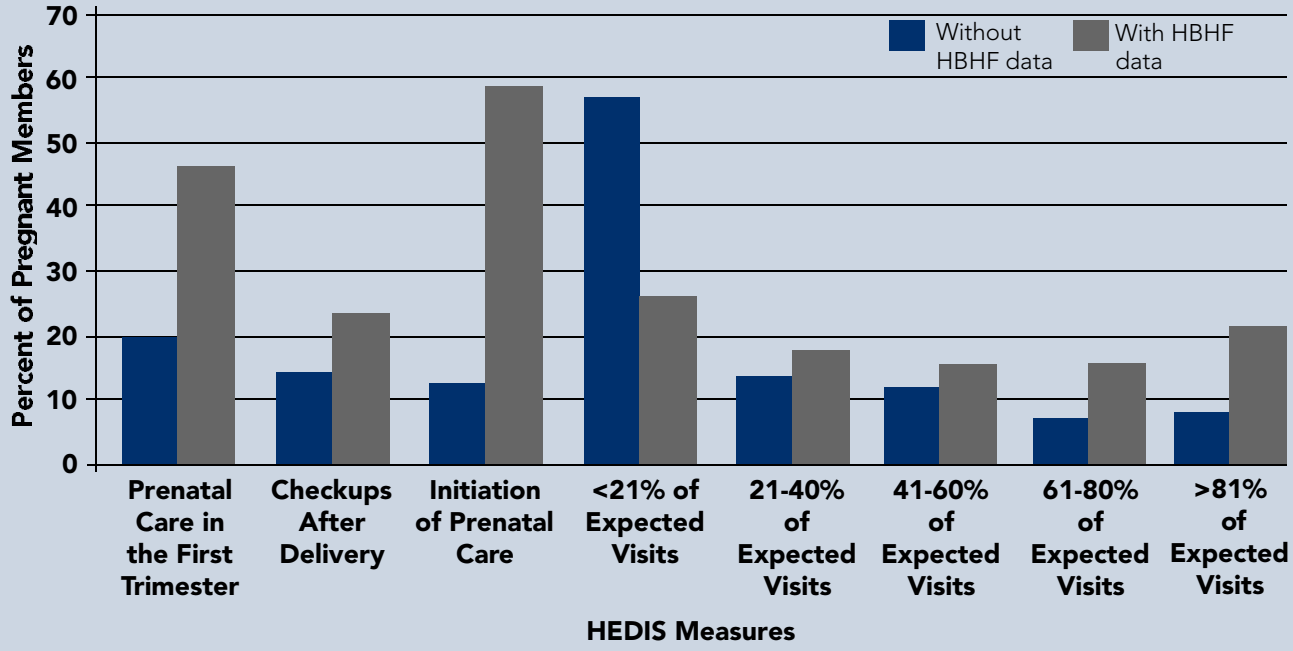
The results of this standardization strategy are impressive:

- A large volume of the universal risk assessment forms are submitted annually, representing 80-90 percent of all expected encounters.
- Adding this data to standard claims and encounter data significantly improved HEDIS scores for prenatal care. (See charts on page 57.)
- The prevalence of selected risk factors in the population reflected some under-reporting but still maintains face validity.
- Correlating clinical data from the universal risk assessment forms with birth certificate-derived outcome data allowed Healthier Babies, Healthier Futures, Inc. to calculate the relative risks for poor birth outcome of different risk factors.

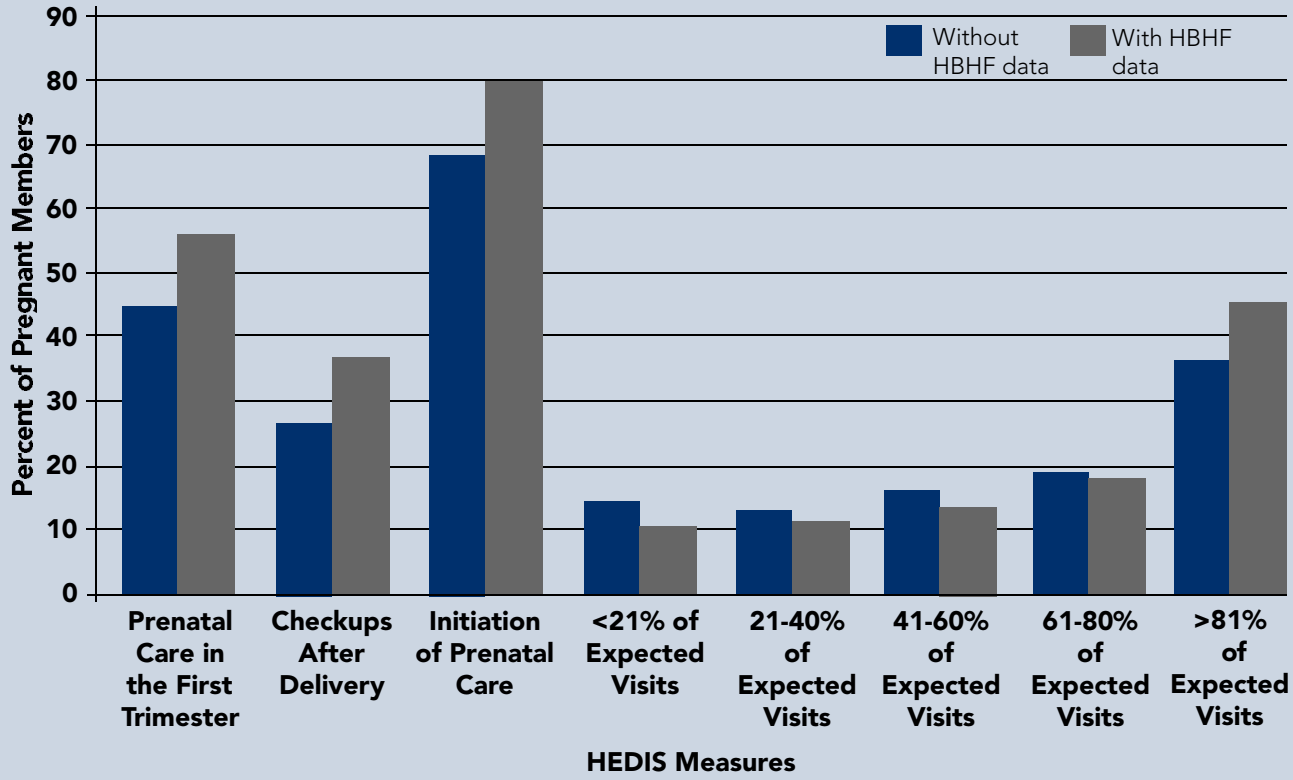
The health plans are now working with the behavioral health carve-out contractor to target behavioral health risk factors for a coordinated approach. They are working on developing ideal clinical capacity and administrative procedures to meet the needs of pregnant women with behavioral health issues.

HEDIS Improvements Using Healthier Babies, Healthier Futures, Inc. Data

Health Plan A: HEDIS Improvement Using Healthier Babies, Healthier Futures, Inc. Data



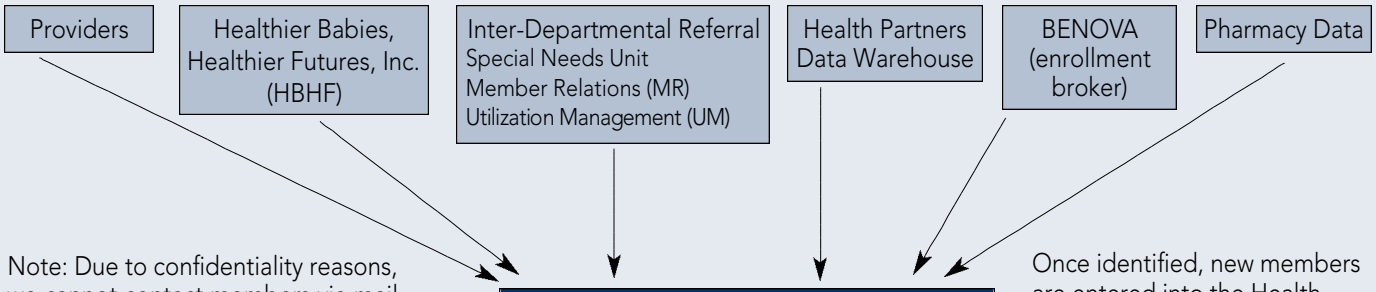
Health Plan B: HEDIS Improvement Using Healthier Babies, Healthier Futures, Inc. Data



Appendix G

Health Partners of Philadelphia Prenatal Program Outreach Algorithm

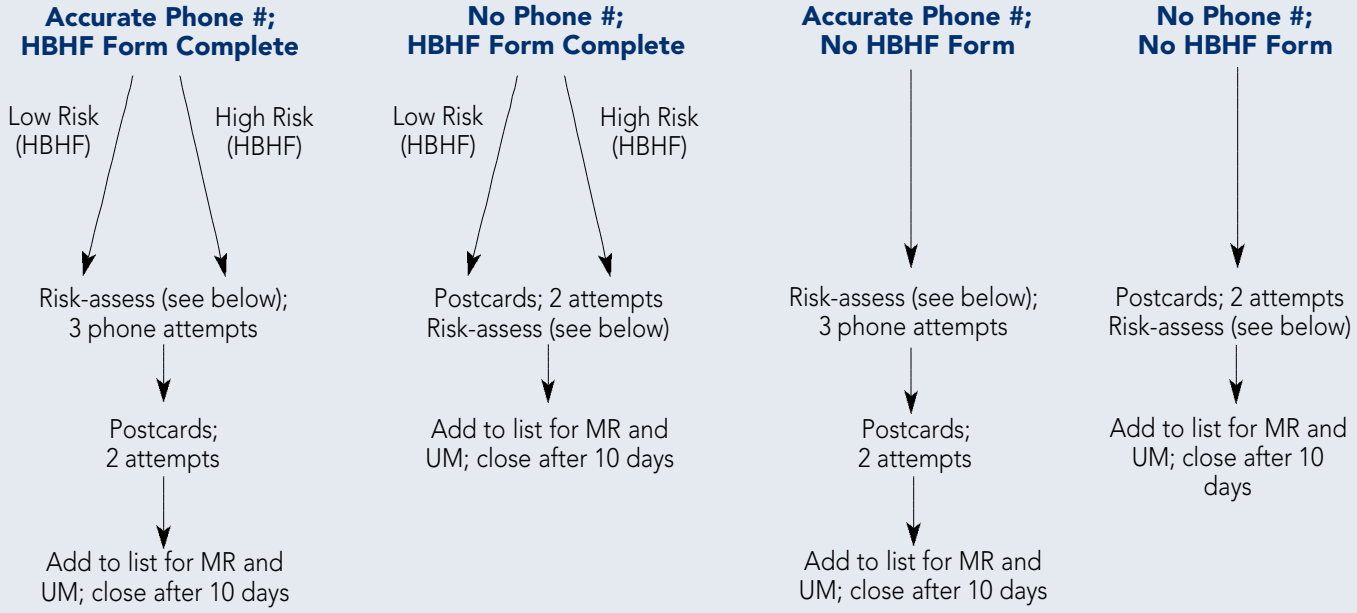
Member Identification



Note: Due to confidentiality reasons, we cannot contact members via mail without their informed consent. Therefore, telephone interview or HBHF data are the two mechanisms for risk stratification.

Once identified, new members are entered into the Health Management System and the identification source is noted in the database for tracking.

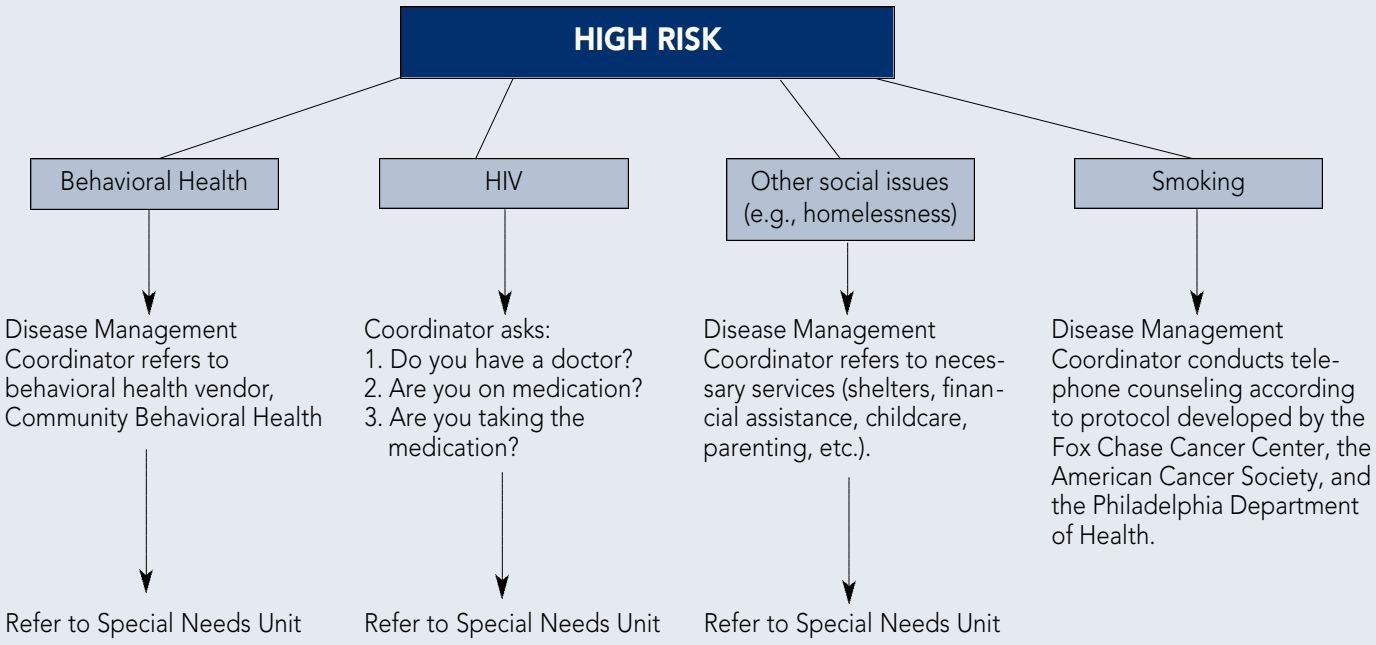
Member Outreach



All high-risk members receive educational materials, home visits, and telephone counseling. All low-risk members receive educational materials.

Health Partners of Philadelphia Prenatal Program Outreach Algorithm

Member Intervention



Appendix H

BCAP Network Exchange Call on Smoking Cessation Programs During Pregnancy

Topic: Smoking Cessation Interventions During Pregnancy

Guest Expert: Robert Goldenberg, MD, Program Director for the Smoke Free Families National Program Office, funded by a grant from The Robert Wood Johnson Foundation

Participants: 18 health plans; ~50 individuals

Date: March 12, 2001, 1:30 PM to 2:30 PM

Summary:

Maternal cigarette smoking has been linked to:

- One-third of infant growth retardation.
- Ten to 15 percent of premature births and low birth weight.
- Ten to 15 percent of infant deaths.

The Agency for Healthcare Research and Quality, the American College of Obstetricians and Gynecologists (ACOG), the Surgeon General's Report, and the Centers for Disease Control and Prevention (CDC) have analyzed a variety of smoking cessation programs, and all concluded that this smoking cessation intervention is the most successful:

> **A five- to 15-minute counseling session with pregnant women on their first prenatal visit by trained providers, using appropriate print materials, will lead to an increase in the rate of smoking cessation from five to seven percent to 15 to 20 percent.**

Key points about this intervention include:

- Doing anything much more involved than this will not yield much more in return.
- It works across all subgroups.
- If practitioners are told there are many ways to do something, many will do nothing. They need a clear answer.
- Simply asking a woman if she smokes, and then telling her to quit, does not work.
- This is not an effective intervention for women who smoke heavily.
- Among women who are hard-core smokers, ten to 40 percent will quit spontaneously early in their pregnancy. With this intervention applied to one million women, an additional 100,000 to 150,000 would quit.
- It is less clear how much repetition of this intervention should be used.
- Sixty-five percent of women who quit smoking during pregnancy resume smoking when the baby is born.

A counselor can be any health care provider (e.g., MD, RN, social worker, pharmacist) with two to three hours of training. ACOG can provide the training materials.

Nicotine Replacement:

Dr. Goldenberg **does not** recommend nicotine replacement for pregnant women. He cited concerns about safety given that pregnant women would constantly be exposed to nicotine while the patch is in place. If, however, a physician feels that the benefit of smoking cessation is greater than potential harm of the patch, he should prescribe it.

Buproprion (antidepressant) Use:

Random trials of this drug have not been conducted among the pregnant population. It is presumed to be safe, but this is inconclusive.

Smoking Cessation Measures of Success:

- When women are asked directly if they smoke or have quit, there is a high deception rate (ten to 50 percent). This is especially true if women are forced to answer "Yes" or "No." In self-reports, women should be given enough of a chance to admit they are still smoking.
- Success or failure also is documented through the use of biologic measures (e.g., cotinine levels or levels of carbon monoxide). The cost of measuring cotinine levels is about $8 to $10 per urine sample. There are some less expensive testing devices available, but they are hard to obtain. The need for consent, however, complicates these measures. Women cannot be tested without being informed, although written consent may not be necessary.
- Newborns of women who have undergone smoking cessation or reduction have a mean birth weight approximately 100 grams higher than infants of women who continued to smoke.
- Use of a carbon monoxide monitor gives women biologic feedback, which may lead to smoking cessation or reduction.

Financial Impact on Health Plans: Favorable

- On average, $3.00 is saved for neonatal care for every $1.00 spent on the program.
- Fifteen to 60 minutes is spent per patient who smokes on the first prenatal visit.
- Training time for providers varies considerably. Plans could purchase a manual or use on-line training options. ACOG, CDC, and others plan to develop materials that will enable providers to be trained in their offices.
- Print materials: $3 to $5 per patient.

Bottom Line:

If a health plan is trying to improve birth outcomes and can focus on only one intervention, smoking cessation would make the biggest difference.

References:

Goldenberg R.L. and Dolan-Mullen P. "Convincing Pregnant Patients to Stop Smoking." *Contemporary OB/GYN* (November 2000);35, 39-44.

Melvin C.L., Dolan-Mullen P., Windsor R.A., Whiteside H.P. Jr., and Goldenberg R.L. "Recommended Cessation Counseling for Pregnant Women who Smoke: A Review of the Evidence." *Tobacco Control* 2000:9 (Suppl. III):iii80-iii84.

"Smoking Cessation During Pregnancy." *ACOG Educational Bulletin*, Number 260, September 2000.

Appendix I

Recommended Readings

Advancing Women's Health: Health Plans' Innovative Programs in Obstetrics and Pregnancy Care. American Association of Health Plans and The Commonwealth Fund. June 1998.

Baldwin L., Larson E.H., Connell F.A., Nodlund D., Cain K.C., Cawthon M.L., Byrns P., Rosenblatt R.A. "The Effect of Expanding Medicaid Prenatal Services on Birth Outcomes." *American Journal of Public Health*. November 1998. (88) 11: 1623-1629.

Goss G.L., Lee K., Heilemann M., Stinson J. "More Does Not Mean Better: Prenatal Visits and Pregnancy Outcome in the Hispanic Population." *Public Health Nursing*. June 1997. (14) 3:183-188.

Hatch H. "Health Plans Address Risk in Pregnancy." *HealthPlan*. January/February 1999. 59-60.

Heins H.C., Nance N.W., McCarthy B.J., Efird C.M. "A Randomized Trial of Nurse-Midwifery Prenatal Care to Reduce Low Birth Weight." *Obstetrics & Gynecology*. March 1990. (75) 3:341-345.

Hobel C.J., Ross M.G., Bemis R.L., Bragonier J.R., et al. "The West Los Angeles Preterm Birth Prevention Project I: Program Impact on High-Risk Women." *American Journal of Obstetrics & Gynecology*. January 1994. (170) 1: 54-62.

Kitzman H., Olds D.L., Henderson C.R., Hanks C., Cole R., et al. "Effect of Prenatal and Infancy Home Visitation by Nurses on Pregnancy Outcomes, Childhood Injuries, and Repeated Childbearing: A Randomized Controlled Trial." *Journal of the American Medical Association*. August 1997. (278)8:644-652.

Lightwood J.N., Phibbs C.S., Glantz S.A. "Short-Term Health and Economic Benefits of Smoking Cessation: Low Birth Weight." *Pediatrics*. 1999;104(6):1312-1320.

McLaughlin F.J., Altemeier W.A., Christensen M.J., Sherrod K.B. et al. "Randomized Trial of Comprehensive Prenatal Care for Low-Income Women: Effect on Infant Birth Weight." *Pediatrics*. January 1992. (89) 128-132.

McCormick M.C. and Siegel J.E. *Prenatal Care: Effectiveness and Implementation*. Cambridge University Press. 1999.

Moore M.L., Meis P.J., Ernest J.M., Wells H.B., Zaccaro D.J., Terrell T. "A Randomized Trial of Nurse Intervention to Reduce Preterm and Low Birth Weight Births." *Obstetrics & Gynecology*. May 1998. (91) 5:656-661.

Oakley A., Rajan L., Grant A. "Social Support and Pregnancy Outcome." *British Journal of Obstetrics and Gynecology*. February 1990. (97) 155-162.

Olds D.L., Henderson C.R., Tatelbaum R., Chamberlin R. "Improving the Delivery of Prenatal Care and Outcomes of Pregnancy: A Randomized Trial of Nurse Home Visitation." *Pediatrics*. January 1986. (77) 1:16-28.

Public Sector Contracting Report. "Plans, Providers Partner to Manage High-Risk Pregnancies: Medicaid Outcomes Improve." August 1999. 122-124.

Resultan E. "Getting Moms to Quit." *HealthPlan*. January/February 1999. 17-22.

Ross M.G., Sandhu M., Bemis R., Nessim S., Bragonier J.R., Hobel C. "The West Los Angeles Preterm Birth Prevention Project II: Cost Effectiveness Analysis of High-Risk Pregnancy Interventions." *Obstetrics & Gynecology*. April 1994. (83) 4:506-511.

Spencer B., Thomas H., Morris J. "A Randomized Controlled Trial of the Provision of a Social Support Service During Pregnancy: The South Manchester Family Worker Project." March 1989. (96) 281-288.

Villar J., Farnot U., Barros F. et al. "A Randomized Trial of Psychosocial Support During High-Risk Pregnancies." *New England Journal of Medicine*. October 1992. (327) 18:1266-1271.

Appendix J

BCAP *Toward Improving Birth Outcomes* Health Plan Contacts

Arkansas Foundation for Medical Care

Nancy Archer
HCQIP Project Manager
Arkansas Foundation for Medical Care
Medicaid Managed Care Services
401 W. Capitol, Suite 410
Little Rock, AR 72201
Phone: 501-375-5700
Fax: 501-375-5705
E-mail: narcher@afmc.org

William Golden, MD
Medical Director, Quality Improvement
Arkansas Foundation for Medical Care
Medicaid Managed Care Services
401 W. Capitol, Suite 410
Little Rock, AR 72201
Phone: 501-686-5236
Fax: 501-686-5609
E-mail:
goldenwilliame@exchange.uams.edu

CareSource

Catherine O'Donnell, RN
Manager, Case Management/Outreach
CareSource
One Dayton Centre
One South Main Street, Suite 440
Dayton, OH 45402
Phone: 937-224-3384
Fax: 937-224-8587
E-mail: ceodonn@care-source.com

Ron Suprenant, MD
Chief Medical Officer
CareSource
One Dayton Centre
One South Main Street, Suite 440
Dayton, OH 45402
Phone: 937-224-3300
Fax: 937-224-3383
E-mail: rmsupre@care-source.com

Colorado *Access*

Mary M. Gomez Chambers, RN, ND
Perinatal Program Coordinator
Colorado *Access*
501 S. Cherry Street, Suite 700
Denver, CO 80246
Phone: 303-316-2105
Fax: 303-333-9677
E-mail: mary_gomez@coaccess.com

Virginia Gurley, MD
Medical Director
Colorado *Access*
501 S. Cherry Street, Suite 700
Denver, CO 80246
Phone: 303-394-6748
Fax: 303-333-9677
E-mail: virginia_gurley@coaccess.com

Coventry Health Care

Terry Farsace
Vice President, Government Programs
Coventry Health Care of Delaware
2751 Centerville Road, Suite 400
Wilmington, DE 19808-1627
Phone: 302-995-6100 Ext.1520
Fax: 302-995-0142
E-mail: tfarsace@cvty.com

Lori Frankfort
Complex Case Manager
Smart Start Program
Coventry Health Care of Delaware
2751 Centerville Rd., Suite 400
Wilmington, DE 19808-1627
Phone: 302-995-6100 Ext. 1135
Fax: 302-633-4044
E-mail: lfrankfort@cvty.com

Jaime "Gus" Rivera, MD
Chief Medical Officer
Coventry Health Care of Delaware
2751 Centerville Road, Suite 400
Wilmington, DE 19808-1627
Phone: 302-995-6100 Ext.1527
Fax: 302-995-0142
E-mail: jrivera@cvty.com

Harmony Health Plan

Henry Hollander, MD
Vice President, Medical Affairs
Harmony Health Plan
125 S. Wacker Dr., Suite 2900
Chicago, IL 60606
Phone: 312-516-4906
Fax: 312-251-1208
E-mail: hhollander@harmonyhpi.com

Kathy LaSpina Morse
Director
Government Relations and Health Policy
Harmony Health Plan
125 S. Wacker Dr., Suite 2900
Chicago, IL 60606
Phone: 312-516-4932
Fax: 312-251-1208
E-mail: klaspina@harmonyhpi.com

Lourdes Reyes
Quality Leader
Harmony Health Plan
125 S. Wacker Dr. Suite 2900
Chicago, IL 60606
Phone: 312-516-4989
Fax: 312-630-2022
E-mail: lreyes@harmonyhpi.com

Health Partners

Sharad Mansukani, MD
Vice President and Medical Director
Health Partners of Philadelphia
833 Chestnut Street, Suite 900
Philadelphia, PA 19107
Phone: 215-991-4345
Fax: 215-991-4107
E-mail: Smansukani@healthpart.com

Paula Moll, MPH, RD
Disease Management Coordinator
Health Partners of Philadelphia
833 Chestnut Street, Suite 900
Philadelphia, PA 19107
Phone: 215-991-4284
Fax: 215-991-4107
E-mail: pmoll@healthpart.com

LA Care

Maggie Hollon
Director, Provider Network Operations
LA Care Health Plan
555 W. Fifth Street, 18th Floor
Los Angeles, CA 90113
Phone: 213-694-1250 Ext. 4297
Fax: 213-694-1246
E-mail: mhollon@lacare.org

Helen DuPlessis, MD
Chief Medical Officer
LA Care Health Plan
555 W. Fifth Street, 18th Floor
Los Angeles, CA 90113
Phone: 213-694-1250 Ext. 4191
Fax: 213-438-5746
E-mail: hduplessis@lacare.org

Monroe Plan for Medical Care

Howard Brill, PhD
Senior Health Economist
Monroe Plan for Medical Care
2700 Elmwood Avenue
Rochester, NY 14618
Phone: 716-256-8424
Fax: 716-244-9647
E-mail: hbrill@monroeplan.com

Joseph A. Stankaitis, MD
Chief Medical Director
Monroe Plan for Medical Care
2700 Elmwood Avenue
Rochester, NY 14618
Phone: 716-256-8425
Fax: 716-244-9647
E-mail: jstankaitis@monroeplan.com

Darlene Walker
Manager, Medical Management
Monroe Plan for Medical Care
2700 Elmwood Avenue
Rochester, NY 14618
Phone: 716-244-5550
Fax: 716-244-9647
E-mail: dwalker@monroeplan.com

Neighborhood Health Plan

Maria Cuppernell
Neighborhood Health Plan
253 Summer Street
Boston, MA 02210-1120
Phone: 617-204-1427
Fax: 617-478-7173
E-mail: maria_cuppernell@nhp.org

Paul Mendis, MD
Medical Director
Neighborhood Health Plan
253 Summer Street
Boston, MA 02210-1120
Phone: 617-428-7426
Fax: 617-478-7173
E-mail: pmendis@nhp.org

Sentara Healthcare

David M. Levin, MD
Medical Director
Sentara Healthcare
4417 Corporation Lane
Virginia Beach, VA 23462
Phone: 757-552-8958
Fax: 757-552-7108
E-mail: dmlevin@sentara.com

Megan Padden
Director of Medicaid
Sentara Healthcare
4417 Corporation Lane
Virginia Beach, VA 23462
Phone: 757-552-7365
Fax: 757-552-7396
E-mail: mppadden@sentara.com

The Bronx Health Plan

Karen Romero
Health Initiatives Coordinator
The Bronx Health Plan
One Fordham Plaza, Suite E-220
Bronx, NY 10458
Phone: 718-817-6755
Fax: 718-817-6893
E-mail: karenromero@tbhp.org

Richard G. Younge, MD
Vice President and Chief Medical Officer
The Bronx Health Plan
One Fordham Plaza, Suite E-220
Bronx, NY 10458
Phone: 718-817-6720
Fax: 718-817-6893
E-mail: ryounge@tbhp.org

CHCS
Center for
Health Care Strategies, Inc.

The BCAP Network

The BCAP Network is an emerging alliance of health plans joined by the common goal of furthering the quality and cost-efficiencies of Medicaid and SCHIP managed care. BCAP Network activities include:

- **BCAP Workgroups** – Up to 15 Medicaid/SCHIP health plans collaborate to develop replicable best practice models for targeted clinical and administrative areas.
- **BCAP Workshops** – Hands-on workshops allow attendees (up to 30 health plans) to develop quality improvement initiatives for their Medicaid/SCHIP populations.
- **BCAP Quality Summit, October 16-18, 2002** – Accomplishments from each BCAP workgroup will be highlighted at this national quality gathering for Medicaid/SCHIP health plans.
- **BCAP e-News Update** – Bi-monthly electronic newsletter containing updates on health plan best practice activities. To subscribe, e-mail rb@chcs.org.
- **BCAP Network Exchange Calls** – Lively teleconference discussions about current issues in health care with experts in the field.
- **CHCS Website** – Features current updates on BCAP projects, resources for Medicaid and SCHIP health plans, and CHCS Managed Care Best Practices Publications. **www.chcs.org**
- **Best Practices Grants** – Grants of up to $100,000 are available to Medicaid and SCHIP health plans that want to develop, test, or refine "best practice" programs to improve delivery of managed care in the public sector.

CHCS Center for Health Care Strategies, Inc.

1009 Lenox Drive, Suite 204
Lawrenceville, NJ 08648
(609) 895-8101
(609) 895-9648 *fax*
www.chcs.org