

Healthy Louisiana Performance

MCO Name: Healthy Blue

**Improving Prenatal and Postpartum Care to Reduce the Risk
for Preterm Birth**

2015-2017

(With planned extension through 2018)

Project Phase: Proposal

Original Submission Date: 3/30/2016

Revised Submission Date:

Project Phase: Baseline

Submission Date: 7/1/2016

Revised Submission Date:

Project Phase: Interim

Submission Date: 6/30/2017

Revised Submission Date:

Project Phase: Final

Submission Date: 6/30/2018

Revised Submission Date:

Submission to: IPRO

State: Louisiana Department of Health

MCO Contact Information

1. Principal MCO Contact Person

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PIP proposal: Principal MCO Contact Signature
Baseline Report: Principal MCO Contact Signature
Interim Report: Principal MCO Contact Signature
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Date
Date
Date
Date

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3. External Collaborators (if applicable): N/A

4. For Final Reports Only: If Applicable, Summarize and Report All Changes in Methodology and/or Data Collection from Initial Proposal Submission:

N/A

5. Attestation

Managed Care Plan Name: Healthy Blue

Title of Project: Pre-Maturity PIP

Required Attestation signatures for PIP Proposal and PIP Final Report:

(1) Medical Director or Chief Medical Officer; (2) Quality Director or Vice President for Quality

The undersigned approve this PIP Proposal and assure involvement in the PIP throughout the course of the project.

Raymond Poliquit, Medical Director 7/11/2018

Christin Cantavespri, Quality Manager 7/11/2018

Aaron Lambert, Plan President 7/11/2018

Virginia Plaisance, VP & COO 7/11/2018

The undersigned approve this FINAL PIP Report:

Raymond Poliquit, Medical Director 7/11/2018

Christin Cantavespri, Quality Manager 7/11/2018

Aaron Lambert, Plan President 7/11/2018

Virginia Plaisance, VP & COO 7/11/2018

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1. Abstract

Describe Project Topic and Rationale for Topic Selection

- **Describe how PIP Topic addresses your member needs and why it is important to your members (e.g., disease prevalence stratified by demographic subgroups):** This PIP addresses the need for a focus on pre-maturity addressing the leading cause of poor birth outcomes in Louisiana. This Performance Improvement Plan is important for the members of Healthy Blue as it aims to stratify the prevalence of pre-maturity and identifying high risk pregnant women in effort to intervene by utilizing the aforementioned performance metrics to reduce the prevalence of poor outcomes for members.
- **Describe current research support for topic (e.g., clinical guidelines/standards):** The March of Dimes aims for a national premature birth rate no higher than 9.6% by 2020 (March of Dimes Foundation, 2014). Early prenatal care allows for timely identification and intervention for actionable risk factors. According to the American College of Obstetricians and Gynecologists, prior preterm birth is one of the strongest risk factors for preterm birth (ACOG, 2012a), and between 5 and 8% of preterm deliveries are attributable to maternal smoking (ACOG, 2010). There is strong evidence for effective interventions to minimize these risks, including pregnancy-tailored tobacco cessation counseling (ACOG, 2010) and progesterone therapy for prior spontaneous preterm birth (ACOG, 2008; Preconception Health Council of California, 2012). Untreated sexually transmitted infections (STI) have been associated with adverse birth outcomes such as preterm delivery (Rours et al, 2011) and stillbirth (USPSTF, 2009), and intrauterine and perinatally transmitted STIs can adversely affect pregnant women and their fetuses (CDC, 2010). The CDC recommends screening pregnant women for STI, including Chlamydia trachomatis and syphilis, early in pregnancy, and screening for Neisseria gonorrhoeae for pregnant women at risk or living in areas with high prevalence (CDC, 2010). Further, rescreening for STI in the third trimester is recommended for women at high risk for infection. The U.S. Preventive Services Task Force recommends that all pregnant women should be screened for HIV infection as early in pregnancy as possible (Chou et al., 2012; Moyer and USPSTF, 2013). Developing strategies to minimize barriers to early initiation of prenatal care and evidence-based care such as tobacco cessation counseling, progesterone therapy and/or STI screening, referral and treatment, can potentially reduce risk for preterm birth. Risk factors for preterm birth can also be addressed in the postpartum period. For example, approximately 50%-60% of women who quit smoking during pregnancy relapse in the first year postpartum, and postpartum visits provide an opportunity to initiate interconception smoking cessation interventions (ACOG, 2010). The postpartum period is also an opportune time to address pregnancy intention and birth spacing according to the mother's personal desires. In light of evidence that birth to pregnancy (BTP) intervals of 18 months or less are associated with preterm delivery, the recommended interval before attempting the next pregnancy is at least 24 months (WHO, 2006; Sober and Schreiber, 2014). Long-acting reversible contraception (LARC) methods are the most effective reversible contraceptives, and immediate postpartum insertion may provide a safe and effective means to reduce unintended pregnancy among eligible women, including eligible adolescent mothers, who are at high risk for rapid, repeat pregnancy (ACOG, 2011; Sober and Schreiber, 2014; ACOG, 2012b). It should be noted that although the inter-pregnancy postpartum visit affords opportunities to potentially reduce the likelihood of preterm birth and improve pregnancy outcomes, all of the Bayou Health Plans scored below the HEDIS 2014 national Medicaid HMO 50th percentile for the measure of attendance at a postpartum visit.
- **Explain why there is opportunity for MCO improvement in this area:** The State of Louisiana's premature birth rate was 15.1% in 2013, and the State pledged to reduce the preterm birth rate by 8% in 2014 (March of Dimes Foundation, 2014). Further, the Department of Health and Hospitals of the State of Louisiana targets a 15% reduction in the statewide prematurity rate by 2017. Healthy People 2020 specifically targets reductions in preterm births (<37 weeks gestational age) and very preterm births (<32 weeks gestational age) to 11.4% and 1.8%, respectively, and corresponding percentages

in Louisiana (LA) are higher, at 12.4% and 2.3% (DHH-LA, 2014). Racial disparities are evident among the LA population. Across all LA regions, preterm birth rates are highest among the African American subpopulation, with the highest rates in Region 7, i.e., 20.5% for preterm and 4.1% for very preterm births (DHH-LA, 2014). Disparities are also evident by type of insurance coverage. In Louisiana, 15.6% (95% CI=12.0-19.1) of publicly insured children were born premature, compared to 10.5% (95% CI=10.0-11.1) of privately insured children nationwide (NSCH, 2011/12). Among the LA subpopulation insured by Medicaid at preconception, the percentage with a prior preterm birth in 2008 was 16.7% (DHH-LA, 2008); this represents a susceptible subpopulation that may benefit from performance improvement project initiatives to improve prenatal, postpartum and inter-conception care. Early prenatal care is recommended by the Centers for Disease Control and Prevention (CDC) as a means for women to reduce the risk for preterm birth (CDC, 2014a), yet only two of the five Bayou Health plans scored at or above the HEDIS 2014 national Medicaid HMO 50th percentile for the measure of early initiation of prenatal care, and none of the plans scored at the 95th percentile.

2. Aim Statement, Objectives and Goals

Aim Statement:

The Collaborative PIP aims to decrease the preterm birth rate by implementing a robust set of health plan, member and provider interventions to improve rates of the following performance indicators:

1. The percentage of women 15-45 years of age with evidence of a previous pre-term singleton birth event (<37 weeks completed gestation) who received one or more Progesterone injections between the 16th and 21st week of gestation (also reported as in the PTB incentive measure).
2. The percentage of women aged 16 years and older who delivered a live birth and had at least one test for Chlamydia during pregnancy.
3. The percentage of women who delivered a live birth and had at least one test for HIV during pregnancy.
4. The percentage of women who delivered a live birth and had at least one test for syphilis during pregnancy.
5. The percentage of postpartum women who:
 - a. Adopt use of a most effective FDA-approved method of contraception, i.e., (i) female sterilization or (ii) Long-Acting Reversible Contraception (LARC), i.e., contraceptive implants, or intrauterine devices of systems (IUD/IUS)
 - b. Adopt use of a moderately effective method of contraception, i.e., use of injectable, oral pills, patch, ring or diaphragm.
 - c. Adopt use of LARC during delivery hospitalization
 - d. Adopt use of LARC outpatient within 56 days postpartum
6. The percentage of women with a postpartum visit as per the HEDIS PPC postpartum measure

Objectives:

Reduce the risk for preterm birth by implementing a robust set of member, provider and health plan initiatives to address the following: (1) Notice of Pregnancy (NOP) provider to plan communications; (2) High risk registry plan to provider communications; (3) Provider specific education (Medicaid 101); and (4) Prenatal care management outreach and engagement program focused on high risk members.

Goal(s):

1. The percentage of women 15-45 years of age with evidence of a previous pre-term singleton birth event (<37 weeks completed gestation) who received one or more Progesterone injections between the 16th and 21st week of gestation (also as reported in the PTB incentive measure).
 - **Baseline to final measurement goal:** Increase the percentage of women 15-45 years of age with evidence of a pre-term birth singleton event who received on or more progesterone injections between

the 16th and 21st week of gestation by 2.5% (from 17.5% to 20%) by November, 2017 in order to meet the target goal of 20% during final measurement period.

2. The percentage of women 15-45 years of age with evidence of a previous pre-term singleton birth event (<37 weeks completed gestation) who received one or more Progesterone injections between the 16th and 24th week of gestation (also as reported in the PTB incentive measure).

- **Baseline to final measurement goal:** Increase the percentage of women 15-45 years of age with evidence of a pre-term birth singleton event who received one or more progesterone injections between the 16th and 24th week of gestation by 1.4% (from 18.6% to 20%) by November, 2017 in order to meet the target goal of 20% during final measurement period.

3. The percentage of women aged 16 years and older who delivered a live birth and had at least one test for Chlamydia during pregnancy.

- **Baseline to final measurement goal:** Increase the percentage of women aged 16 years and older who delivered a live birth and had at least one test for Chlamydia during pregnancy by 7.6% (from 52.4% to 60%) by November, 2017 in order to meet the target goal of 60% during final measurement period.

4. The percentage of women who delivered a live birth and had at least one test for HIV during pregnancy.

- **Baseline to final measurement goal:** Increase the percentage of women who delivered a live birth and had at least one test for HIV during pregnancy by 18.3% (from 31.7% to 50%) by November, 2017 in order to meet the target goal of 50% during final measurement period.

5. The percentage of women who delivered a live birth and had at least one test for syphilis during pregnancy.

- **Baseline to final measurement goal:** Increase the percentage of women who delivered a live birth and had at least one test for syphilis during pregnancy by 19.5% (from 44.5% to 64%) by November, 2017 in order to meet the target goal of 64% during final measurement period.

6. The percentage of postpartum women who:

a. Adopt use of a most effective FDA-approved method of contraception, i.e., (i) female sterilization or (ii) Long-Acting Reversible Contraception (LARC), i.e., contraceptive implants, or intrauterine devices of systems (IUD/IUS)

- **Baseline to final measurement goal:** Increase the percentage of postpartum women who: a. Adopt use of a most effective FDA-approved method of contraception, i.e., (i) female sterilization or (ii) Long-Acting Reversible Contraception (LARC), i.e., contraceptive implants, or intrauterine devices of systems (IUD/IUS) by 4.16% (from 15.84% to 20%) by November, 2017 in order to meet the target goal of 20% during final measurement period.

b. Adopt use of a moderately effective method of contraception, i.e., use of injectable, oral pills, patch, ring or diaphragm.

- **Baseline to final measurement goal:** Increase the percentage of postpartum women who: Adopt use of a moderately effective method of contraception, i.e., use of injectable, oral pills, patch, ring or diaphragm by 9.8% (from 34.2% to 44%) by November, 2017 in order to meet the target goal of 44% during final measurement period.

c. Adopt use of LARC during delivery hospitalization

- **Baseline to final measurement goal:** Increase the percentage of postpartum women who: Adopt use of LARC during delivery hospitalization by 42.6% (from 1.4% to 44%) by November, 2017 in order to meet the target goal of 44% during final measurement period.

d. Adopt use of LARC outpatient within 56 days postpartum

- **Baseline to final measurement goal:** Increase the percentage of postpartum women who: Adopt use of LARC outpatient within 56 days postpartum by 33.4% (from 10.6% to 44%) by November, 2017 in order to meet the target goal of 44% during final measurement period.

7. The percentage of women with a postpartum visit as per the HEDIS PPC postpartum measure

- **Baseline to final measurement goal:** Increase the percentage of women with a postpartum visit as per the HEDIS PPC postpartum measure by 5.56% (from 61.97% to 67.53%) by November, 2017 in order to meet the target goal of 67.53% during final measurement period.

3. Methodology

Performance Indicators

Utilize the Prematurity PIP Performance Measures specifications referenced below for each performance indicator.

1. The percentage of women 15-45 years of age with evidence of a previous pre-term singleton birth event (<37 weeks completed gestation) who received one or more Progesterone injections between the 16th and 21st week of gestation: 17P_PIP_Measure_5_17_16_clean.docx
2. The percentage of women 15-45 years of age with evidence of a previous pre-term singleton birth event (<37 weeks completed gestation) who received one or more Progesterone injections between the 16th and 24th week of gestation (PTB incentive measure): LA Performance Measure Submission Guide
3. The percentage of women aged 16 years and older who delivered a live birth and had at least one test for Chlamydia during pregnancy: chlamydia_screening_7_25_15.docx
4. The percentage of women who delivered a live birth and had at least one test for HIV during pregnancy: HIV_and_syphilis_screening_10_27_15.docx
5. The percentage of women who delivered a live birth and had at least one test for syphilis during
 - a. Pregnancy: HIV_and_syphilis_screening_10_27_15.docx.
6. The percentage of postpartum women who:
 - a. Adopt use of a most effective FDA-approved method of contraception, i.e., (i) female sterilization or (ii) Long-Acting Reversible Contraception (LARC), i.e., contraceptive implants, or intrauterine devices of systems (IUD/IUS)
 - b. Adopt use of a moderately effective method of contraception, i.e., use of injectable, oral pills, patch, ring or diaphragm.
 - c. Adopt use of LARC during delivery hospitalization
 - d. Adopt use of LARC outpatient within 56 days postpartum
7. The percentage of women with a postpartum visit as per the HEDIS PPC postpartum measure

Data Collection and Analysis Procedures

Is the entire eligible population being targeted by PIP interventions? Entire population

Describe sampling methodology: NA

Sample Size and Justification: NA

Data Collection:

Data will be collected by multiple departments within the Health Plan. Data collection will be completed by Business Data Analysts, Manager of Case Management, OB Practice Consultant, Quality Improvement Manager and HEDIS Manager. The tools that are used to collect the data include the use of SQL Server Management Studio and Teradata to analyze claims data. Additionally, the Case Management data is obtained through the use of referrals from a vendor who manages high risk population, health risk assessments and the notice of pregnancy forms. The use of the LEERS file and High Risk Registry provided by LDH is also utilized for data collection.

Validity and Reliability

Data collection is done in conjunction with the specifications set forth by the measures. The Business Analyst performs an audit of data pulled and addresses any gaps in missing data by conducting a deep dive of data collection method. The LEER file is bumped up against the eligible population criteria to determine the high risk members. Claims data (CPT, HCPCS, ICD-10Cm and/or NCD's) are used to determine numerator compliance.

Data Analysis:

Once data is obtained it is analyzed and compared to the goals set forth for each performance measure. In addition, the data is trended and compared to prior results for identification of opportunity of improvement. Also, data is stratified by region and member demographics to identify opportunity for targeted interventions to address specific performance measures.

Timeline

| Event | Timeframe |
|-----------------------------------|-------------------------------------|
| Baseline Measurement Period | November 6, 2014 –November 5, 2015 |
| Interim Measurement Period | November 6, 2015 – November 5, 2016 |
| Submission of Interim Report | June 30, 2017 |
| Final Re-measurement Period | November 6, 2016 – November 5, 2017 |
| Intervention Implementation | November 6, 2015 – November 5, 2017 |
| Analysis of Project Data | Ongoing |
| Submission of Final Report | June 30, 2018 |
| Extension Measurement Period | November , 2017- November 5, 2018 |
| Submission of Extended PIP Report | June 30, 2019 |

4. Barriers and 5. Interventions

This section describes the barriers identified and the related interventions planned to overcome those barriers in order to achieve improvement.

Table of Barriers Identified and the Interventions Designed to Overcome Each Barrier.

| Description of Barrier | Method and Source of Barrier Identification | Number of Intervention | Description of Intervention Designed to Overcome Barrier | Intervention Timeframe |
|--|---|------------------------|---|--|
| Communication of member pregnancy to the health plan | Provider | 1 | Distributed a NOP Fax Blast to all network OBGYN's educating on the purpose, scope and how to complete the NOP form | Planned Start: 4/2016 Actual 5/1/2016 |
| Communication of member pregnancy to the health plan | Health Plan | 1A | Health Plan posted the NOP form to Health Plan's Member Web-Site | Planned Start: 4/2016 Actual 5/1/2016 |
| Provider awareness | Provider/Health Plan | 2 | Medicaid 101 Roadshow conducted by OB Practice Consultant targeting the top OB providers. Roadshow developed to address educational opportunities identified. | Planned Start:5/2016 Actual Start:1/2017 Date Revised: N/A |
| Provider Awareness | Provider | 2A | Health Plan sent all DHH LARC Bulletin as a fax blast to all OBGYN and Hospitals and the network | Planned Start:5/2016 Actual Start:6/2016 Date Revised: N/A |
| Low Case Management Engagement | Case Management | 3 | Case Management High Risk Outreach- Case Managers will make outreach to all high risk members using LEERS data to engage members into Healthy Blue's CM Program to increase 17- P utilization and STI screenings during pregnancy | Planned Start: 5/2016 Actual Start:6/2016 Date Revised: on-going |

| Description of Barrier | Method and Source of Barrier Identification | Number of Intervention | Description of Intervention Designed to Overcome Barrier | Intervention Timeframe |
|----------------------------|---|------------------------|---|--|
| Case Management Education | Case Management | 3A | OB Practice Consultant provide education to internal Case Management Department on importance of member engagement of high risk OB members | Planned Start: 1/2018 Actual Start: Date Revised: N/A |
| Post-Partum Follow-up Care | Access to Care | 3 | Corporate CM nurses Provide outreach to all women who delivered a live birth by offering postpartum appointment scheduling assistance | Planned Start: 5/2016 Actual Start:6/2016 Date Revised: N/A |
| Post-Partum Follow-up Care | Access to Care | 4A | Corporate CM nurses Provide outreach to all women who delivered a live birth by offering home visit option for those members who are unable to access outpatient appointments | Planned Start: 5/2016 Actual Start:6/2016 Date Revised: N/A |
| Post-Partum Follow-up Care | Member Engagement | 4B | Member Incentive Plan for members will receive \$50 for completing Postpartum visit | Planned Start: 5/2016 Actual Start:6/2016 Date Revised: N/A |
| Low STI Screening Rates | Member Engagement | 5 | Member Incentive Plan for members receive \$10 for completing STI screenings | Planned Start: 5/2016 Actual Start:6/2016 Date Revised: N/A |
| Member Education | Member Engagement | 6 | Pregnancy packets distributed to high risk mother's to include information on importance of LARC | Planned Start:1/2018 Actual Start:1/2018 Date Revised: N/A |
| Low LARC usage | Provider | 7 | OB Practice Consultant Targeting providers in the Top 10 Regions with lowest LARC usage | Planned Start:1/2018 Actual Start:1/2018 Date Revised: N/A |

Monitoring Table YEAR 1: Quarterly Reporting of Rates for Intervention Tracking Measures, with corresponding intervention numbers. Add rows as needed.

| Number of Intervention | Description of Intervention Tracking Measures ⁶ | Qtr. 1: 11/2015 – 01/2016 Num Den Rate | Qtr. 2: 02/2016 – 04/2016 Num Den Rate | Qtr. 3: 05/2016 – 07/2016 Num Den Rate | Qtr. 4: 08/2016 – 11/2016 Num Den Rate |
|------------------------|---|---|---|---|---|
| 1-1A | Submission of NOP form to the Health Plan #1-1A Num: Number of NOP forms received from Providers Denom: Number of women who delivered | Numerator: 487 Denominator: 1637 Rate: 29.75% | Numerator: 537 Denominator: 1581 Rate: 33.97% | Numerator: 647 Denominator: 1708 Rate: 37.88% | Numerator: 706 Denominator: 2002 Rate: 35.26% |
| 2 | OB Practice Consultant provider visits targeting the top OB providers. Roadshow developed to address educational opportunities identified. #2 Num: # of visits completed Denom: top OB provider total | Intervention started in Q1 2017 | Intervention started in Q1 2017 | Intervention started in Q1 2017 | Intervention started in Q1 2017 |
| 3 | Case management engagement rate #3 Num: # of members engaged in case management Denom: # of high risk women who received an injectable progesterone | Quarterly Data not Available | Quarterly Data not Available | Quarterly Data not Available | Numerator: 7 Denominator: 85 Rate: 8.23% |
| 4 | Post-Partum Appointment Rate #4 Num: # appointments scheduled for postpartum Denom: # of women who deliver | Numerator: 674 Denominator: 1637 Rate: 41.17% | Numerator: 606 Denominator: 1581 Rate: 38.33% | Numerator: 693 Denominator: 1708 Rate: 40.57% | Numerator: 944 Denominator: 2002 Rate: 47.15% |
| 4A | Post-Partum Follow-up Visit Rate #4A Num: # home visits Denom: # of women who deliver | Quarterly Data not Available | Quarterly Data not Available | Quarterly Data not Available | Quarterly Data not Available- Total home Visits for 2016= 17 |
| 4B | Member Incentive Post-Partum Follow-Up Reward Utilization Rate #4B Num: # of women who received a Postpartum Healthy reward Denom: # of women who deliver | Numerator: 86 Denominator: 1637 Rate: 5.25% | Numerator: 82 Denominator: 1581 Rate: 5.18% | Numerator: 94 Denominator: 1708 Rate: 5.50% | Numerator: 213 Denominator: 2002 Rate: 10.64% |

| | | | | | |
|---|--|--|---|--|--|
| 5 | Member STI Screening Reward Utilization Rate #4B Num: # of women who revived STI Healthy Rewards Benefits Denom: /# of women who deliver | Numerator: 106 Denominator: 1637 Rate: 6.48% | Numerator: 46 Denominator: 1581 Rate: 2.91% | Numerator: 153 Denominator: 1708 Rate: 8.95% | Numerator: 153 Denominator: 2002 Rate: 7.64% |
|---|--|--|---|--|--|

Monitoring Table YEAR 2: Quarterly Reporting of Rates for Intervention Tracking Measures, with corresponding intervention numbers.

| Number of Intervention | Description of Intervention Tracking Measures | Q1 November 2016- November 2017 | Q2 November 2016- November 2017 | Q3 November 2016- November 2017 | Q4 November 2016- November 2017 |
|------------------------|--|--|--|---|---|
| 1-1A | Submission of NOP form to the Health Plan #1-1A Num: Number of NOP forms received from Providers Denom: Number of women who delivered | Numerator: 570 Denominator: 1465 Rate: 38.9% | Numerator: 628 Denominator: 1368 Rate: 45.9% | Numerator: 523 Denominator: 1565 Rate: 33.42% | Numerator: 479 Denominator: 1084 Rate: 44.19% |
| 2 | 2 OB Practice Consultant provider visits targeting the top OB providers. Roadshow developed to address educational opportunities identified. #2 Num: # of visits completed Denom: # top OB Provider total | Numerator: 4 Denominator: 48 Rate: 8.33% | Numerator: 6 Denominator: 44 Rate: 13.64% | Numerator: 19 Denominator: 38 Rate: 50% | Numerator: 2 Denominator: 19 Rate: 10.53% |
| 3A | Case management Education #3 Num: total number of case management participation Denom: total number of case managers | Numerator: 34 Denominator: 39 Rate: 87.18% | Q1 2018 Intervention Only | Q1 2018 Intervention Only | Q1 2018 Intervention Only |
| 4 | 4 Post-Partum Appointment Rate #4 | Numerator: 577 Denominator: | Numerator: 566 Denominator: | Numerator: 626 Denominator: | Numerator: 291 Denominator: |

| Number of Intervention | Description of Intervention Tracking Measures | Q1 November 2016- November 2017 | Q2 November 2016- November 2017 | Q3 November 2016- November 2017 | Q4 November 2016- November 2017 |
|------------------------|--|--|---|---|--|
| | Num: # appointments scheduled for postpartum Denom: /# of women who deliver | 1465 Rate: 39.39% | 1368 Rate: 41.37% | 1565 Rate: 40.0% | or: 1084 Rate 26.85 % |
| 4B | Member Incentive Post-Partum Follow-Up Reward Utilization Rate #4B Num: # of women who received a Postpartum Healthy reward Denom: /# of women | Numerator: 122 Denominator: 1465 Rate: 8.33% | Numerator: 152 Denominator: 1368 Rate: 11.11% | Numerator: 115 Denominator: 1565 Rate: 7.35% | Numerator: 153 Denominator: 1084 Rate 14.11% |
| 5 | Member STI Screening Reward Utilization Rate #4B Num: # of women who revied STI Healthy Rewards Benefits Denom: /# of women who deliver | Numerator: 99 Denominator: 1465 Rate: 6.76% | Numerator: 102 Denominator: 1368 Rate: 7.46% | Numerator: 168 Denominator: 1565 Rate: 10.73% | Numerator: 103 Denominator: 1084 Rate 9.50% |
| 6 | Pregnancy Packets distribution Num: # of women who received pregnancy packets Denom: # of high risk women | Numerator: 84 Denominator: 835 Rate: 10.06% | Numerator: 190 Denominator: 264 Rate: 71.97% | Numerator: 120 Denominator: 139 Rate: 86.33% | Numerator: 133 Denominator: 236 Rate 56.36% |

6. Results

Results Table.

| Performance Indicator | Administrative (A) or Hybrid (H) Measure? | Baseline Period November 6, 2014- November 5, 2015 | Interim Period November 6, 2015- November 5, 2016 | Final Period November 6, 2016- November 5, 2017 | Final Goal/Target Rate |
|---|---|--|---|---|---|
| Indicator #1 The percentage of women 15-45 years of age with evidence of a previous pre-term | A | Eligible Population = 97 Exclusions= 0 If "H", Sample size = | Eligible Population = 562 Exclusions= 0 If "H", Sample size = N/A Numerator = 85 | Eligible Population = 614 Exclusions= 0 If "H", Sample size = | Target Rate: 20% Rationale: LDH Set Target |

| | | | | | |
|--|---|---|---|---|--|
| singleton birth event (<37 weeks completed gestation) who received one or more Progesterone injections between the 16th and 21st week of gestation. | | N/A Numerator = 17 Denominator = 97 Rate = 17.5% | Denominator = 562 Rate = 15.12% | N/A Numerator = 106 Denominator = 614 Rate = 17.3% | |
| Indicator #2 The percentage of women 15-45 years of age with evidence of a previous pre-term singleton birth event (<37 weeks completed gestation) who received one or more Progesterone injections between the 16th and 24th week of gestation (PTB incentive measure) | A | Eligible Population = Enter # Exclusions= 0 If "H", Sample size = N/A Numerator = 18 Denominator = 97 Rate = 18.6% | Eligible Population = Enter # Exclusions= 0 If "H", Sample size = N/A Numerator = 107 Denominator = 562 Rate = 19.0% | Eligible Population = Enter # Exclusions= 0 If "H", Sample size = N/A Numerator = 119 Denominator = 614 Rate = 19.4% | Target Rate:20% Rationale: LDH Set Target Rationale: Health Plan to increase rate by 10-15 percentage points over time |
| Indicator #3 The percentage of women aged 16 years and older who delivered a live birth and had at least one test for Chlamydia during pregnancy | A | Eligible Population = 6447 Exclusions= 0 If "H", Sample size = NA Numerator = 3380 Denominator = 6447 Rate = 52.4% | Eligible Population = 5949 Exclusions= 0 If "H", Sample size = NA Numerator = 3436 Denominator = 5949 Rate = 57.80% | Eligible Population = 5835 Exclusions= 0 If "H", Sample size = NA Numerator = 3791 Denominator = 5835 Rate = 65% | Target Rate: 60% Rationale: 75th NCQA Percentile Rationale: Health Plan to increase rate by 10-15 percentage points over time |
| Indicator #4 The percentage of women aged 16 years and | A | Eligible Population = 6447 Exclusions= 0 If "H", Sample | Eligible Population = 5949 Exclusions= 0 If "H", Sample | Eligible Population = 5835 Exclusions= 0 If "H", Sample | Target Rate: 42-50% Rationale: Health Plan to |

| | | | | | |
|--|---|---|--|---|--|
| older who delivered a live birth and had at least one test for HIV during pregnancy | | size = NA Numerator = 2045 Denominator = 6447 Rate = 31.7% | size = NA Numerator = 2358 Denominator = 5949 Rate = 39.63% | size = NA Numerator = 1586 Denominator = 5835 Rate = 27.2% | increase rate by 10-15 percentage points over time |
| Indicator #5 The percentage of women aged 16 years and older who delivered a live birth and had at least one test for syphilis during pregnancy | A | Eligible Population = 6447 Exclusions= 0 If "H", Sample size = NA Numerator = 2869 Denominator = 6447 Rate = 44.5% | Eligible Population = 5949 Exclusions= 0 If "H", Sample size = NA Numerator = 2403 Denominator = 5949 Rate = 40.40% | Eligible Population = 5835 Exclusions= 0 If "H", Sample size = NA Numerator = 1669 Denominator = 5835 Rate = 28.6% | Target Rate: 54%-64% Rationale: Health Plan to increase rate by 10-15 percentage points over time |
| Indicator #6a The percentage of women who adopt use of a most effective FDA-approved method of contraception | A | Eligible Population = 6447 Exclusions= 14 If "H", Sample size = NA Numerator = 1019 Denominator = 6433 Rate = 15.84% | Eligible Population = 5949 Exclusions= 16 If "H", Sample size = NA Numerator = 815 Denominator = 5933 Rate = 13.7% | Eligible Population = 5835 Exclusions= 9 If "H", Sample size = NA Numerator = 240 Denominator = 5826 Rate = 4.12% | Target Rate: 20% Rationale LDH Set Target |
| Indicator #6b The percentage of women who adopt use of a moderately effective FDA-approved method of contraception | A | Eligible Population = 6447 Exclusions= 14 If "H", Sample size = NA Numerator = 2202 Denominator = 6433 Rate = 34.2% | Eligible Population = 5949 Exclusions= 16 If "H", Sample size = NA Numerator = 2003 Denominator = 5933 Rate = 33.8% | Eligible Population = 5835 Exclusions= 9 If "H", Sample size = NA Numerator = 616 Denominator = 5826 Rate = 10.6% | Target Rate: 44% Rationale: LDH Set Target |
| Indicator #6c The percentage of women who adopt use of LARC during delivery hospitalization | A | Eligible Population = 6447 Exclusions= 14 If "H", Sample size = NA Numerator = 92 Denominator = 6433 Rate = 1.4% | Eligible Population = 5949 Exclusions= 16 If "H", Sample size = NA Numerator = 87 Denominator = 5933 Rate = 1.5% | Eligible Population = 5835 Exclusions= 9 If "H", Sample size = NA Numerator = 30 Denominator = 5826 Rate = .51% | Target Rate: 44.0% Rationale LDH Set Target |

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| <p>Indicator #6d The percentage of women who adopt use of LARC outpatient 56 days postpartum</p> | <p>A</p> | <p>Eligible Population = 6447 Exclusions= 14 If "H", Sample size = NA Numerator = 683 Denominator = 6433 Rate = 10.6%</p> | <p>Eligible Population = 5949 Exclusions= 16 If "H", Sample size = NA Numerator = 658 Denominator = 5933 Rate = 11.1%</p> | <p>Eligible Population = 5835 Exclusions= 9 If "H", Sample size = NA Numerator = 4 Denominator = 5826 Rate = .1%</p> | <p>Target Rate: 44.0% Rationale: LDH Set Target</p> |
| <p>Indicator #7 The percentage of women with a postpartum visit as per the HEDIS PPC postpartum measure</p> | <p>H</p> | <p>Eligible Population = 6423 Exclusions= 2 If "H", Sample size = 428 Numerator =264 Denominator = 426 Rate = 61.97%</p> | <p>Eligible Population = 5964 Exclusions= 5 If "H", Sample size = 412 Numerator = 265 Denominator = 407 Rate = 65.11%</p> | <p>Eligible Population = 5845 Exclusions= 0 If "H", Sample size = 411 Numerator = 268 Denominator = 411 Rate = 65.21%</p> | <p>Target Rate: 67.53% Rationale: LDH Set Target</p> |

7. Discussion

The discussion section is for explanation and interpretation of the results. Please draft a preliminary explanation and interpretation of results, limitations and member participation for the Interim Report, then update, integrate and comprehensively interpret all findings for the Final Report. Address dissemination of findings in the Final Report.

Discussion of Results

Interpret the performance indicator rates for each measurement period, i.e., indicate whether or not target rates were met, describe whether rates improved or declined between baseline and interim, between interim and final and between baseline and final measurement periods:

- Indicator 1- The percentage of women 15-45 years of age with evidence of a previous pre-term singleton birth event (<37 weeks completed gestation) who received one or more Progesterone injections between the 16th and 21st week of gestation results from baseline to interim declined, then improvement was seen for final. The target was not met by a total of 2.7% percentage points.
- Indicator 2- The percentage of women 15-45 years of age with evidence of a previous pre-term singleton birth event (<37 weeks completed gestation) who received one or more Progesterone injections between the 16th and 24th week of gestation results from baseline to interim improved, also improvement was seen for final. The target was not met by a total of .6% percentage points.
- Indicator 3- The percentage of women aged 16 years and older who delivered a live birth and had at least one test for Chlamydia during pregnancy results from baseline to interim improved, also improvement was seen for final. The target was met exceeding by 5% points.
- Indicator 4- The percentage of women aged 16 years and older who delivered a live birth and had at least one test for HIV during pregnancy results from baseline to interim improved then a decline was seen for final. The target was not met.
- Indicator 5- The percentage of women aged 16 years and older who delivered a live birth and had at least one test for syphilis during pregnancy results from baseline to interim declined then a decline was seen for final. The target was not met.
- Indicator 6a- The percentage of women who adopt use of a most effective FDA-approved method of contraception results from baseline to interim declined then a decline was seen for final. The target was not met.
- Indicator 6b- The percentage of women who adopt use of a moderately effective FDA-approved method of contraception results from baseline to interim declined then a decline was seen for final. The target was not met.
- Indicator 6c- The percentage of women who adopt use of LARC during delivery hospitalization results from baseline to interim declined then a decline was seen for final. The target was not met.
- Indicator 6d- The percentage of women who adopt use of LARC outpatient 56 days postpartum results from baseline to interim declined then a decline was seen for final. The target was not met.
- Indicator 7- The percentage of women with a postpartum visit as per the HEDIS PPC postpartum measurer results from baseline to interim improved, also improvement was seen for final The target was not met.

Explain and interpret the extent to which improvement was or was not attributable to the interventions, by interpreting quarterly or monthly intervention tracking measure trends: Based on intervention tracking the extent to which improvement for some measures was attributable to the increase surrounding provider education and members benefiting from member incentive rewards. Additionally, education sent to members increased significantly.

What factors were associated with success or failure? Improvement was noted for use of 17-p from baseline to final measurement. This success can be attributed to increase in education to members and providers regarding the usage of 17-p. As it relates to obtaining the above measures for LARC, there has been much discussion with providers regarding the factors of failure for usage of LARC and contraceptive

choices. The following factors have been determined: Members often change their minds regarding contraceptive methods,. As it relates to the screening of STI rates, factors related to member’s personal choice to have the screening completed plays a role in the failure of meeting the rates. The ability for members to obtain a post-partum visit has increased although not meeting the rate. The health plan has made strides in assisting the member is obtaining an appointment whether it be in the provider office or by means of a home visit.

Limitations

As in any population health study, there are study design limitations for a PIP. Address the limitations of your project design. Examples of study limitations include: Accuracy of administrative measures that are specified using diagnosis or procedure codes are limited to the extent that providers and coders enter the correct codes; Accuracy of hybrid measures specified using chart review findings are limited to the extent that documentation addresses all services provided.

- **Were there any factors that may pose a threat to the internal validity the findings?** The ability of the Health Plan to identify members who are currently pregnant in real time. Often times, there is a delay in obtaining this information through claims data.
- **Were there any threats to the external validity the findings?** Provider coding; if providers are not utilizing the correct coding for the Health Plan to correctly track and analyze. Additionally timely submission of claims could pose a potential threat. Claims processing lag time could potentially skew the validity of findings.
- **Describe any data collection challenges.** Collection of data related to intervention tracking has been a challenge as real time identification of high risk members has been a challenge. Additionally, obtaining NOP forms by providers has been a challenge as it is not a requirement by the state which has resulted in barriers for the health plan.

Member Participation

Describe methods utilized to solicit or encourage membership participation: Healthy rewards is offered to members who complete follow-up screenings and appointments. Additionally, outreach conducted to engage members in case management, option of home visits in addition to mailings sent to members to educate them throughout the course of their pregnancy.

Dissemination of Findings

- **Describe the methods used to make the findings available to members, providers, or other interested parties:** Healthy Blue makes Quality Improvement information available to members via Quality Program Up-Date Post Card sent out to members annually. The information is also up-dated on our Web-site.

8. Next Steps

This section is completed for the Final Report. For each intervention, summarize lessons learned, system-level changes made and/or planned, and outline next steps for ongoing improvement through the PIP extension period.

| Description of Intervention | Lessons Learned | System-level changes made and/or planned | Next Steps |
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| <p>NOP Fax Education blast to in network providers</p> | <p>Providers are not utilizing the NOP forms as frequently as they should be. This is an issue across all MCO's.</p> | <p>NOP form posted on HP's web-site for easy access. OB Practice Consultant working to educate providers on the importance of use of the NOP form.</p> | <p>On-going monitoring of usage; Additionally the Health Plan is implementing a portal 10/2018 for providers to utilize which will include a "benefit look up tool" which will allow for real time identification of pregnant women.</p> |
| <p>Medicaid 101 Roadshow conducted by OB Practice Consultant targeting the top OB providers. Roadshow developed to address educational opportunities identified.</p> | <p>Level of provider outreach needed to be expanded</p> | <p>Expansion from top 50 providers to top 75</p> | <p>Development of a OB report card to address gaps in care</p> |
| <p>Case Management High Risk Outreach- CM make outreach to all high risk members using LEERS data to engage members into Healthy Blue's CM Program to increase 17- P utilization and STI screenings during pregnancy.</p> | <p>Case Managers were utilizing the LEERS list, but not engaging all members timely.</p> <p>Case Managers were not adequately using Optum to help administer 17P injections.</p> <p>Notification of Pregnancies were not being sent in by all providers, so some members were being missed.</p> | <p>Case Managers are now being assigned cases bi-weekly based off LEERS list and the NOP forms received from providers.</p> <p>17P list is generated based on information from My Advocate and cases are assigned to encourage the start of 17P in a timely manner.</p> <p>Education of the CM staff to ensure that 17P and STI screenings are being discussed with pregnant members, in which this HEDIS measure may apply.</p> | <p>Healthy Blue is currently working on trying to collaborate with providers to fax notification of pregnancies and ensure that the case management department screens those NOP forms for high risk members.</p> <p>Case managers will be required to discuss members in MCS rounds if case is complicated and barriers exist to obtaining or complying with 17P</p> <p>Healthy Blue is ensuring that claims data is utilized to identify members who received a positive pregnancy test. Once these members are identified, a screener is performed on the member to determine if they are high risk. If the member is high risk the member is engaged in Case Management.</p> |

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| OB Practice Consultant provide education to internal Case Management Department on importance of member engagement of high risk OB members. | Case Management Department needed to gain a better understanding regarding the importance of member engagement of high risk OB members | On-going training and engagement of Case Management staff in the implementation and management of the PIP | Increased collaboration between Quality and the Case Management Department |
| Corporate CM nurses Provide outreach to all women who delivered a live birth by offering postpartum appointment scheduling assistance. | Availability of vendor to access multiple regions for appointments were limited. | Contracted with a new vendor with a wider regional reach for appointment access. | Implementation of new vendor. |
| Corporate CM nurses Provide outreach to all women who delivered a live birth by offering home visit option for those members who are unable to access outpatient appointments. | See above | See above | See above |
| Member Incentive Plan for members will receive \$50 for completing Postpartum visit | Member incentives are well received by members. The need for increased education of incentives available identified | Development and outreach of member education on available incentives | Implementation of education |
| Member Incentive Plan for members receive \$10 for completing STI screenings | See above | See above | See above |
| Pregnancy packets distributed to high risk mother's to include information on importance of LARC. | Although education was being sent to members, engagement of high risk members in Case Management | Education of the CM staff performed. | On-going training and engagement of Case Management staff in the implementation and management of the PIP |

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| | was low. | | |
| OB Practice Consultant Targeting providers in the Top 10 Regions with lowest LARC usage. | Facilities who are faith based are not utilizing LARC techniques. Additionally, barriers identified for LARC usage for mother's while inpatient after birth. | In addition to looking at LARC usage while in-patient, data for LARC usage in the outpatient setting will be a focus. | Development of focused LARC trainings for providers in the outpatient setting , also a collective approach that incorporates the hospitals postpartum staff, Pharmacy, Hospital staff, providers who utilize LARC and support member choice to be considered. |
| Healthy Blue, in collaboration with the other MCO's, is using the Plan-Do-Study-Act (PDSA) cycles to test interventions, identify root causes/barriers and revise interventions by measuring and interpreting progress of/barriers to interventions for 6 identified ITM's Identified Below: | See below | See below | See below |
| 1 Identification and Stratification of pregnant women with prior preterm singleton birth, | | | Implement a SharePoint Site with Case Management to include tracking case management processes for the measure. This development will occur beginning 07/20/18 and Quality members will participate in the development of the site to ensure validity, capture and meaningful use of the data within the site and to members. This close collaboration is a result of prior PIP identified opportunities between groups to form better collaborations with regard to implementation of ITM's. Process flow charts were created and distributed to all OB team members to identify where in the process of pregnancy the |

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| | | <p>interventions will need to take place. GAP analysis was performed and items addressed. Education on the measures were given to all OB/Quality team members to kick off the PIP.</p> <p>OB Health Promotions team will educate providers on the importance of competing and submitting the NOP forms to the Health Plan and will work to adopt a best practice for form submittal.</p> <p>These initiatives also address early recognition and risk stratification primary driver.</p> |
| 2 Member receipt of face-to-face care coordination, | | <p>Implement a Share point Site with Case Management to include tracking case management processes for the measure. This development will occur beginning 07/20/18 and Quality members will participate in the development of the site to ensure validity, capture and meaningful use of the data within the site and to members.</p> <p>This close collaboration is a result of prior PIP identified opportunities between groups to form better collaborations with regard to implementation of ITM's.</p> <p>Process flow charts were created and distributed to all OB team members to identify where in the process of pregnancy the interventions will need to take place. GAP analysis was performed and items addressed. Education on the measures were given to all OB/Quality team members to kick off the PIP.</p> <p>These initiatives also address early recognition and risk stratification primary driver.</p> |
| 3 Member receipt of care management outreach with completed contact for 17P education and facilitation for OB appointment | | <p>Implement a Share point Site with Case Management to include tracking case management processes for the measure. This development will</p> |

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| | | <p>occur beginning 07/20/18 and Quality members will participate in the development of the site to ensure validity, capture and meaningful use of the data within the site and to members.</p> <p>This close collaboration is a result of prior PIP identified opportunities between groups to form better collaborations with regard to implementation of ITM's.</p> <p>Process flow charts were created and distributed to all OB team members to identify where in the process of pregnancy the interventions will need to take place. GAP analysis was performed and items addressed. Education on the measures were given to all OB/Quality team members to kick off the PIP.</p> <p>OB Health Promotions team will continue to educate the provider And encourage them to share the potential benefits of 17 P use.</p> <p>These initiatives also address early recognition and risk stratification primary driver.</p> |
| <p>4 Member receipt of contraception education during third trimester with completion of a reproductive plan,</p> | | <p>Implement a SharePoint Site with Case Management to include tracking case management processes for the measure. This development will occur beginning 07/20/18 and Quality members will participate in the development of the site to ensure validity, capture and meaningful use of the data within the site and to members.</p> <p>This close collaboration is a result of prior PIP identified opportunities between groups to form better collaborations with regard to implementation of ITM's.</p> <p>Process flow charts were created and distributed to all OB team members to identify where</p> |

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| | | <p>in the process of pregnancy the interventions will need to take place. GAP analysis was performed and items addressed. Education on the measures were given to all OB/Quality team members to kick off the PIP.</p> <p>OB Health Promotions team will continue to work with providers to establish teachable moments to introduce family planning in the third trimester and document education of such.</p> <p>These initiatives also address early recognition and risk stratification primary driver.</p> |
| <p>5 Members at risk for preeclampsia whose provider received notification from the plan and</p> | | <p>Implement a tracking mechanism with the Healthy Blue OBGYN Practice Consultant to include tracking education documentation for the measure.</p> <p>This close collaboration is a result of prior PIP identified opportunities between groups to form better collaborations with regard to implementation of ITM's. CM is working on a CMAP document that will allow member names and information to be submitted to the provider directly and timely with those members to consider for low dose aspirin regimen.</p> <p>These initiatives also address early recognition and risk stratification primary driver Preeclampsia preventions- low dose aspirin</p> |
| <p>6 Women with a current preterm delivery with postpartum outreach within six weeks of delivery for comprehensive education on chronic disease management as indicated; pregnancy spacing and contraception planning; progesterone, and ASA and had an appointment with a PCP scheduled..</p> | | <p>Implement a SharePoint Site with Case Management to include tracking case management processes for the measure. This development will occur beginning 07/20/18 and Quality members will participate in the development of the site to ensure validity, capture and meaningful use of the data within the site and to members.</p> |

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| | | | <p>This close collaboration is a result of prior PIP identified opportunities between groups to form better collaborations with regard to implementation of ITM's.</p> <p>Process flow charts were created and distributed to all OB team members to identify where in the process of pregnancy the interventions will need to take place. GAP analysis was performed and items addressed. Education on the measures were given to all OB/Quality team members to kick off the PIP.</p> <p>These initiatives also address early recognition and risk stratification primary driver.</p> |
| <p>Healthy Blue will be building on the following proposed drivers to address the aims for early initiation of high quality patient centered care</p> <p>Expedited progesterone supplementation</p> <p>Birth spacing</p> | TBD | TBD | <p>TBD-State discussion is scheduled for October 18, 2018 to review proposed diagram.</p> |