Payer Workgroup Pregnancy Management Intervention Deliverables
July 19, 2011

Healthy Texas Babies (HTB) Expert Panel (EP) Meeting Attendees: Please review the document below for content only. All HTB workgroup intervention deliverables will be consistently formatted following the July 30, 2011 EP meeting.

1.1 Detailed Intervention Description: Management of Fertility and Coordination of Care

Goal: Earlier (ideally preconception) identification and management of any maternal illness or condition which may adversely affect pregnancies; pregnancies in mothers with histories of poor reproductive outcome (such as preterm delivery); poor parental (mother/father and other household members) habits (tobacco, illegal drug, and ETOH), and obesity (associated with maternal hypertension, preeclampsia, gestational diabetes, deep venous thrombosis, intrauterine fetal demise, cesarean section, wound infection and neural tube defects such as spina bifida).

Also, one of our best ways to reduce morbidity and mortality is to directly and aggressively address teen pregnancy,, which has a significantly higher rate of preterm birth and low birth weight babies. Managing the inter-pregnancy intervals with respect to the woman's health, timing of subsequent pregnancies, availability of birth control options, etc., will also help to reduce the incidence of both maternal and infant complications. Such programs should be designed to decrease/prevent premature births by increasing access to, and frequency of, prenatal medical visits, with an emphasis on targeted education/behavior modification, including using social media approaches. These "condition-management" programs could leverage the allure and current extreme popularity and growth of online social networks to mothers who are motivated to pursue a healthy lifestyle.

Outcome: Minimizing maternal morbidity prior to conception and throughout the pregnancy. Appropriate referrals, as needed, to high-risk obstetricians and tertiary care centers for planned deliveries (meaning – these patients may need to be seen with maternal-fetal medicine and/or internal medicine, etc.), and the appropriate choice of delivery hospital and doctor should be determined early.

Measurement of outcome: Through a collaborative effort to develop, validate, implement, and evaluate an outreach/health management program for pregnant women in Texas, we should see reductions in pre-term births and their associated health and economic impacts, by increasing access to earlier and regular prenatal care visits among mothers in Texas. A reduction in NICU admissions, decreased maternal complications of pregnancy, labor, and delivery, decrease in teen pregnancy rate, improved post-natal health opportunities, early referral and follow-up for the infant(s), and increases in inter-pregnancy periods of time with comprehensive obstetrical and gynecological services available to mothers during this time.

Reduction in first trimester HgA1c in diabetics, overall reduction of a BMI > 30 at time of presentation for prenatal care, increase in the number of patients who have at least two prenatal visits during the first trimester. Consider using the Problem Oriented Perinatal Risk Assessment (POPRAS) record-keeping form or other appropriate form, if applicable, for this metric.

Intervention: Easy and immediate access to Texas Medicaid eligibility (54% of deliveries are Medicaid). Goal should be first prenatal visit within two weeks of positive pregnancy test. Advertisement of registration process for all pregnancies in Texas, i.e., if you have private insurance you contact your carrier, if you have no insurance, you contact Medicaid (Note: that there is presumptive eligibility for women to qualify for Medicaid due to pregnancy.) Medicaid HMOs should adopt pregnancy monitoring process similar to United ("Healthy Pregnancy") and Blue Cross Blue Shield ("Baby Yourself"). The hope is that with appropriate education every woman will register with some entity upon a positive pregnancy test because they understand the need to do so. Within two weeks of registration there should be contact from the registering authority to get the mother into obstetrical/pre-natal care and to begin to identify any problems. After the delivery, establish the mother and her new infant in a health (medical, mental health, and dental) home. This would also include prenatal care regardless of payment eligibility.

Activities:

1. Register all women as early in pregnancy as possible; establish easily understood and readily available provider systems. This is most important for the uninsured and underinsured.
2. Use social media to interact with pregnant patient and fathers (another group is working on this – we should partner) Online outreach/health management which uses social media tools (including Text4Baby, or OB Counselor™, *et al*) to facilitate access to care, especially for pregnant teens, and reinforces compliance with recommended prenatal and postpartum visits, and any teen mom\infant\young child well-child checkups.
3. Online health and wellness resources that offer exclusive educational content on nutrition and exercise, and well-baby and well-child information.
4. Online obstetrical and pediatric medical provider profiles with contact information, office hours, and patient intake and

other enrollment forms for providers participating in the pregnancy management program.

5. Coordinate post-natal and inter-pregnancy care.
6. Coordinate the baby's post-natal pediatric care.
7. Identify funding gaps and supply patient navigation so that interventions for the underinsured can also be determined in the future.
8. Encourage a discussion with private health insurance companies to pay for single embryo IVF benefits instead of paying for multiple embryo transfer. For example, United Healthcare has a program to support embryo transfer by referring patients to IVF "centers for excellence" to perform single embryo transfer.
9. Cover early ultrasound for gestational age determination and number
10. Consider financial or other incentives to women who participate in at least 11 prenatal visits (this is done in other countries and improves compliance with prenatal care)
    a. Identify what national companies are doing with regard to this activity by contacting the National Health Insurance Plans professional association
11. Automatic enrollment into the Women's Health Program (post partum birth control access for 5 years after delivery)

1.2 Are there best practices associated with this intervention?

Suggest revising this section to the following:

- Early registration and intervention system for all new pregnancies as done in Japan
- Encouraging single embryo transfers rather than multiple embryo transfers for IVF

1.3 Intervention -Desired Outcomes

Short-term (1-3 years): Support the pregnancy through a program which reinforces key milestones in the pregnancy: making and keeping scheduled doctor appointments, maintaining a healthy diet, and other health metrics, such as blood pressure and weight gain.

A. Identify and implement interventions specific to high-risk populations
B. Increased number and frequency of prenatal visits
C. Earlier entry into prenatal care
D. Decrease avoidable perinatal complications (mother and baby) and prematurity

E. Begin discussing the feasibility of insurance company covering IVF to reduce iatrogenic multiple births
F. Develop a registration process
G. Use social media to educate pregnant women and fathers
H. Improving the education levels of moms by:
    - Reinforcing positive efforts and progress toward individual education goals
    - Providing patient navigators to assist with goal-setting and accessing resources

Long-term (5-7 years):

A. Comprehensive intra-conception care
B. Develop financial or other incentives to support early and active participation in prenatal care and breastfeeding
C. Improve breastfeeding rates
D. Increase number of planned pregnancies by 50% from current rates
E. Eliminate financial barriers to early entry to prenatal care and intra-conception care
F. 90% first trimester registration of pregnancies
G. Positively influencing parenting behaviors that will lead to healthier babies through education and skill building.

1.4 Data Elements to be Collected and Evaluated

Pre-Intervention: What is the current average Kessner index per payer (a measurement of the adequacy of prenatal care)

Monitoring: establish a base line of current trends and review on a bi-annual basis

Post-Intervention: Improvement of Kessner Index

Process evaluation: review of trends of
1) number of prenatal visits
2) time of entry to prenatal visits
3) reduction of iatrogenic multiple births
4) control of one maternal morbidity index (first trimester HgA1c or BMI for example and see if that % of pregnant women with BMI > 40 or HgA1C > 7 can be reduced over time).

1.5 Has the intervention been implemented in Texas? If yes, please provide specific details and contact information.

No, all of this would be new.

1.6 Possible Partners (both public and private)

- Federal –
  A. Department of Health and Human Services
     - Agency for Healthcare Research and Quality (AHRQ)
     - Centers for Medicare and Medicaid Services (CMS)

- National –
  A. March of Dimes
  B. Healthy Mothers, Healthy Babies Coalition
  C. Text4baby

- State –
  A. Commercial Health Insurance Payers
  B. Texas Department of State Health Services (DSHS)
     - Women, Infants and Children Program (WIC)
  C. Health and Human Services Commission (HHSC)
     - Women's Health Program
     - Public Payers
       - Texas Medicaid
       - Texas Medicaid Healthcare Partnership (Fee-for-Service Medicaid)
       - Disease Management Broker(s) for Medicaid
       - Texas Medicaid Managed Care Organizations
  D. Texas Academy of Family Practice
  E. Texas Association of Obstetricians and Gynecologists
  F. Texas Campaign to Prevent Teen Pregnancy
  G. Texas Chapter of March of Dimes
  H. Texas Medical Association
  I. Texas Nurses Association
  J. Texas Osteopathic Medical Association

- Regional –
  A. Healthcare Educational Institutions

- Local –
  A. Public Health Clinics
  B. Hospital Districts
  C. Healthcare Networks
  D. Self pay patients

1.7 Recommended appropriate assessment tools (e.g., Perinatal Periods of Risk (PPOR))

A. Measures developed by the state public health agency for assessing the efficacy and utilization of the various pregnancy management programs which will develop (looking at both maternal and infant outcomes)
B. Relevant HEDIS Measures
C. AHRQ-Proposed Healthcare Outcomes Measures
D. Other published measures

1.8 Recommended Lead Agency for Intervention

- Texas Department of State Health Services and the Texas Health and Human Service Commission

1.9 Target Audience(s) – define for each specific activity included in the intervention

Activities:

1. Private Health Insurance Companies
2. Public Health Insurance Entities
    a. Texas Medicaid
    b. Texas Medicaid Healthcare Partnership (Fee-for-Service Medicaid)
    c. Disease Management Broker(s) for Medicaid
    d. Texas Medicaid Managed Care Organizations
3. General Public

4. Women's Healthcare Providers
5. Hospitals and other Healthcare Facilities which Provide Obstetrical Care
6. Partner Organizations
7. Private Business (Health Insurance Purchasers)
8. Federal, State and Local Policy Makers
9. Any other interested stakeholders

1.10 Recommended Time Period for Implementation by Activity

1. Activity #1: develop the core particulars of the ideal pregnancy management programs and begin development of the assessment measures (Time Period from and To)
2. Activity #2: organize the payers and other stakeholders for input on the program and measures and gather, review, and implement accepted recommendations (Time Period from and To)
3. Activity #3: present finalized core pregnancy management program to payers and involved stakeholders (Time Period from and To)

1.11 Required Resources - (e.g. financial, human, in-kind, etc.)

1. Given the complexity of this intervention, the specific resources needed to meet this requirement will require additional development

1.12 Possible Challenges to Implementation

1. Given the complexity of this intervention, the possible challenges with this intervention will require additional development

1.13 Communication Strategies – including who, what, when, where, how

1. Given the complexity of this intervention, the specific communication strategies needed to meet this requirement will require additional development. Some possibilities are listed below.

Web-based/electronic communications interventions - we should establish a website where patients can enroll regardless of

insurance carrier (this website should communicate with the various insurance entities or have links to them)..

Radio – We should have an educational campaign about

1. Enrollment with first pregnancy test regardless of insurance status
2. Educate the public regarding the need to maintain optimal weight range and about gestational and Type II diabetes
3. There needs to be a strong message that every pregnancy needs to be a planned pregnancy (same for below).

Television – None identified at this time

Print - None identified at this time

In-person – This educational campaign that every pregnancy be a planned pregnancy and the consequences of uncontrolled weight gain and medical illness on pregnancy should begin as age appropriate.

1.14 Detailed Implementation Steps (how this intervention should be operationalized)

1. Work with Texas School Board Association to determine educational campaign concerning maintaining an appropriate weight (BMI b/w 24-26); control of medical conditions; and that it is best that all pregnancies are planned pregnancy. This should be done in conjunction with appropriate age based sex education, but sex education has proven to be difficult in Texas to get accurate sex education in our public schools controversial.
2. Increase access to contraception for the uninsured and underinsured with special attention to teen and immigrant populations
3. Create centralized agency to coordinate pregnancy registration process (the main emphasis will be on the uninsured and underinsured)
4. Begin discussing the feasibility of insurance coverage for single embryo transfer

1.15 Plan for sustainability

1. Given the complexity of this intervention, the specific plan for sustainability needed to meet this requirement will require additional development

1.16 Plan for scalability to acknowledge that resources available for implementation may vary

1. Given the complexity of this intervention, the specific plan for scalability needed to meet this requirement will require additional development

1.17 Best Practice Evidence Table

Best Practices Evidence			
Farmington, Conn. (August 31, 2010) – Nurtur® *Enhanced Healthy Pregnancy Program*	Health, wellness and A A. Nurtur PeopleCare™ introduced enhancements to its Healthy Pregnancy program for expectant mothers which has been expanded to incorporate Nurtur PeopleCare™ integrated life and health management capabilities.	Purpose is to improve current program. Program Includes: ▪ health and work-life assessments by experienced Registered Nurses; • referral for high-risk pregnancies to the Nurtur High Risk Maternity Management Program; • telephonic health coaching supported with printed and online educational materials and resources throughout pregnancy; • post-delivery follow-up and referrals; and • specialty consults with work-life Consultants to address issues such as choosing and locating licensed child care providers, return-to-work planning and financial concerns.	**Results:** [Background] According to the U.S. Centers For Disease Control and Prevention, 13 percent of babies are born preterm and eight percent are low birth-weight. This represents a significant financial burden for employers, which typically cover 94 percent of the cost of pregnancy. Direct healthcare costs related to a preterm delivery average $41,610 versus $2,830 for a healthy full-term delivery. **Pertinence:** High Risk Maternity Management programs deliver both positive birth outcomes and financial savings.

Best Practices Evidence			
Mason MV, Poole-Yaeger A, Lucas B, Krueger CR, Ahmed T, Duncan I. (2011) *Effects of a Pregnancy Management Program On Birth Outcomes in Managed Medicaid. Centene Corp., St. Louis, MO.* 2011 Apr; 20 (4):39-46.	Retrospective propensity-adjusted comparison of pregnant women in a managed Medicaid plan enrolled in a prenatal program and pregnant women who were not enrolled. Program enrollment was initiated by receipt of a Notification of Pregnancy (NOP) risk screening assessment.	To examine the effect of a prenatal program on birth outcomes, specifically birth weight, in a managed Medicaid pregnant population, and identify the potential barriers to obtaining the risk screening information required for successful interventions.	**Results**: Demonstrated a statistically significant improvement in delivery outcomes in the women who participated in the pregnancy management program (NOP group) compared with those who do not (non-NOP group). The incidence of low-birth-weight infants was lower in the NOP group compared to the non-NOP group. Odds ratio estimates indicate that the NOP participants are likely to have 7.9% lower adverse event frequency for delivery weights <2500 g; 20% lower adverse event frequency for delivery weights <1500 g; and 31.2% lower adverse event frequency for delivery weights <1000 g. All p values are statistically significant. The results indicate that this is an important area for investment if birth outcomes are to be improved. Low-birth-weight outcome was reduced when women participated in a managed maternity program, compared with non-participants. **Pertinence:** This study shows importance of participation in a pregnancy management program does improve birth outcomes in women who are at risk of low-birth-weight deliveries. Early identification of pregnant women and their risk factors for the purpose of enrollment in a managed Medicaid prenatal program is an important factor in improving birth outcomes, specifically birth weight.
John C. Hauth, MD *Professor and Division Director, Maternal-Fetal Medicine, Department of Obstetrics and Gynecology, University of Alabama at Birmingham,*	Comprehensive risk assessment enables the prenatal care provider to determine whether the woman, the fetus, or the infant is at increased risk.	The primary goals of early and ongoing risk assessment are to prevent or treat conditions associated with morbidity and mortality and to improve linkages to inpatient care through more effective referral and	**Results:** Standardization of data collection and recording, as well as early systematic risk assessment, will accomplish the following: ▪ Better match of care to patient needs ▪ More efficient use of resources ▪ Expeditious and appropriate transfers and referrals ▪ Reduced numbers of emergency transfers and referrals.

Best Practices Evidence			
Birmingham, Alabama. Prenatal Care Documentation and Triage		consultation mechanisms.	**Pertinence:** The content and timing of prenatal care should vary depending on the risk status of the mother and fetus.