Healthy Louisiana Performance Improvement Project (PIP)

Aetna Better Health of Louisiana

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: 3/31/2016
Project Phase: Baseline
Submission Date: 6/30/2016
Revised Submission Date: 7/26/2016
Project Phase: Interim
Submission Date: 6/30/2017
Revised Submission Date: 7/31/2017
Project Phase: Final
Submission Date: 6/28/2018
Revised Submission Date: 10/10/2018

Submission to: IPRO
State: Louisiana Department of Health

MCO Contact Information

1. Principal MCO Contact Person

[PERSON RESPONSIBLE FOR COMPLETING THIS REPORT AND WHO CAN BE CONTACTED FOR QUESTIONS]

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PIP proposal: Refer to embedded document below 3/31/2016
Baseline Report: Refer to embedded document below 6/30/2016
Interim Report: Refer to embedded document below 6/30/2017
Final Report: *Ashley Bailey* 6/28/2018

03/31/2016 Signatory	06/30/2016 Signatory	06/30/2017 Signatory
ABH PIP Proposal Submission	ABH PIP Baseline Submission	ABH PIP Interim Submission

2. Additional Contact(s)

[PERSON(S) RESPONSIBLE IN THE EVENT THAT THE PRINCIPAL CONTACT PERSON IS UNAVAILABLE]

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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 – no changes in Methodology and/or Data Collection from initial proposal

5. Attestation

Managed Care Plan Name: Aetna Better Health of Louisiana
Title of Project: Improving Prenatal and Postpartum Care to Reduce the Risk for Preterm Birth

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.

Medical Director Signature 6/28/2018
Madhavi Rajulapalli, MD

Shelley Krawchuk RN
Quality Director Signature 6/28/2018
Shelley Krawchuk

CEO Signature 6/28/2018
Richard Born

The undersigned approve this FINAL PIP Report:

Medical Director Signature 6/28/2018
Madhavi Rajulapalli, MD

Shelley Krawchuk RN
Quality Director Signature 6/28/2018
Shelley Krawchuk

CEO Signature 6/28/2018
Richard Born

Abstract

The Abstract should be drafted for the Interim Report and finalized for the Final Report submission. Should not exceed 2 pages.

Project Topic/Rationale/Aims

Title of Project: Improving Prenatal and Postpartum Care to Reduce the Risk for Preterm Birth
Rationale for Project: 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 Louisiana Department of Health of the State of Louisiana targets a 15% reduction in the statewide prematurity rate by 2017.
Project Aims: The Collaborative PIP aims to decrease the preterm birth rate by implementing a robust set of health plan, member and provider interventions.

Methodology

Eligible Population: Aetna Better Health of Louisiana pregnant members

Description of Annual Performance Indicators: The performance indicators for the Prematurity PIP are as follows:

1. **Initiation of Injectable Progesterone for Preterm Birth Prevention**: The percentage of women 15–45 years of age with evidence of a previous spontaneous preterm singleton birth event as identified by the high-risk registry(< 37 weeks completed gestation) who received one or more progesterone injections (17 alpha-OH progesterone caproate, 17P) for prevention of future preterm birth
2. **Use of Most Effective Contraceptive Methods by High-Risk Postpartum Women:** The percentage of women in the high risk registry, who adopted the use of a most effective contraceptive method [(1) use of female sterilization, (2) contraceptive implants, (3) intrauterine devices or (4) systems (IUD/IUS); the latter three (2, 3, & 4) represent LARC method of contraception] during delivery hospitalization and the postpartum period
3. **Modified HEDIS® Chlamydia Screening in High-Risk Pregnant Women Administrative Measure**: The percentage of women 16–24 years of age, who were identified as pregnant, and in the high-risk registry, who had at least one test for Chlamydia during the prenatal period
4. **HIV and Syphilis Screening Among Pregnant Women During Pregnancy**:
5. **HEDIS® Postpartum Measure (Administrative)**

Sampling Method: Sampling is not used and all eligible members are included in the reporting for process measures.
Baseline and Re-measurement Periods:

Event	Timeframe
Baseline Measurement Period	November 6, 2104 –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 6, 2017- November 5, 2018
Submission of Extended PIP Report	June 30, 2019

Data Collection Procedures:

The following data sources will be used by the plan for reporting outcome measures, process measures and implementing interventions:

1. The high risk indicator sent on the daily 834 enrollment file. Maximus is the data source for new enrollees with prior pre-term birth history contained within the high risk registry. Historical data dates back to October 1, 2014.
2. Plan will utilize the HEDIS Deliveries Value Set, and/or a delivery on an infant claim (Deliveries Infant Record Value Set).
3. Plan Care management system and utilization management system software
4. LEERS weekly report
5. Notice of Pregnancy Form
6. Claims data and pharmacy encounters

Interventions

Member Barriers Identified: The member barriers identified for the Prematurity PIP include: lack of member knowledge, member access, data access and streamlining, and process standardization.
Interventions to address member barriers: In order to overcome these barriers, interventions were created to include: Notification of Pregnancy form, Internal Pregnancy Registry, Member education, and Care Management effectiveness.
Provider Barriers Identified: The provider barriers identified for the Prematurity PIP include: lack of provider knowledge, data access and streamlining, and process standardization.
Interventions to address provider barriers: In order to overcome these barriers, interventions were created to include: Notification of Pregnancy form, Internal Pregnancy Registry, Provider education, and Care Management effectiveness.

Results

Report Data for Annual Performance Indicators:

	Baseline Period (June 2016)	Interim (June 2017)	Final (June 2018)	Target Goal
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.	10.81%	8.05%	19.01%	20%
The percentage of women aged 16 years and older who delivered a live birth and had at least one test for Chlamydia during pregnancy.	72.40%	85.30%	85.94%	87%
The percentage of women who delivered a live birth and had at least one test for HIV during pregnancy.	70.30%	85.70%	79.68%	87%
The percentage of women who delivered a live birth and had at least one test for syphilis during pregnancy.	73.60%	88.50%	84.24%	87%
The percentage of postpartum women who 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., Intrauterine Device (IUD), or Intrauterine System (IUS)	7.70%	10.1%	17.06%	19%
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.	9.00%	29.42%	26.04%	31%
The percentage of postpartum women who adopt use of either a most or moderately effective FDA-approved method of contraception	15.80%	41.12%	38.99%	43%
HEDIS Postpartum Measure	58.28%	63.08%	63.50%	63.12%

Conclusions

Interpret improvement in terms of whether or not Target Rates were met for annual performance indicators:

ABH met goal for final report for the following performance indicator:

1. The percentage for HEDIS Postpartum Measure was 63.5% for the final measurement period. The State Target goal is 63.12% per contract. We exceeded the established State goal by 0.38 percentage points.

ABH did not meet goal for the final report, but did increase the percentage rates compared to baseline measurement for the following:

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 is 19.01% for the final measuring period. This is just below the 20% target rate by 0.99 percentage points.
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 is 85.94% for the final measurement period. The target rate for this measure is 87%.
3. The percentage of women who delivered a live birth and had at least one test for HIV during pregnancy is 79.68% for the final measurement period. This measure is 7.3 percentage points below the target rate of 87%.
4. The percentage of women who delivered a live birth and had at least one test for syphilis during pregnancy is 84.24% during the final measurement period. The current rate is 2.8 percentage points below the target rate of 87%.
5. The percentage of postpartum women who 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., Intrauterine Device (IUD), or Intrauterine System (IUS) is 17.06% for the final measurement period. This is an increase of 1.26 percentage points from the baseline measurement rate of 15.8%.
6. The percentage of postpartum women who: Adopt use of a moderately effective method of contraception, i.e., use of injectables, oral pills, patch, ring or diaphragm is 26.04% for the final measurement period. This is an increase of 17.04 percentage points from the baseline measurement rate of 9.0%.

Indicate interventions that did and did not work in terms of quarterly intervention tracking measure trends:

ABH increased from the 2016 measurement on the following metrics:

1. # of distinct providers submitted NOP forms / # PCP & OB Specialty providers
2. # pregnant members who received Promise Rewards / # delivered member
3. # Pregnant Members in Care management / #Pregnant Members
4. # high risk members who received 17P / # of at risk pregnant members whose provider was faxed an alert
5. # providers administering 17P / #OB & PCP Provider

ABH decreased from the 2016 measurement on the following metrics:

1. # NOP forms submitted by providers and pregnant members/ total # pregnant members
2. #of previous preterm pregnant members in care management / # of previous preterm pregnant members
3. # High risk pregnant members receiving 3rd trimester calls / # at risk pregnant members
4. # of delivered members who received postpartum CM assessment / # of delivered members
5. # of delivered members who completed post-partum office visit / # of delivered members

Study Design Limitations: Throughout the PIP project, several limitations occurred to which ABH evaluated and attempted to overcome. One such issue includes lack of patient engagement and ability for case management to successfully reach out to them. Coding accuracy is another limitation. Staffing limitations due to turnover also contributed.

Lessons Learned and Next Steps: The MCO has learned that the best opportunities for improvement stem from patient and provider education, whether it is regarding benefits, pregnancy, or coding. It is essential that members and providers are taught the correct information about these items so that whatever processes are created and implemented can be successful.

1. Project Topic/ Rationale and 2. Aim

Suggested length: 2 pages

1. 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):** 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 Louisiana Department of Health 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% (LDH-LA, 2014). Racial disparities are evident among the LA population. Across all LA regions, preterm birth rates are highest among the black subpopulation, with the highest rates in Region 7, i.e., 20.5% for preterm and 4.1% for very preterm births (LDH-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% (LDH-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 Healthy Louisiana 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 rates scored at the 95th percentile.
- **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. 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 black 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 rates 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 injectables, 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 interventions to address the following intervention strategies: (1) Notice of Pregnancy (NOP) provider to plan communication; (2) High Risk Registry Plan to provider communication; (3) Provider education (Medicaid 101); and (4) Prenatal Care Management Outreach and Engagement Program Targeted to High Risk Members.

Goal(s):
Each of the 9 performance indicators (1-6, above) should have its own unique goal. Enter a goal statement for each performance indicator, below:

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 who received one or more Progesterone injections between the 16th and 21st week of pregnancy by 10 percentage points (from 10% to 20%).

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.
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 15 percentage points (from 72% to 87%).

3. 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 number of women who delivered a live birth and had at least one test for HIV during pregnancy by 17 percentage points (from 70% to 87%).

4. 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 number of women who delivered a live birth and had at least one test for syphilis during pregnancy by 14 percentage points (from 73% to 87%).

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)
Baseline to final measurement goal: Increase the percentage of postpartum women who adopt use of the most effective FDA-approved method of contraception by 12 percentage points (from 7% to 19%).

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 contraception by 22 percentage points (from 9% to 31%).

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 28 percentage points (from 15% to 43%).

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 within 56 days postpartum by 28 percentage points (from 15% to 43%).

6. 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 10 percentage points (from 58% to 68%).

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 pregnancy: HIV_and_syphilis_screening_10_27_15.docx.
6. The percentage of postpartum women who (LA_Prematurity_PIP_contraceptive_measure_revised_5_17_16clean.docx; group to discuss use of CMS Adult Core Set measure CCP-AD Contraceptive Care Postpartum Women age 21-44 years and CMS Child Core Set measure CCP-CH Contraceptive Care Postpartum Women age 15-20 years as next step for PIP extension measurement year 2018):
    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 injectables, 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? Yes

If sampling was employed: N/A
Describe sampling methodology: None, not applicable
Sample Size and Justification: None, not applicable

Data Collection:
The IT team assists with data collection and calculations, and the quality management team reviews the data for validity and reliability. The tool used for data collection is Microsoft SQL Server. Aetna utilizes the SQL Server to link all sources of data. The IT team assists with data collection and rate calculations, and the quality management team reviews the data for validity and reliability. Sampling is not used and all eligible members are included in the reporting for process measures.

Validity and Reliability
(For definitions, refer to Glossary of PIP Terms in HEALTHY_LOUISIANA_PIP_TEMPLATE_w_example)**:**

The quality management team reviews the data for validity and reliability on a monthly and quarterly basis – this process of monthly data collection and reviews were implemented during Q12018 as new staffing came aboard.

Data Analysis:

Performance Indicators	Data Sources
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.	LEERS File Eligibility Records Administrative Claims
The percentage of women aged 16 years and older who delivered a	HEDIS Delivery Value

live birth and had at least one test for Chlamydia during pregnancy.	Set, Administrative Claims
The percentage of women who delivered a live birth and had at least one test for HIV during pregnancy.	HEDIS Delivery Value Set, Administrative Claims
The percentage of women who delivered a live birth and had at least one test for syphilis during pregnancy.	HEDIS Delivery Value Set, Administrative Claims
The percentage of postpartum women who 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., Intrauterine Device (IUD), or Intrauterine System (IUS)	HEDIS Delivery Value Set, Administrative Claims
The percentage of postpartum women who: Adopt use of a moderately effective method of contraception, i.e., use of injectables, oral pills, patch, ring or diaphragm.	HEDIS Delivery Value Set, Administrative Claims
The percentage of postpartum women who adopt use of either a most or moderately effective FDA-approved method of contraception	HEDIS Delivery Value Set, Administrative Claims
HEDIS Postpartum Measure	HEDIS Software (Innovalon)

The following data sources will be used by the plan for reporting outcome measures, process measures and implementing interventions:

1. The high risk indicator sent on the daily 834 enrollment file. Maximus is the data source for new enrollees with prior pre-term birth history contained within the high risk registry. Historical data dates back to October 1, 2014.
2. Plan will utilize the HEDIS Deliveries Value Set, and/or a delivery on an infant claim (Deliveries Infant Record Value Set).
3. Plan Care management system and utilization management system software
4. LEERS weekly report
5. Notice of Pregnancy Form
6. Claims data and pharmacy encounters – based on specific codes from encounters, the plan determines if a member qualifies for sub-populations such as: previous pre-term birth, third trimester, first pregnancy, etc.

This information will be used to create the internal pregnancy registry. The plan will develop look back procedures to ensure members omitted from previous periods will be added and/or cross referencing procedures to address duplicate members.

The IT team assists with data collection and calculations, and the quality management team reviews the data for validity and reliability. The tool used for data collection is Microsoft SQL Server. Aetna utilizes the SQL Server to link all sources of data. The IT team assists with data collection and rate calculations, and the quality management team reviews the data for validity and reliability. Sampling is not used and all eligible members are included in the reporting for process measures.

Timeline

Event	Timeframe
Baseline Measurement Period	November 6, 2104 –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 6, 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.

Populate the tables below with relevant information, based upon instructions in the footnotes.
Add rows as needed.

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

Description of Barrier[2]	Method and Source of Barrier Identification[3]	Number of Intervention	Description of Intervention Designed to Overcome Barrier[4]	Intervention Timeframe[5]
Lack of notification of newly pregnant members and delayed care and benefit implementation	Claims information	1, 2	**Implementation of NOP Form** • Standard Operating Procedure/process to submit NOP forms by providers	*Planned Start:1/2016 Actual Start:3/2016 Date Revised: 7/2016*
Lack of accurate information/data regarding newly and current pregnant members as well as delivered members	Claims Information	*16, 17 – These interventions /process measures were used as a process measure during the first year to assess our improvement with data as a new MCO. While it was continued to be used during year two, it was not counted as a process measure.	**Internal Pregnancy Registry** – use of multiple data sources to pull most accurate and up-to-date information regarding ABH pregnant member population	*Planned Start:1/2015 Actual Start:6/2015 Date Revised: 7/2016*
Provider and Member Education	Provider and Provider/member feedback, claims information	3, 4, 5	**Provider and Member Education** Standardized Tools and Procedures • Plan is developing and refining how we communicate to Providers, example: newsletter articles, provider meetings/focus group,	*Planned Start:10/2015 Actual Start:12/2015*

Description of Barrier[2]	Method and Source of Barrier Identification[3]	Number of Intervention	Description of Intervention Designed to Overcome Barrier[4]	Intervention Timeframe[5]
			blast fax, email notices, Provider relations handouts, and letters. Community outreach events for members Promise Rewards Program to incentivize members to receive timely prenatal and postpartum care Enrollment in care management for high risk pregnant members to provide additional availability and assistance to resources as needed	*Date Revised: 9/2016*
Lack of member and provider knowledge regarding available benefits and coordination of care	Provider/member feedback, claims information	6-18	**Care Management Effectiveness** Pregnant members, inclusive of high risk pregnant members, enrolled in case management Care management care coordination with Optum Home Health and Providers administering 17P Number of high risk pregnant members receiving a call during the 3rd trimester for LARC education and post-partum care planning Members enrolled in Nurse Family Program (NFP) – program for first time mothers that provide a nurse as an additional resource from pregnancy through early years of childhood Members enrolled in Parent and Teachers Program (PAT) – community program for any parent that provides other parents as a resource for additional questions from pregnancy through early childhood Members who complete a post-partum office visit Post-partum women involved in case management with a completed CM assessment	*Planned Start:2/2015 Actual Start:2/2015 Date Revised: 9/2016*

2,3,4,5: See PIP HEALTHY_LOUISIANA_PIP_TEMPLATE_w_examples for examples and additional guidance.

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]	Q1 2016	Q2 2016	Q3 2016	Q4 2016
1	Submitted NOP forms Num: # NOP forms submitted by providers and pregnant members Denom:total # pregnant members	No baseline data found in original submission	Num: 12 Denom: 1456 Rate: 0.78%	Num: 35 Denom: 2316 Rate: 2%	Num: 65 Denom: 2612 Rate: 2%
2	Providers that submit to	No baseline	Num: 7	Num: 7	Num: 7

Number of Intervention	Description of Intervention Tracking Measures[6]	Q1 2016	Q2 2016	Q3 2016	Q4 2016
	NOP form Num: # of providers submitted NOP forms Denom:# PCP & OB Specialty providers	data found in original submission	Denom: 6691 Rate: 0.10%	Denom: 1638 Rate: 0.43%	Denom: 1648 Rate: 0.42%
3	Community Outreach events Num (count only): # of community outreach events related to maternal health (YTD sum)	No baseline data found in original submission	N/A	N/A	Num: 2 Denom: 6 Rate: 33%
4	Members receiving promise program rewards Num: # pregnant members who received Promise Rewards Denom:# pregnant members	No baseline data found in original submission	Num: 311 Denom: 1456 Rate: 21%	Num: 601 Denom: 2316 Rate: 26%	Num: 762 Denom: 2612 Rate: 29%
5	Number of high risk members enrolled in care management Num: #of High Risk pregnant members in care management Denom:# of High Risk pregnant members	No baseline data found in original submission	Num: 1 Denom: 140 Rate: .07%	Num: 86 Denom: 279 Rate: 31%	Num: 7 Denom: 38 Rate: 18%
6	Number of high risk pregnancy members receiving 3rd trimester calls Num: #High Risk members receiving 3rd trimester calls Denom:# High Risk pregnant members	No baseline data found in original submission	Num: 60 Denom: 279 Rate: 22%	Num: 79 Denom: 395 Rate: 20%	Num: 97 Denom: 488 Rate: 20%
7	Pregnant members enrolled in case management Num: # Pregnant Members in Care management Denom:#Pregnant Members	No baseline data found in original submission	Num: 9 Denom: 1354 Rate: 0.66%	Num: 41 Denom: 2100 Rate: 2%	Num: 196 Denom: 3581 Rate: 5%
8	High risk members enrolled in case management Num: # of at-risk pregnant members meeting 17P criteria enrolled in care management Denom:# of at risk pregnant members	No baseline data found in original submission	Num: 1 Denom: 140 Rate: .07%	Num: 86 Denom: 279 Rate: 31%	Num: 7 Denom: 38 Rate: 18%

Number of Intervention	Description of Intervention Tracking Measures[6]	Q1 2016	Q2 2016	Q3 2016	Q4 2016
	meeting 17P criteria				
9	Providers administering 17P Num: # providers administering 17P Denom:#OB & PCP Providers	No baseline data found in original submission	Num: 43 Denom: 6691 Rate: 0.64%	Num: 27 Denom: 1638 Rate: 2%	Num: 36 Denom: 1648 Rate: 2%
10	Members referred to NFP program Num: # of pregnant members referred to NFP program (count only)	No baseline data found in original submission	Rate: 8	Rate: 11	Rate: 0
11	Number of members enrolled in NFP Num: # of pregnant members enrolled in NFP Denom:# of pregnant members referred to NFP program	No baseline data found in original submission	Num: 3 Denom: 8 Rate: 38%	Num: 4 Denom: 11 Rate: 36%	Num: 4 Denom: 11 Rate: 36%
12	Members referred to PAT program Num: # of pregnant members referred to PAT program (count only)	No baseline data found in original submission	Rate: 0	Rate: 0	Rate: 0
13	Number of members enrolled in PAT Num: # of pregnant members enrolled in PAT Denom:# of pregnant members referred to PAT program	No baseline data found in original submission	Num: 0 Denom: 0 Rate: 0%	Num: 0 Denom: 0 Rate: 0%	Num: 0 Denom: 0 Rate: 0%
14	Delivered members with a CM assessment Num: # of delivered members with documented PP CM assessments Denom:# of delivered members	No baseline data found in original submission	Num: 103 Denom: 1354 Rate: 8%	Num: 143 Denom: 2100 Rate: 6%	Num: 177 Denom: 3581 Rate: 7%
15	Members who complete a post-partum office visit Num: # of delivered members who completed post-partum office visit Denom:# of delivered members	No baseline data found in original submission	Num: 697 Denom: 1546 Rate: 45%	Num: 1117 Denom: 1980 Rate: 56%	Num: 1483 Denom: 2582 Rate: 57%
16	Internal Pregnancy Registry Num: # data denominators completed Denom: # data denominators identified	No baseline data found in original submission	Num:2 Denom: 6 Rate: 33%	Num:2 Denom: 6 Rate: 33%	Num:2 Denom: 6 Rate: 33%
17	Internal Pregnancy	No baseline	Num: 2	Num: 2	Num: 7

Number of Intervention	Description of Intervention Tracking Measures[6]	Q1 2016	Q2 2016	Q3 2016	Q4 2016
	Registry Num: # reportable pregnancy elements completed Denom: # elements identified	data found in original submission	Denom: 13 Rate: 15%	Denom: 13 Rate: 15%	Denom: 13 Rate: 53%

6: See PIP HEALTHY_LOUISIANA_PIP_TEMPLATE_w_examples for examples and additional guidance.

Monitoring Table YEAR 2: 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]	Q1 2017	Q2 2017	Q3 2017	Q4 2017
1.	Submitted NOP forms Num: # NOP forms submitted by providers and pregnant members Denom:total # pregnant members	Num: 18 Denom:1490 Rate: 1%	Num:52 Denom: 2142 Rate: 2%	Num: 0 Denom: 3359 Rate: 0%	Num: 58 Denom: 4065 Rate: 1.4. %
2	Providers that submit to NOP form Num: # of providers submitted NOP forms Denom:# PCP & OB Specialty providers	Num: 5 Denom: 1653 Rate:0.3%	Num: 7 Denom: 1679 Rate:0.42%	Num: 0 Denom: 1766 Rate: 0%	Num: 1 Denom: 981 Rate: 0.3%
3	Number of providers that attend education events Num: # Unique providers who completed educational program opportunities (WebEx, peer to peer, etc.) Denom:total # providers	Num: 1 Denom: 8 Rate: 13%	Num: 2 Denom: 8 Rate: 25%	Num: 6 Denom: 8 Rate: 75%	***Under revision to create a rate for future reporting**
4	Community Outreach events Num: # of community outreach events related to maternal health (YTD sum)	Total: 11	Total: 15	Total: 18	Total: 26
5	Members receiving promise program rewards Num: # pregnant members who received Promise Rewards Denom:# pregnant members	Num: 138 Denom: 170 Rate: 81%	Num: 303 Denom: 515 Rate: 59%	Num: 576 Denom: 1375 Rate: 42%	Num: 1739 Denom:4065 Rate:42.77%
6	Number of high risk members enrolled in care	Num: 73 Denom: 165	Num: 104 Denom: 220	Num: 138 Denom: 334	Num: 120 Denom: 475

Number of Intervention	Description of Intervention Tracking Measures[6]	Q1 2017	Q2 2017	Q3 2017	Q4 2017
	management Num: #of High Risk pregnant members in care management Denom:# of High Risk pregnant members	Rate: 44%	Rate: 47%	Rate: 41%	Rate: 25.26%
7	Number of high risk pregnancy members receiving 3rd trimester calls Num: #High Risk members receiving 3rd trimester calls Denom:# High Risk pregnant members	Num: 13 Denom: 52 Rate: 25%	Num: 26 Denom: 93 Rate: 28%	Num: 36 Denom: 125 Rate: 29%	Num:23 Denom:143 Rate:16.08%
8	Pregnant members enrolled in case management Num: # Pregnant Members in Care management Denom:#Pregnant Members	Num: 259 Denom: 1490 Rate: 17%	Num: 390 Denom: 2144 Rate: 18%	Num: 749 Denom: 3359 Rate: 22%	Num: 634 Denom: 4065 Rate: 15.60%
9	High risk members receiving 17P Num: # high risk members who received timely injectable progesterone initiation Denom:# of at risk pregnant members meeting 17P criteria	Num: 22 Denom: 176 Rate: 13%	Num: 26 Denom: 218 Rate: 12%	Num: 28 Denom: 334 Rate: 8%	Num:17 Denom:102 Rate:16.67%
10	High risk members enrolled in case management Num: # of at-risk pregnant members meeting 17P criteria enrolled in care management Denom:# of at risk pregnant members meeting 17P criteria	No baseline data found in original submission and in subsequent submissions	Num: 104 Denom: 220 Rate: 47%	Num: 138 Denom: 334 Rate: 41%	Num: 120 Denom: 475 Rate: 25.26%
11	Providers administering 17P Num: # providers administering 17P Denom:#OB & PCP Providers	Num: 11 Denom: 1653 Rate:0.67%	Num: 21 Denom: 1679 Rate: 1%	Num: 97 Denom: 1766 Rate: 5%	Num: 57 Denom: 981 Rate: 21.70%
12	Members referred to NFP program Num: # of pregnant members referred to NFP program	Num: 0 Denom: 2 Rate: 0%	Num: 2 Denom: 8 Rate: 25%	Num: 5 Denom: 14 Rate: 36%	Total – zero referred due to a pause in referrals via vendor request

Number of Intervention	Description of Intervention Tracking Measures[6]	Q1 2017	Q2 2017	Q3 2017	Q4 2017
	Denom:# of pregnant members eligible for NPF				– process re-implemented for 2018 after clarification was provided regarding information sharing
13	Number of members enrolled in NFP Num: # of pregnant members enrolled in NFP Denom:# of pregnant members referred to NFP program	Num: 4 Denom: 11 Rate: 36%	Num: 1 Denom: 2 Rate: 50%	Num: 1 Denom: 2 Rate: 50%	Num: 1 Denom: 2 Rate: 50%
14	Members referred to PAT program Num: # of pregnant members referred to PAT program Denom:# of pregnant members eligible for PAT	Num: 10 Denom: 121 Rate: 8%	Num: 15 Denom: 150 Rate: 13%	Num: 15 Denom: 210 Rate: 7.14%	Total – zero referred due to a pause in referrals via vendor request – process re-implemented for 2018 after clarification was provided regarding information sharing
15	Number of members enrolled in PAT Num: # of pregnant members enrolled in PAT Denom:# of pregnant members referred to PAT program	Num: 0 Denom: 0 Rate: 0%	Num: 0 Denom: 10 Rate: 0%	Num: 1 Denom: 19 Rate: 5%	Num: 1 Denom: 19 Rate: 5%
16	Delivered members with a CM assessment Num: # of delivered members with documented PP CM assessments Denom:# of delivered members	Num: 0 Denom: 259 Rate: 0%	Num: 4 Denom: 390 Rate: 1.03%	Num: 41 Denom: 749 Rate: 5.47%	Num:42 Denom:1927 Rate: 2.18%
17	Members who complete a post-partum office visit Num: # of delivered members who completed post-partum office visit Denom:# of delivered members	Num: 23 Denom: 170 Rate: 14%	Num: 155 Denom: 515 Rate: 30%	Num: 679 Denom: 1511 Rate: 45%	Num: 816 Denom: 1927 Rate: 42.36%
18	Postpartum women enrolled in care management	N/A	N/A	N/A	Num:361 Denom:1927 Rate:18.7%

Number of Intervention	Description of Intervention Tracking Measures[6]	Q1 2017	Q2 2017	Q3 2017	Q4 2017
	Num: # of delivered members in care management Denom:# of delivered members				

6: See PIP HEALTHY_LOUISIANA_PIP_TEMPLATE_w_examples for examples and additional guidance.

6. Results

The results section should present project findings related to performance indicators. Indicate target rates and rationale, e.g., next Quality Compass percentile. Accompanying narrative should describe, but ***not*** interpret the results in this section.

OPTIONAL: Additional tables, graphs, and bar charts can be an effective means of displaying data that are unique to your PIP in a concise way for the reader. If you choose to present additional data, include only data that you used to inform barrier analysis, development and refinement of interventions, and/or analysis of PIP performance.

Results Table.

Performance Indicator	**Administrative (A) or Hybrid (H) Measure?**	**Baseline Period** 2015	**Interim Period** 2016	**Final Period** 2017	**Final Goal/Target Rate**
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.	A	Eligible Population = 55 Exclusions= 0 If "H", Sample size = N/A Numerator = 5 Denominator = 55 Rate = 9.1%	Eligible Population = 112 Exclusions= 0 If "H", Sample size = N/A Numerator = 11 Denominator = 112 Rate = 9.8%	Eligible Population = 142 Exclusions= 0 If "H", Sample size = N/A Numerator = 24 Denominator = 142 Rate = 16.9%	Target Rate: 20% Rationale: The final target was based on the baseline measurements, along with the plan's initial interventions and processes and ability to increase and change the necessary factors to improve the adherence rates over the timeframe of the project.
Indicator #2 The percentage of women 15-45 years of age with evidence of a previous pre-term singleton birth	A	Eligible Population = 55 Exclusions= 0 If "H", Sample size = N/A Numerator = 7 Denominator = 55	Eligible Population = 112 Exclusions= 0 If "H", Sample size = N/A Numerator = 13 Denominator = 112	Eligible Population = 142 Exclusions= 0 If "H", Sample size = N/A Numerator = 27 Denominator = 142	Target Rate: 20% Rationale: The final target was based on the baseline measurements, along with the

event (<37 weeks completed gestation) who received one or more Progesterone injections between the 16th and 24th week of gestation (PTB incentive measure)		Rate = 12.7%	Rate = 11.6%	Rate = 19.01%	plan's initial interventions and processes and ability to increase and change the necessary factors to improve the adherence rates over the timeframe of the project.
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 = 1386 Exclusions= 0 If "H", Sample size = N/A Numerator = 1004 Denominator = 1386 Rate = 72.4%	Eligible Population = 2444 Exclusions= 0 If "H", Sample size = N/A Numerator = 2085 Denominator = 2444 Rate = 85.3%	Eligible Population = 1993 Exclusions= 0 If "H", Sample size = N/A Numerator = 1711 Denominator = 1993 Rate = 85.94%	Target Rate: 87% Rationale: The final target was based on the baseline measurements, along with the plan's initial interventions and processes and ability to increase and change the necessary factors to improve the adherence rates over the timeframe of the project.
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	A	Eligible Population = 1386 Exclusions= 0 If "H", Sample size = N/A Numerator = 975 Denominator = 1386 Rate = 70.3	Eligible Population = 2444 Exclusions= 0 If "H", Sample size = N/A Numerator = 2094 Denominator = 2444 Rate = 85.7%	Eligible Population = 1993 Exclusions= 0 If "H", Sample size = N/A Numerator = 1588 Denominator = 1993 Rate = 79.68%	Target Rate: 87% Rationale: The final target was based on the baseline measurements, along with the plan's initial interventions and processes and ability to increase and change the necessary factors to improve the adherence rates

					over the timeframe of the project.
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 = 1386 Exclusions= 0 If "H", Sample size = N/A Numerator = 379 Denominator = 1386 Rate = 27.3%	Eligible Population = 2444 Exclusions= 0 If "H", Sample size = N/A Numerator = 1120 Denominator = 2444 Rate = 45.8%	Eligible Population = 1993 Exclusions= 0 If "H", Sample size = N/A Numerator = 1679 Denominator = 1993 Rate = 84.24%	Target Rate: 87% Rationale: The final target was based on the baseline measurements, along with the plan's initial interventions and processes and ability to increase and change the necessary factors to improve the adherence rates over the timeframe of the project.
Indicator #6a The percentage of women who adopt use of a most effective FDA-approved method of contraception	A	Eligible Population = 1386 Exclusions= 0 If "H", Sample size = N/A Numerator = 19 Denominator = 1386 Rate = 1.4%	Eligible Population = 2444 Exclusions= 0 If "H", Sample size = N/A Numerator = 188 Denominator = 2444 Rate = 7.7%	Eligible Population = 1993 Exclusions= 0 If "H", Sample size = N/A Numerator = 340 Denominator = 1993 Rate = 17.06%	Target Rate: 19% Rationale: The final target was based on the baseline measurements, along with the plan's initial interventions and processes and ability to increase and change the necessary factors to improve the adherence rates over the timeframe of the project.
Indicator #6b The percentage of women who adopt use of a moderately effective FDA-approved method of	A	Eligible Population = 1386 Exclusions= 0 If "H", Sample size = N/A Numerator = 125 Denominator =	Eligible Population = 2444 Exclusions= 0 If "H", Sample size = N/A Numerator = 717 Denominator =	Eligible Population = 1993 Exclusions= 0 If "H", Sample size =N/A Numerator = 519 Denominator =	Target Rate: 31% Rationale: The final target was based on the baseline measurements, along with the

contraception		1386 Rate = 9%	2444 Rate = 29.3%	1993 Rate = 26.04%	plan's initial interventions and processes and ability to increase and change the necessary factors to improve the adherence rates over the timeframe of the project.
Indicator #6c The percentage of women who adopt use of LARC during delivery hospitalization	A	Eligible Population = 1386 Exclusions= 0 If "H", Sample size = N/A Numerator = 0 Denominator = 1386 Rate = 0%	Eligible Population = 2444 Exclusions= 0 If "H", Sample size =N/A Numerator = 41 Denominator = 2444 Rate = 1.7%	Eligible Population = 1993 Exclusions= 0 If "H", Sample size = N/A Numerator = 25 Denominator = 1993 Rate = 1.25%	Target Rate: 19% Rationale: The final target was based on the baseline measurements, along with the plan's initial interventions and processes and ability to increase and change the necessary factors to improve the adherence rates over the timeframe of the project.
Indicator #6d The percentage of women who adopt use of LARC outpatient 56 days postpartum		Eligible Population = 1386 Exclusions= 0 If "H", Sample size = N/A Numerator = 88 Denominator = 1386 Rate = 6.3%	Eligible Population = 2444 Exclusions= 0 If "H", Sample size = N/A Numerator = 206 Denominator = 2444 Rate = 8.4%	Eligible Population = 1993 Exclusions= 0 If "H", Sample size = N/A Numerator = 169 Denominator = 1993 Rate = 8.48%	Target Rate: 19% Rationale: The final target was based on the baseline measurements, along with the plan's initial interventions and processes and ability to increase and change the necessary factors to improve the adherence rates over the timeframe of the project.

Indicator #7 The percentage of women with a postpartum visit as per the HEDIS PPC postpartum measure (Hybrid)	H The measure can be obtained using administrative claims data or by hybrid method which is completed via medical record audit. Aetna elects to use Hybrid data and medical record review for this measure.	Eligible Population = 1386 Exclusions= 0 If "H", Sample size = 429 Numerator = 250 Denominator = 429 Rate = 58.28%	Eligible Population = 2444 Exclusions= 0 If "H", Sample size = 432 Numerator = 251 Denominator = 432 Rate = 63.08%	Eligible Population =1993 Exclusions= 0 If "H", Sample size = 411 Numerator = 261 Denominator = 411 Rate = 63.50%	Target Rate: 63.12% (per State contract) The NCQA 50th percentile is 64.38% Rationale: The final target was based on the baseline measurements, along with the plan's initial interventions and processes and ability to increase and change the necessary factors to improve the adherence rates over the timeframe of the project.

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:

Quantitative Analysis:
Improvement from the baseline was shown for all annual performance indicators.

ABH met goal for final report for the following performance indicator:

1. The percentage for HEDIS Postpartum Measure was 63.5% for the final measurement period. This is an increase of 0.42 percentage points from the interim rate of 63.08% and an increase of 5.22 percentage points of the baseline measurement period of 58.28%. The State Target goal is 63.12% per contract. We exceeded the established State goal by 0.38 percentage points.

ABH did not meet goal for the final report, but did increase the percentage rates compared to baseline measurement for the following:

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 is 19.01% for the final measuring period. This is an increase of 10.96% percentage points from the interim rate of 8.05%, and just below the 20% target rate by 0.99 percentage points.
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 is 85.94% for the final measurement period. This is an increase of .64 percentage points from the interim rate of 85.3%. The target rate for this measure is 87%.
3. The percentage of women who delivered a live birth and had at least one test for HIV during pregnancy is 79.68% for the final measurement period. This is a decrease of 6.02 percentage points from the interim measurement period of 85.7%. This measure is 7.3 percentage points below the target rate of 87%.
4. The percentage of women who delivered a live birth and had at least one test for syphilis during pregnancy is 84.24% during the final measurement period. This is a 38.44 percentage point increase from the interim rate of 45.8%. The current rate is 2.8 percentage points below the target rate of 87%.
5. The percentage of postpartum women who 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., Intrauterine Device (IUD), or Intrauterine System (IUS) is 17.06% for the final measurement period. This is a decrease of 30.14 percentage points from the interim rate of 47.2% and an increase of 1.26 percentage points from the baseline measurement rate of 15.8%.
6. The percentage of postpartum women who: Adopt use of a moderately effective method of contraception, i.e., use of injectables, oral pills, patch, ring or diaphragm is 26.04% for the final measurement period. This is a decrease of 3.3 percentage points from the interim rate of 29.3% but an increase of 17.04 percentage points from the baseline measurement rate of 9.0%.

ABH has met the target goal for the HEDIS postpartum based on the State contract.

Qualitative:
This success is attributed to improved reporting, more comprehensive claims data, change of staffing, education programs initiative for care management staff knowledge deficits, modification of forms and templates. Existing processes were refined from the first year of business that contributed to a more standard level set on the scores and the refining of different measures. The interim measurement period did see improvements.

There remains room for improvement in all annual performance indicators to exceed the target rates (goals) by the extended re-measurement PIP phase. We will continue to improve our 17P rate which has reached just below the target rate. The plan attests the increases from baseline to interim measurements to the interventions set forth in the PIP document on a marginal level and that further performance improvement activities and interventions are needed to improve our rating scores, and member outcomes.

ABH has diligently worked to improve outcomes of all indicators through practitioner and member education and implementing and updating new interventions and processes as needed. As new staff has been hired and trained, they have reviewed current processes and are working daily to determine which ones benefit our members and which ones should be revised to in order to provide a greater impact. The plan continues to experience barriers in reporting, staffing, and member compliance due to accessibility as reviewed below.

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:
ABH increased from the 2016 measurement on the following metrics:

1. # of distinct providers submitted NOP forms / # PCP & OB Specialty providers
2. # pregnant members who received Promise Rewards / # delivered member
3. # Pregnant Members in Care management / #Pregnant Members
4. # high risk members who received 17P / # of at risk pregnant members whose provider was faxed an alert
5. # providers administering 17P / #OB & PCP Provider

ABH decreased from the 2016 measurement on the following metrics:

1. # NOP forms submitted by providers and pregnant members/ total # pregnant members
2. #of previous preterm pregnant members in care management / # of previous preterm pregnant members
3. # High risk pregnant members receiving 3rd trimester calls / # at risk pregnant members
4. # of delivered members who received postpartum CM assessment / # of delivered members
5. # of delivered members who completed post-partum office visit / # of delivered members

The degree and extent to which improvement was or not attributable to the interventions is listed below:

- In 2017, ABH saw a substantial increase in the NOP forms being submitted. ABH conducted 17 unique educational program opportunities in provider settings. Community outreach events were not tracked successfully; with a new hire and placement of full-time Maternal Health Program Manager, we anticipate resolution in 2018.

- Value Add incentives were successful with 4065 being issued. The rate of our high-risk pregnancies was between 25.26% to 47% per quarter. ABH plans to increase this in 2018 by active enrollment of all high-risk members into our Home Health program with Optum health.

- The calls in the third trimester by our care management team averaged 18% in 2017. A workgroup was established to focus on the rating scores, and to boost these in 2018. All members enrolled in care management should receive a telephone call by ABH to collaborate their care.

- The total enrollment of pregnant members in care management ranges averaged at 14.9% as many members opt out of this program. Many are multiparous and refuse services.

- The text for baby program was unable to provide aggregate reports per quarter. Aetna National team is working with the vendor in resolution.

- Care management assessment and documentation of the care plan rating is between 0% to 2.18%. The results reflect ineffective processes. The results have been discussed with the care management team, and quality management to begin routine quality checks, and track/trend documentation by care management in 2018.

- ABH continues to have problems obtaining reports from the PAT and NFP programs; this is secondary to them being a third party vendor and their interpretation of HIPAA laws. This creates a barrier in provision of care. In 2018, ABH plans to meet with the vendors to rectify any misunderstanding of law, and establish a reporting framework and frequency report.

Although improved, there continues to be a low percentage of our high-risk members identified for 17P injections receiving care management services. Quality management met with Optum health and our care management team for resolution, including deep-dive in to the referral process. We identified that the file identifying the members was not being sent to the vendor. We have implemented a new process whereby a report will be sent to the vendor in real time as new cases are identified. There is also a survey being conducted in quarter one of 2018 regarding provider and member opinions on reasons they do not receive any or complete the course of 17P treatments. Results of this survey should be available in quarter two of 2018.

Limitations (For definitions and examples, refer to HEALTHY_LOUISIANA_PIP_TEMPLATE_w_example)

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?** There were several internal limitations that may have posed a threat to the internal validity of the findings. These include ABH staffing and reporting.
- **Were there any threats to the external validity the findings?** External validity threats include accessibility and practitioners. Women in the Medicaid Prospective Eligibility aid category lose coverage at the end of the month in which they deliver. This is a limitation to the study for the outcome measures related to postpartum care and contraceptives. Women with dual health coverage (Commercial and Medicaid) receive benefits from Medicaid as a secondary payer. This is a limitation to the study because the outcome measurements exclude this population, yet their perinatal care is addressed through our process measure and intervention.
- **Describe any data collection challenges.** There has been difficulty within the MCO in regards to collecting data from business leads in a regular and timely manner, as well as difficulties with reporting systems that are sometimes unavailable when needed for extended periods of time.

Limitation	**Description**	**Interventions being conducted or considered (specify) to address this barrier** (all interventions listed here should also appear in the Interventions table above)
Accessibility	Members have difficulty getting to physician's office to receive appropriate care.	Implement one Home Health prenatal visit for every pregnant member to be completed by a nurse practitioner or midwife. At the

		initial appointment, follow-up and additional needs such as 17P can be determined and Home Health will return as needed for follow up.
Practitioners	Difficulty capturing appropriate codes for billing and lack of knowledge regarding member benefits and services which potential affects the accuracy of reports based on claims and coding.	Face-to-face visits with practitioners to explain importance of PIP procedures and implementation with patients and education on billing etc.
Staffing	During 2017, there was significant staff turnover including the Quality Director position which remained vacant for 6 months and the Maternal Health PIP Project Manager position which remained vacant for 6 months as well.	Both positions have been filled as of December 29, 2017. The PM is evaluating processes and reviewing items that may have been missed in the absence of review. Also, the PIP Project Manager position was divided into two positions allowing one FTE to focus solely on each of the PIPs.
ABH Reporting	Unable to obtain reports from business leaders, and/or reports not readily available or maintained	Re-formatting of reporting structure and record keeping to ensure timeliness of reports, and availability. A new monthly accountability system has been created by quality to collect CM data on a monthly basis. Revisions to actual reporting systems are also being evaluated on a national level.
Reporting	Reports received from a 3rd party vendor	The reports for several metrics had to be re-evaluated because of issues receiving information from the 3rd party vendor. The methods by which these vendors are sending the data are being re-evaluated as is the reporting metric for future inquiries.

Member Participation

Member participation was included to create processes based on member feedback to case management as well as member surveys.

Describe methods utilized to solicit or encourage membership participation: Members were encouraged to participate through calls from case management congratulating them on a new pregnancy and explaining available benefits, mailers that included available benefit information. Member surveys were also used to for root-cause analysis to determine the best ways to improve and implement process measures. Provider education was giving to providers so that they could inform members of benefits, and community outreach events such as baby showers through the different regions.

Dissemination of Findings

- **Describe the methods used to make the findings available to members, providers, or other interested parties:**

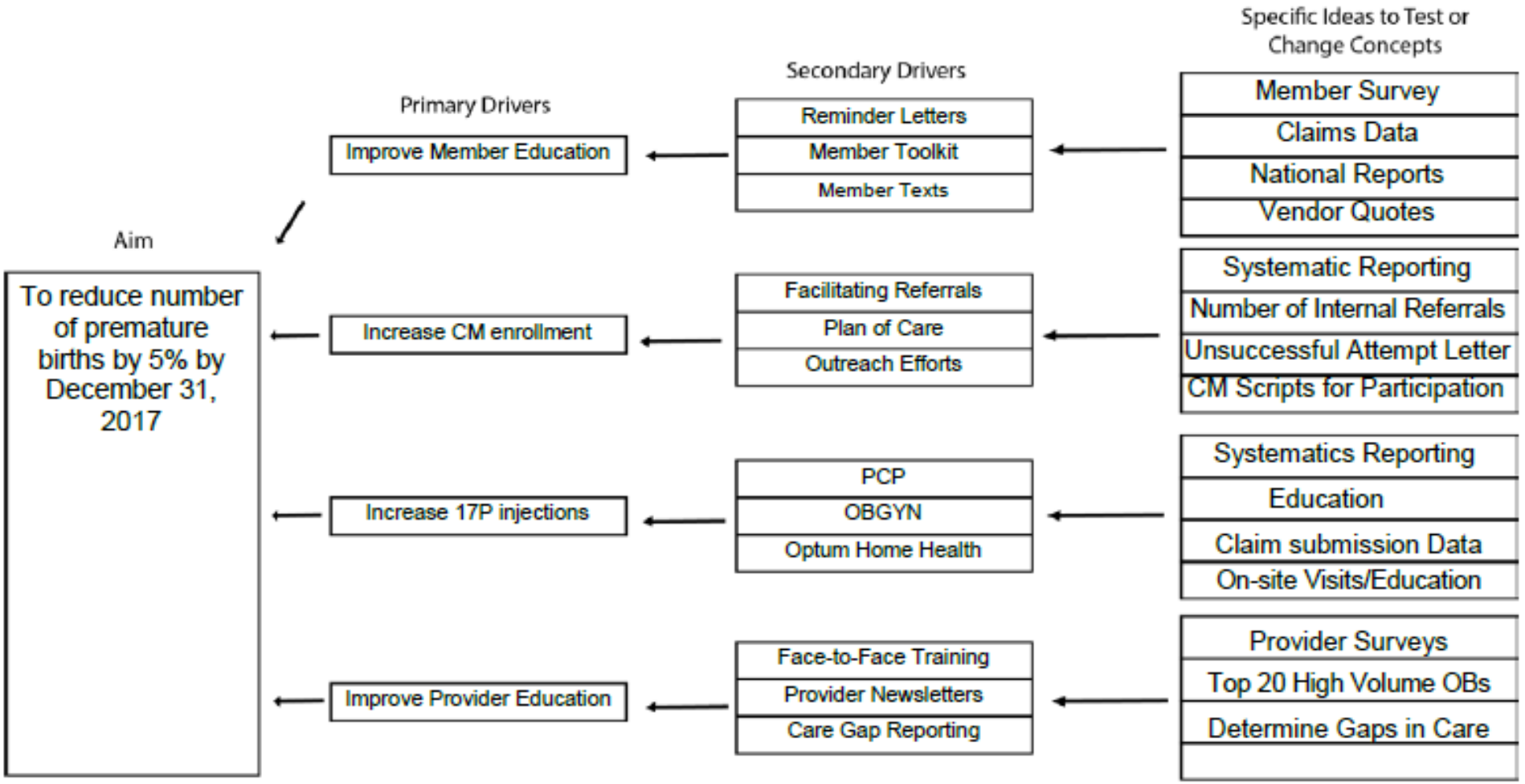
  Findings are made available to members through the ABH-LA website. Findings are made available to providers and other interested parties through the ABH-LA website as well as education presentations throughout the project.

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**
NOP Forms	ABH created a process for providers to submit the form online – the online form did not always work, leading to provider frustration and missed opportunities for form submission	ABH reviewed the current processes, lessons and opportunities to improve the process – noting that most forms from provider offices are submitted via fax	ABH is researching a process for all providers to submit forms via fax through a program that can review the received information and auto-transfer the data to a log for timely collection
Provider Education	Providers have limited time. Previously, visits were made to providers to speak solely about maternal health	In order to be cognoscente of provider's limited time, PIP PM is working with other QM staff and provider relations to create a presentation with information about all areas that need education. Therefore providers can have one reference tool and feel that they are gaining more from the session.	Creation of revised provider education and scheduling visits PR outreach to practitioners in collaboration with the Maternal Health Program Manager and Medical Directors, as indicated
Member Education	ABH was not capitalizing on face-to-face opportunities with members due to randomization of community events and participation	New Community Outreach manager has been hired and evaluated current processes for scheduling and opportunities for improvement	Community Outreach to schedule events collaboratively with CM to ensure CM presence at all events therefore making them available to answer member questions in real time
Members receiving promise program rewards	ABH created the program to provide incentive for the member to receive and complete timely prenatal and postpartum care	Through observation, the MCO has determined that some actions are higher value than others and is currently reevaluating the program and incentive rates to determine how best to care for members and	Incentive program benefits under revision.

		encourage prenatal care	
Case Management Interventions	Ability to contact members often has small time frame due to changes in membership, address or phone number	CM has worked with QM to develop scripts in order to maximize on what information is given to the member when a successful contact is made	Scripts to be created and implemented in process for CM member contacts
17P Timely Injections	Transportation and time constraints hindered multiple members from completing the injections in their provider's office	Partner with Optum Home Health for referrals to be sent to the vendor and the vendor to reach out to the provider to complete injections	New process implementation in march with vendor for direct provider outreach from qualified/ expert prenatal home health agency. Partnership implemented in March 2018 and results will be ready for extended PIP measurement period
NFP and PAT referrals	ABH has had difficulty in successfully engaging and enrolling members into programs. There were also discrepancies with the vendor regarding what type of information could be shared with the MCO under HIPAA rules and regulations	ABH created a script for the initial contact with a pregnant member that includes information regarding NFP and PAT. ABH asked that MIECHV clarify abilities to share information. It has since been confirmed that they do have the ability to share information via HIPAA regulations	CM Script is being developed and CM staff educated on how to engage and enroll a larger portion of members
Postpartum care and CM outreach	ABH has learned that the ability to contact members often has small time frame due to changes in membership, address or phone number is	In order maximize the potential for CM to contact the member postpartum as well as the member's likelihood to complete postpartum care, each contact CM has prior to delivery, contact information is verified and the member is educated on the importance of both prenatal and postpartum care	Script is being implemented to engage and enroll larger portion of members in case management or other programs that will assist in providing the education needed so that members know to complete postpartum care; promise reward program includes postpartum care incentive

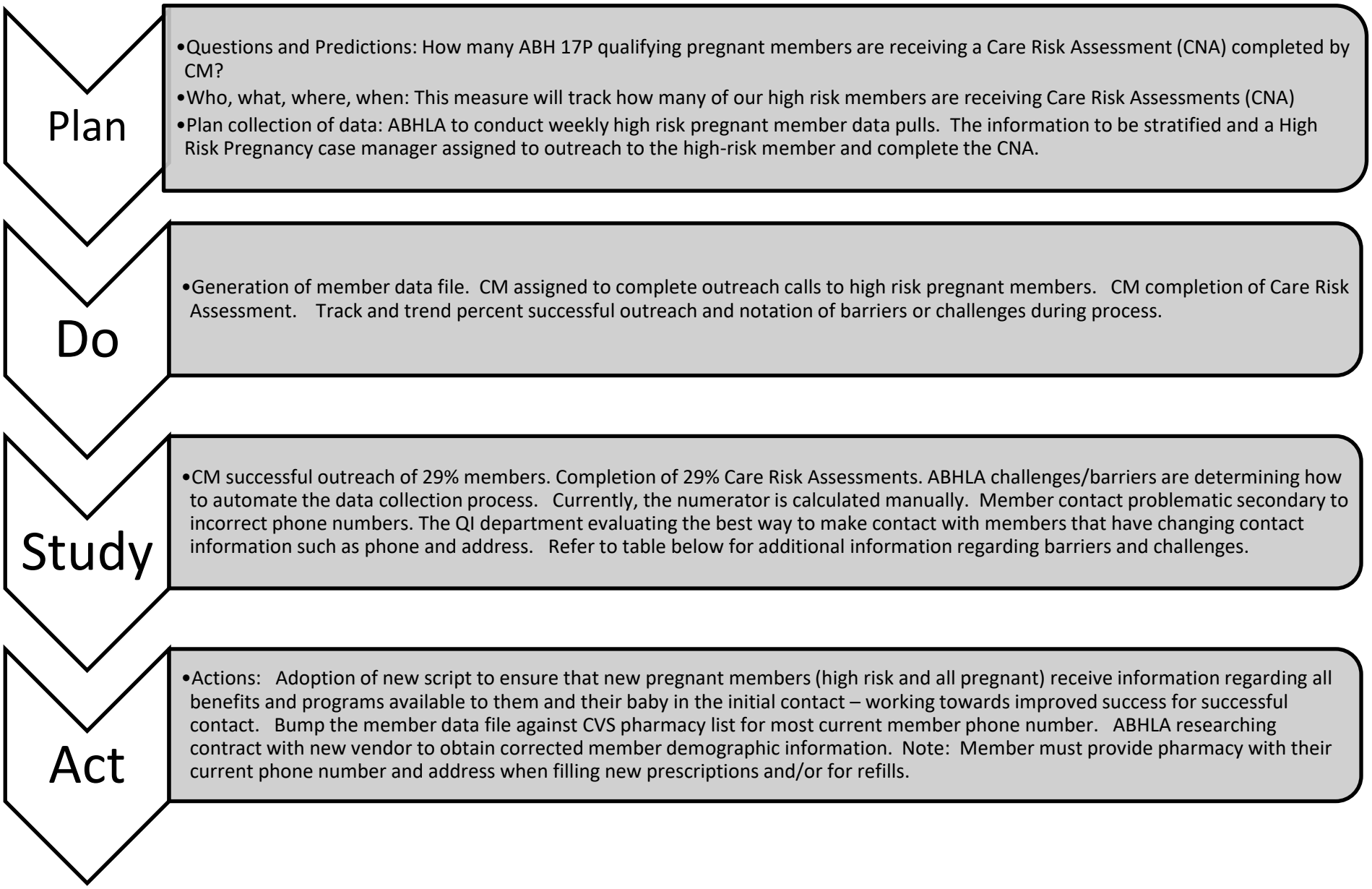

Aim
To reduce number of premature births by 5% by December 31, 2017
Primary Drivers
Improve Member Education
Increase CM enrollment
Increase 17P injections
Improve Provider Education
Secondary Drivers
Reminder Letters
Member Toolkit
Member Texts
Facilitating Referrals
Plan of Care
Outreach Efforts
PCP
OBGYN
Optum Home Health
Face-to-Face Training
Provider Newsletters
Care Gap Reporting
Specific Ideas to Test or Change Concepts
Member Survey
Claims Data
National Reports
Vendor Quotes
Systematic Reporting
Number of Internal Referrals
Unsuccessful Attempt Letter
CM Scripts for Participation
Systematics Reporting
Education
Claim submission Data
On-site Visits/Education
Provider Surveys
Top 20 High Volume OBs
Determine Gaps in Care

Throughout the entirety of the PIP, interventions have been created, implemented, and evaluated to determine the impact each has on the preterm birth outcomes of Aetna Better Health of Louisiana pregnant members. As the project has progressed and more data has become available, including additional training tools, the plan has decided to focus on six different metrics in its next steps of the PIP. We will use the PDSA cycle to test the interventions and evaluate the effectiveness of each of the following metrics:

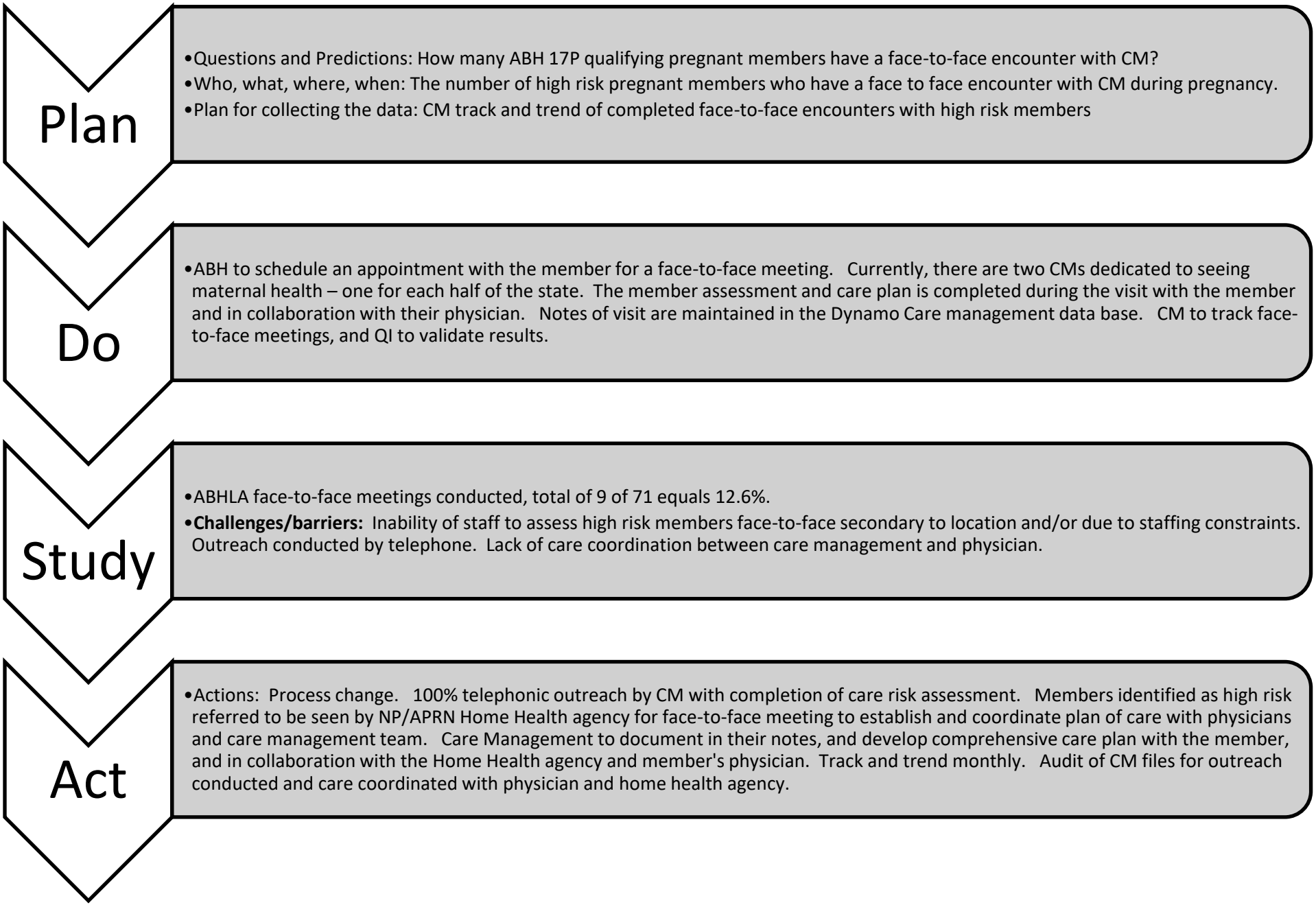
1. Identification and risk stratification of pregnant women with prior preterm singleton birth
2. Member receipt of face-to-face care coordination with ABHLA care management
3. Member receipt of care management outreach with completed contact for 17P education and facilitation for OB appointment
4. Member receipt of contraception education during third trimester with completion of a reproductive plan
5. Members at risk for preeclampsia whose provider received notification from the plan
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

These metrics were chosen as additional research and data has become available and been shown that certain factors such as care management intervention for high risk pregnancies, education on 17P for qualifying pregnant women, birth spacing, preeclampsia interventions improve the outcomes of preterm births. Aetna Better Health of Louisiana has identified barriers for each and is working to improve each as follows:

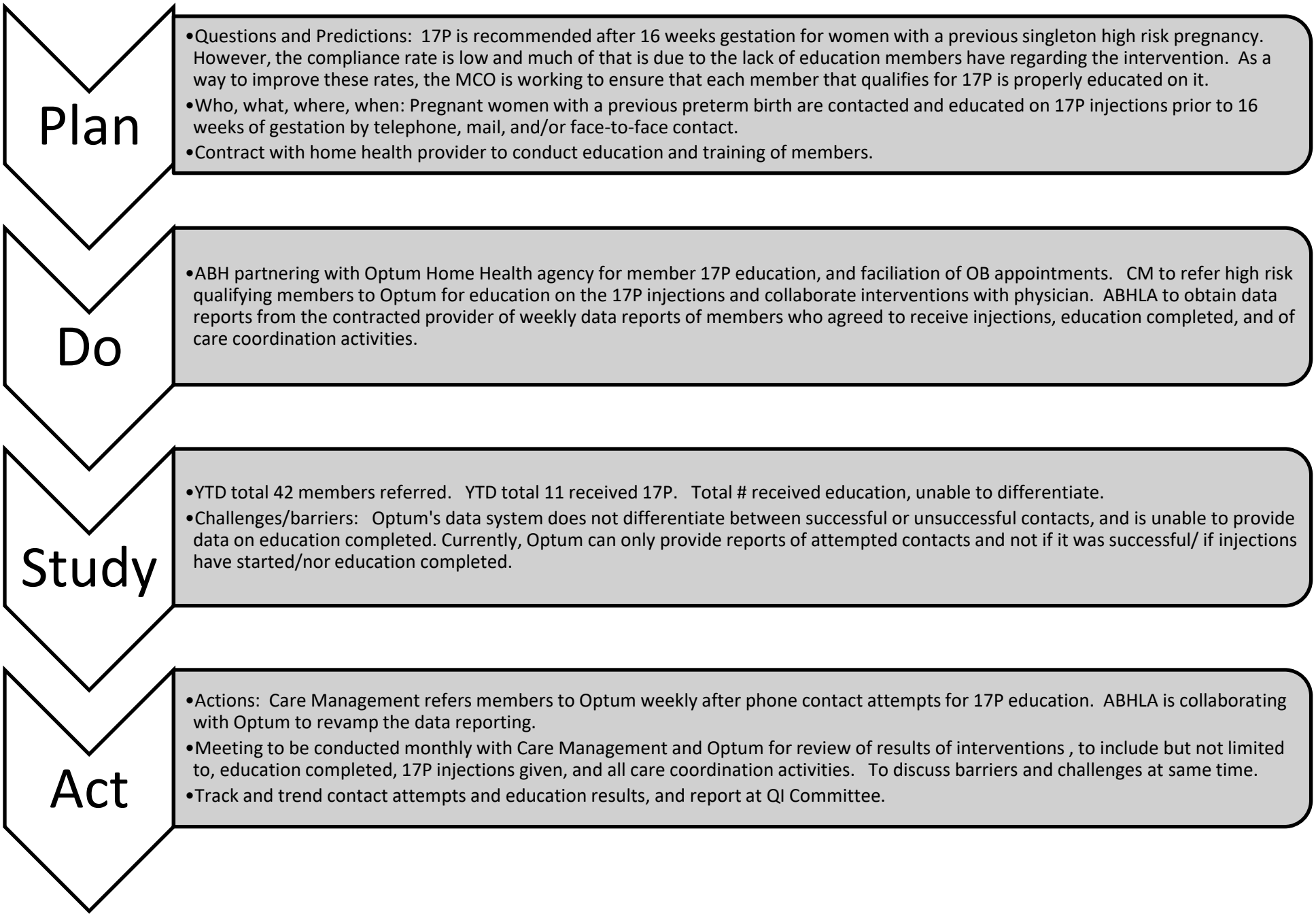
1. Identification and risk stratification of pregnant women with prior preterm singleton birth



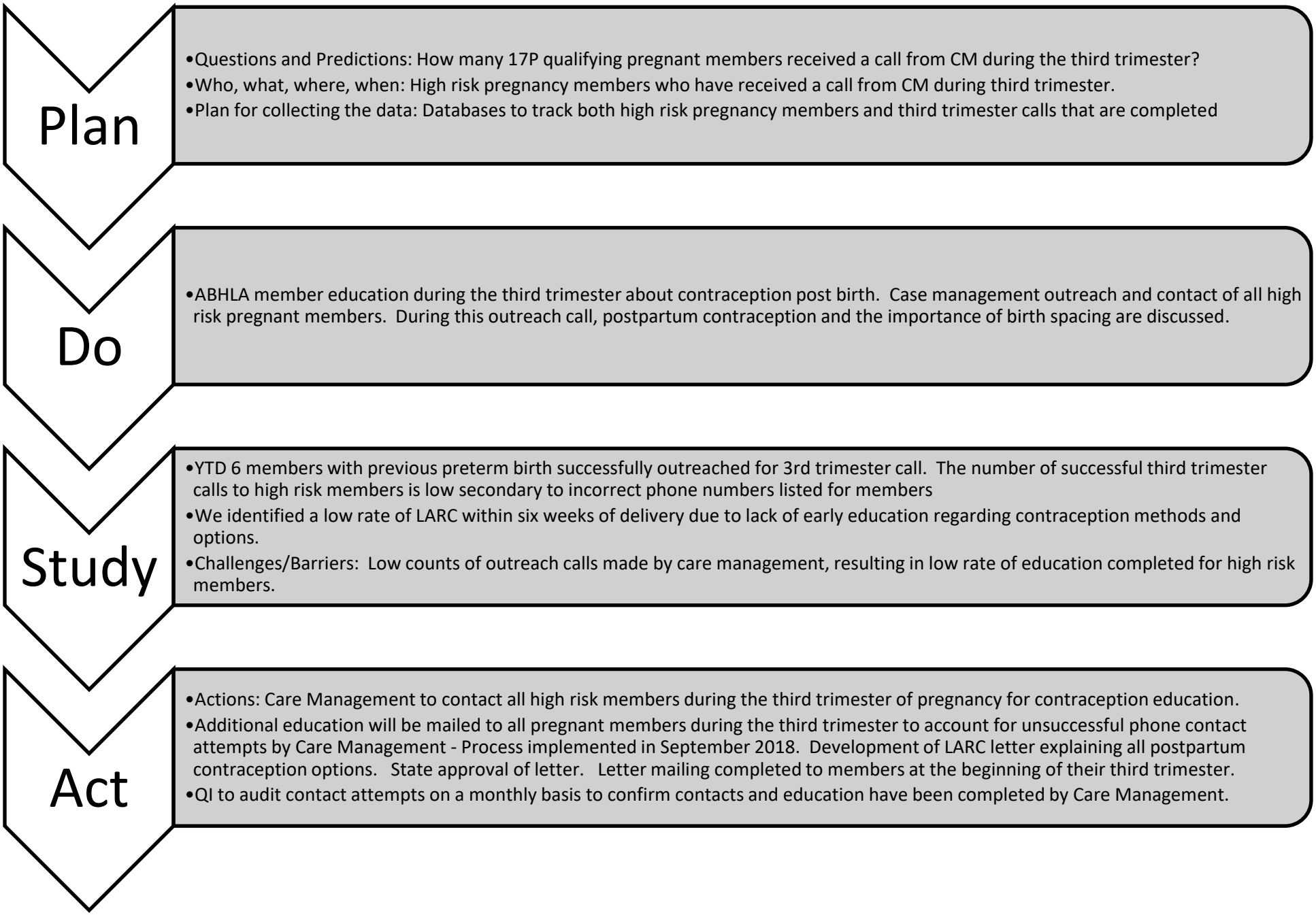
2. Member receipt of face-to-face care coordination



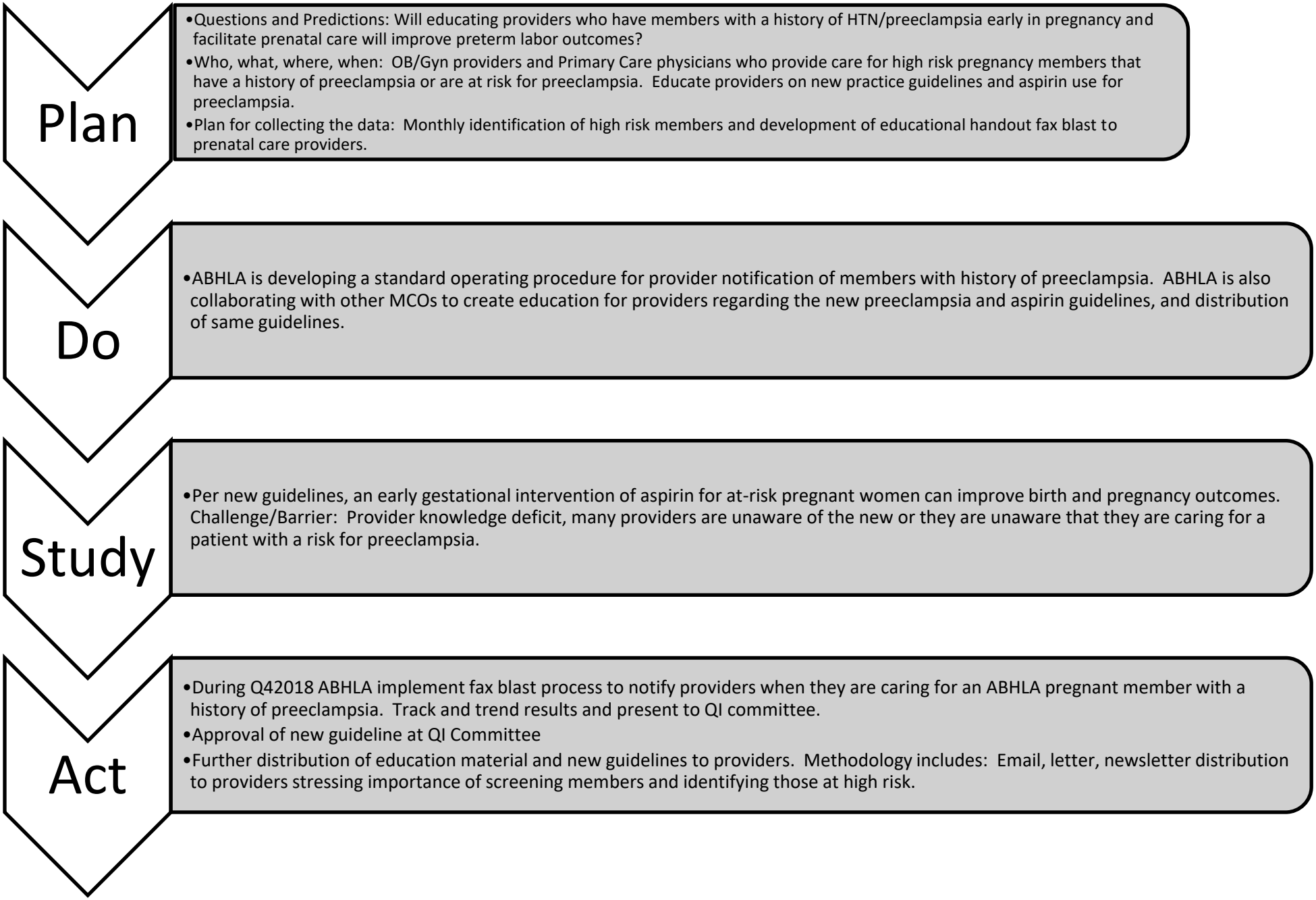
3. Member receipt of care management outreach with completed contact for 17P education and facilitation for OB appointment



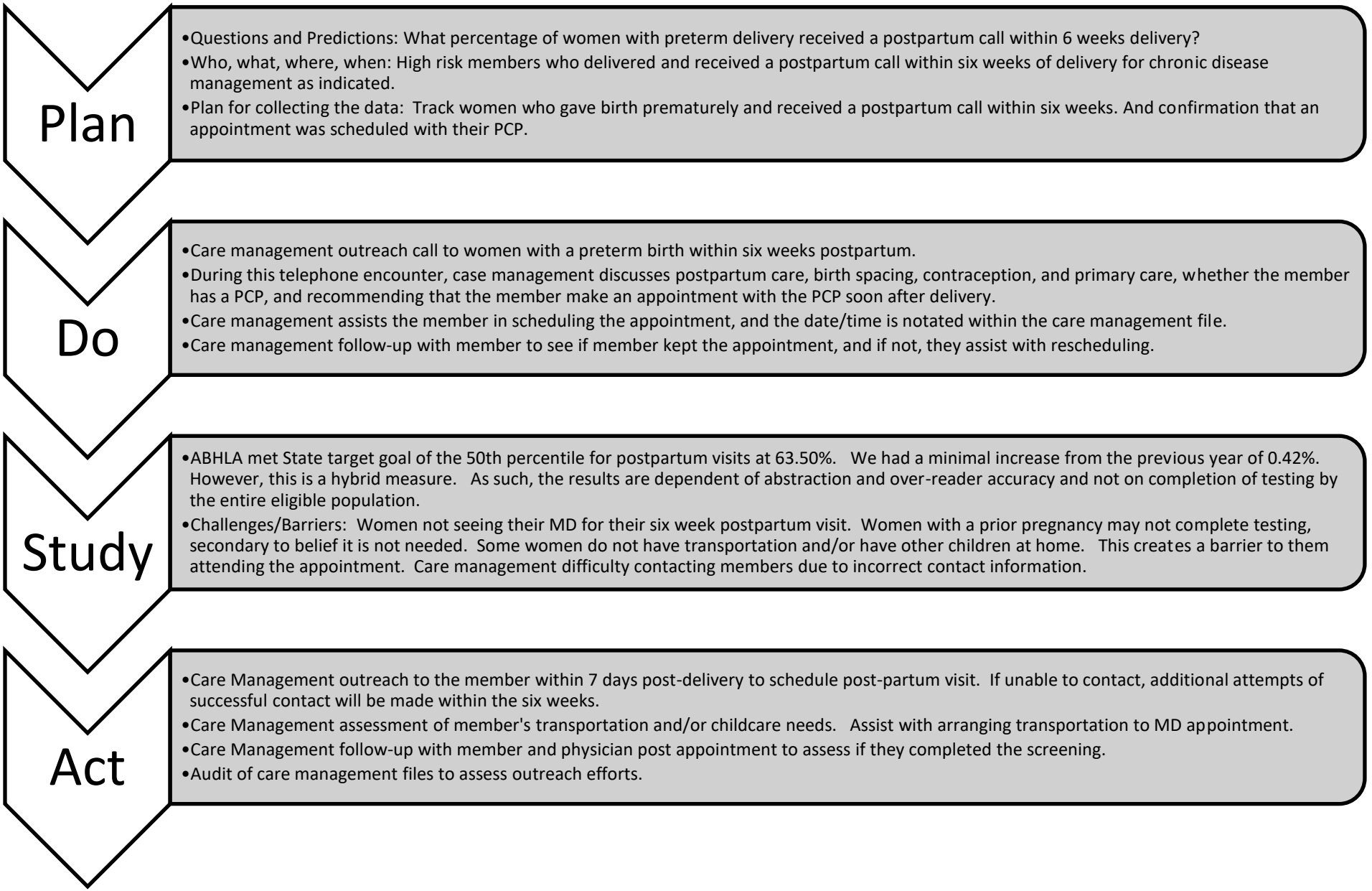
4. Member receipt of contraception education during third trimester with completion of a reproductive plan



5. Members at risk for preeclampsia whose provider received notification from the plan



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**



There are three specific drivers that ABHLA is working to build upon in the Reducing Preterm Birth Performance Improvement Project:

(i) Improve the initiation of progesterone between 16-24 weeks gestational age for the high risk maternity Medicaid population (prior spontaneous preterm birth) from 16% to 25%

ABHLA is working with Optum Home Health to coordinate care for 17P injections and create the ability to provide this service in-home to our members since it is such a long course of treatment. Case Management works to review pregnant members as they are identified and refer qualifying members to Optum Home Health so that the vendor can reach out to the appropriate members and providers and educate them on the treatment and services. ABHLA has improved significantly since the beginning of the PIP project on a year over year basis and with this new partnership, expects to continue to trend upward.

(ii) Reduce preterm births before 32 weeks gestation by 10% in women who have experienced a prior preterm singleton birth.

In an effort to reduce preterm births before 32 weeks gestation by 10%, ABHLA has implemented or is in the process of implementing all six of the above mentioned interventions. The earlier a plan knows that a member is pregnant, the sooner they can implement impactful interventions such as education regarding 17P and aspirin regimen for those at risk of preeclampsia based on previous known risk factors. ABHLA has also created interdisciplinary teams with medical management, quality and other departments to encourage collaboration and information sharing in order to find the root causes and trends of preterm births, therefore preventing and reducing the number in the future.

(iii) Improved Care Management Outreach.

In an effort to ensure members receive the support and education needed to improve maternal health care and outcomes, ABHLA is reevaluating care management processes. The QI department will be auditing files for outreach attempts, completed education, and other interactions via the Dynamo data base on a monthly basis. The QI department will report its findings back to care management for accountability and real time evaluation on the effectiveness of interventions.