Healthy Louisiana Performance Improvement Project (PIP)

MCO Name: UnitedHealthcare

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

2015- 2018

Project Phase: Proposal
Original Submission Date: 8/1/2015
Revised Submission Date: Click here to enter a date
Project Phase: Baseline
Submission Date: 6/30/2016
Revised Submission Date: Click here to enter a date
Project Phase: Interim
Submission Date: 6/30/2017
Revised Submission Date: 9/13/2017
Project Phase: Final
Submission Date: 06/29/2018
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: Principal MCO Contact Signature Date
Baseline Report: Principal MCO Contact Signature Date
Interim Report: Trenesser Smith 10/26/2017
Final Report: 06/28/2018

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): Obstetric Providers

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

New Interventions:

- Redesign and continue our existing Maternal Child Health Program known as Healthy First Steps
- Ongoing Health Education
- Collaborate with providers by facilitating care coordination
- Expanded Scope of Care and Community Partners

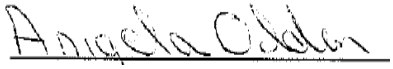
5. Attestation

Managed Care Plan Name: UnitedHealthcare
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.

Kevin Stephens M.D. 10/26/2017



Angela Olden 10/26/2017

IS Director Signature (when applicable) Date
Printed Name

Allison Young 10/26/2017

The undersigned approve this FINAL PIP Report:

Julie Morial, M.D. Date 10/5/2018

Deborah Junot, BSN, RN Date 10/5/2018

IS Director Signature (when applicable) Date
Printed Name

Allison Young Date 10/5/2018

Abstract

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

Provide an abstract of the PIP highlighting the project topic, rationale and aims, briefly describe the methodology and interventions, and summarize results and major conclusions of the project (refer to instructions in full report template or appendix).

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 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. Using the 2012 prematurity rate of 15.3% to estimate, the potential opportunity for impact is 2,000 deliveries per year. The improvement of birth outcomes and prevention of even one prolonged NICU stay has a significant financial impact, not to mention the emotional consequences and physical risk to the newborn and its parents. The Medicaid population is already known to suffer socioeconomic disadvantages such as access to transportation and healthy food options. These issues can cause further complication should there be a preterm birth and/or medical complications. This PIP allows UHCCP to serve its Medicaid members in working toward a collaborative, better understanding how to increase positive outcomes in the health of mothers and newborns. As noted previously, the Plan has done well with preterm delivery rates at the <37 weeks designation, but believe there to be opportunity for further improvement.
Project Aims: 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. 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. 6. The percentage of women with a postpartum visit as per the HEDIS® PPC postpartum measure.

Methodology

Eligible Population: All pregnant women from the high risk registry receiving 17P, with singleton birth deliveries.

Description of Annual Performance Indicators: 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. Increase the use of progesterone therapy to reduce recurrent preterm birth in accordance with ACOG recommendations.

Sampling Method: The study did not use sampling and included the entire eligible Population.

Baseline and Re-measurement Periods: 2015, 2016 & 2017

Data Collection Procedures: The plan may identify the eligible population by obtaining evidence of a previous preterm singleton birth from any one or combination of the following data sources: High Risk Registry, Notice of Pregnancy Form. To identify deliveries, the plan may use evidence of birth from the LEERS vital records, or a delivery on an infant claim (Deliveries Infant Record Value Set) where the organization can link infant and mother eligibility records.

Interventions

Member Barriers Identified: Lack of member adherence, Lack of high risk member relationship with provider, & Lack of high risk member awareness of appropriate treatment

Interventions to address member barriers: Prenatal Care Management Outreach and Engagement Program Targeted to High Risk, Pregnant Members

UHC has developed an internal registry to identify and track pregnant women with history of prior preterm birth and collect the data needed to monitor performance measures compared to the State high-risk registry. Interventions will address member barriers to evidence-based care, e.g., progesterone therapy for eligible women with a prior spontaneous preterm birth, screening for STI during pregnancy, engagement in postpartum care and offering and uptake of long-acting reversible contraception.

Health plan interventions and processes will target at-risk subpopulations (e.g., women with disproportionate burden of adverse birth outcomes due to prior history of preterm birth, region of residence, race and age) for engagement in case management and/or interventions to reduce the risk of preterm birth (e.g., facilitation of progesterone therapy, screening and treatment, Chlamydia, syphilis and HIV, and uptake of long-acting reversible contraception among eligible women).

Provider Barriers Identified: Lack of provider knowledge regarding plan services such as care management and coordination, benefit coverage, billing & coding for progesterone and contraception interventions.

Interventions to address provider barriers: Plan to Provider Communication, Medicaid 101

Results

Report Data for Annual Performance Indicators: Baseline Rate-3.1 %
Interim Rate-14.59% Final Incentive Rate-18.06%

Conclusions

Interpret improvement in terms of whether or not Target Rates were met for annual performance indicators: Initial 17P target goal was 6%. Target goal was increased to 20.4% after Interim period measurement to allow for similar variability.

Indicate interventions that did and did not work in terms of quarterly intervention tracking measure trends: NOP provider to plan communication, Plan to provider communication and Prenatal Care Management Outreach and Engagement Program Targeted to High Risk, Pregnant Members

Study Design Limitations: Validity of the High Risk pregnancy file received from the State that has notable claims lag and transfer of members from MCO to MCO. The State is doing a review to enhance report as requested by MCOs and adding additional elements to the current report.

Lessons Learned and Next Steps: There is additional opportunity for improvement regarding educating providers. Our quality team will continue to educate providers on standards. There is also room for improvement regarding coordination of care between OBGYN's and other medical providers, such as primary care physicians. The quality team provides ongoing education about care coordination, as well as encourages

providers to complete the appropriate documentation and forms to ensure continuity of care.

1. Project Topic/ Rationale and 2. Aim

Suggested length: 2 pages

1. Describe Project Topic and Rationale for Topic Selection

Preterm birth has been historically defined as the birth of an infant prior to 37 weeks of pregnancy, which causes higher risk of serious disability or death the earlier a baby is born. In the final weeks and months of pregnancy, a developing baby goes through important growth in many organ systems, including the brain, lungs, and liver. These organs need the final weeks of pregnancy to develop fully.
Potential medical complications for preterm babies may include:

- Respiratory problems
- Feeding difficulties
- Cerebral palsy
- Developmental delay
- Vision problems
- Hearing impairment

In addition, preterm births may cause heavy emotional and economic burdens for families.
Preterm-related causes of death made up 35% of all infant deaths. That is more than any other single cause of death in newborns. Preterm birth is also a leading cause of long-term neurological disabilities in children and cost the United States health care system more than $26 billion. Each year, this is more than half a million infants in the United States. Nationally, preterm births have been declining in all but one state since 2006.
At a State level, Louisiana acknowledges the importance of reducing pre-term deliveries. Births prior to 37 weeks gestation could be attributed to many factors, such as:

- Prior preterm delivery
- Nutrition
- Quality of prenatal care
- Medical problems
- Infections
- Use of cigarettes, alcohol and other substances
- Mother's age
- Obesity
- Stress
- Violence
- Poverty

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.

2. Aim Statement, Objectives and Goals

Aim Statement:

An aim should be specific, measurable, and should answer the questions, How much improvement, to what, for whom, and by when?

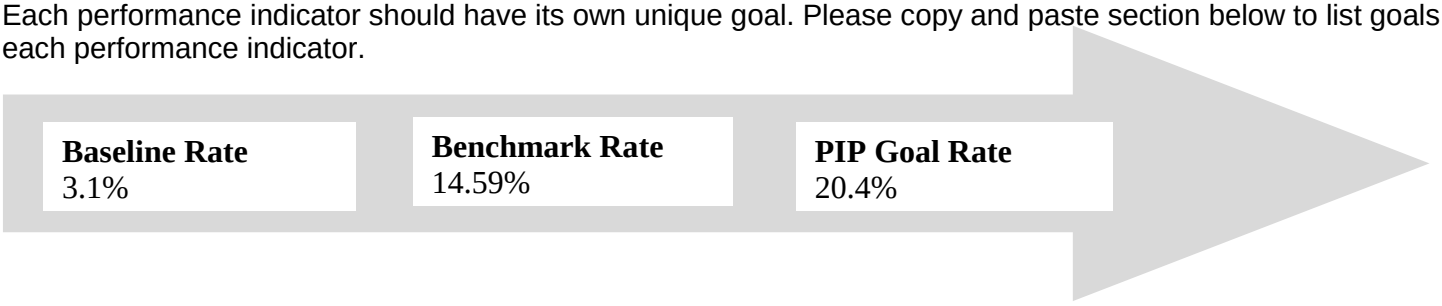
The MCO aims *to increase the initiation of progesterone between 16-21 weeks gestational age for the High Risk Maternity Medicaid population from 3.1% to 20.4% by the end of 2018* and *decrease the deliveries <39 weeks gestation for year over year, per Louisiana State goal.*

Objective(s):

"Implement NOP provider to plan communication, Plan to provider communication and Prenatal Care Management Outreach Program targeted to high risk pregnant members to improve 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 from baseline to final measurement."

Goal(s):

Each performance indicator should have its own unique goal. Please copy and paste section below to list goals for each performance indicator.



Using the information you entered above, complete following goal statements:

Baseline to interim measurement goal: Increase usage of 17P, year over year through duration of the study by 2%. Goal for next measurement is 6.0%.

Baseline to final measurement goal: Increase usage of 17P, year over year through duration of the study. Goal for next measurement is 20.4% which is a meaningful improvement goal. Targets were set outside the 95% confidence interval of the baseline rate. This increase allowed for statistical variability of the target rate by an amount comparable to the variability of the baseline rate.

Aim Statement:

An aim should be specific, measurable, and should answer the questions, How much improvement, to what, for whom, and by when?

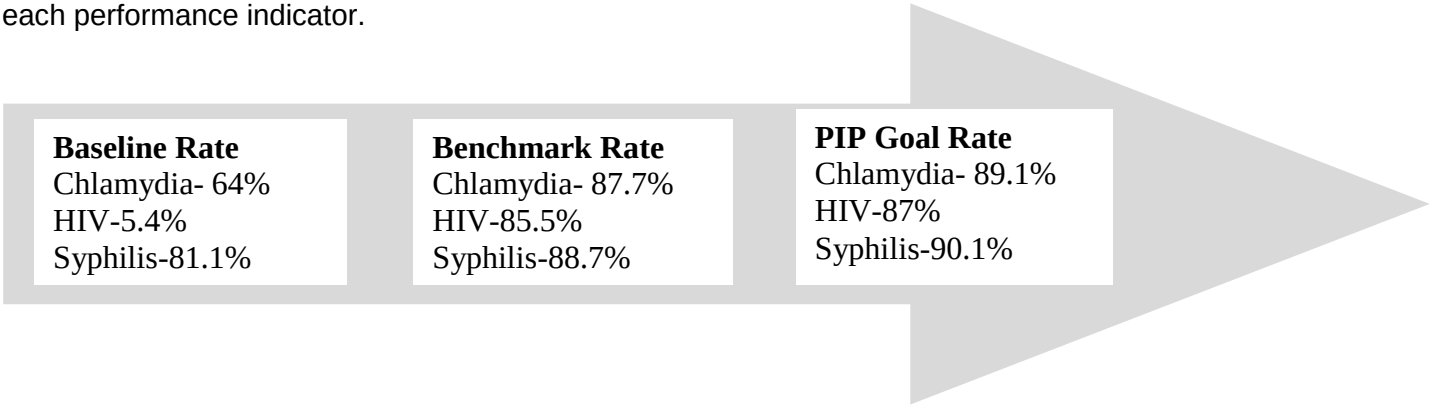
By *the end of 2018* the MCO aims *increase STI screenings by 5% are greater* among pregnant women who delivered in the measurement year that were high risk pregnancies and all deliveries.

Objective(s):

"Implement Prenatal Care Management Outreach Program targeted to high risk pregnant members to improve the percentage of women who delivered a live birth and had at least one test for HIV, one test for chlamydia and at least one test for syphilis during pregnancy from baseline to final measurement."

Goal(s):

Each performance indicator should have its own unique goal. Please copy and paste section below to list goals for each performance indicator.



Using the information you entered above, complete following goal statements:
Baseline to interim measurement goal: *Increase STI screening at minimum 2% from the baseline period scores for high risk population*
Chlamydia target goal: 66%
Syphilis target goal: 83.01%
HIV target goal: 8.0%

Baseline to final measurement goal: Increase Chlamydia from 64.0% at baseline to 89.1% at final re-measurement for the high risk population. This allows for sufficient statistical variability, and a meaningful improvement goal.
Increase Syphilis from 81.1% at baseline to 90.01% at final re-measurement for the high risk population. This allows for sufficient statistical variability, and a meaningful improvement goal.
Increase HIV screening from 5.4% at baseline to 87% at final re-measurement for the high risk population. This allows for sufficient statistical variability, and a meaningful improvement goal.
Targets were set outside the 95% confidence interval of the baseline rate. This increase allowed for statistical variability of the target rate by an amount comparable to the variability of the baseline rate.

Aim Statement:

An aim should be specific, measurable, and should answer the questions, How much improvement, to what, for whom, and by when?
By *the end of 2018* the MCO aims *Increase PPC rates year over year by 2% or greater beginning with the UHC baseline 58.72% final HEDIS® 2016 vs. State goal of 60.98% for HEDIS® 2018.*

Objective(s):

Implement Medicaid 101/Provider Education Initiative and Postpartum Care Management Outreach to improve the percentage of women with a postpartum visit as per the HEDIS® PPC postpartum measure from baseline to final measurement."

Goal(s):

Each performance indicator should have its own unique goal. Please copy and paste section below to list goals for each performance indicator.

Baseline Rate	Benchmark Rate	PIP Goal Rate
58.72%	64.84%	63.12 %(state goal)

Using the information you entered above, complete following goal statements:

Baseline to interim measurement goal: Increase PPC rates year over year by 2% or greater beginning with the UHC baseline 58.72% final HEDIS® 2016 vs. State goal of 63.12% for 2016. UHC has set a Target/Goal for next measurement of 65.43%. Concern for financial incentive measures as it appears this is expected for HEDIS® 2016 rates or is the reporting penalty for 2018 at the end of the PIP with the State Goal being 63.12%.

Baseline to final measurement goal: Increase PPC rates year over year by 2% or greater beginning with the UHC baseline 58.72% final HEDIS® 2016 vs. State goal of 63.12% for HEDIS® 2018. UHC has set an Internal Target/Goal for next measurement of 67.53% which is a meaningful improvement goal. UHC interim rate was 64.84% for HEDIS®2017.

Aim Statement:

By *the end of 2018* the MCO aims to *increase the use of contraceptive measures in postpartum women from 32.7% at baseline to 50% at final re-measurement.*

Objective(s):

"Implement Medicaid 101/Provider Education Initiative and Postpartum Care Management Outreach to improve the percentage of postpartum women who adopt use of a most or moderately effective FDA-approved method of contraception from baseline to final measurement."

Goal(s):

Each performance indicator should have its own unique goal. Please copy and paste section below to list goals for each performance indicator.

Baseline Rate	Benchmark Rate	PIP Goal Rate
32.7%	34.7%	50%

Using the information you entered above, complete following goal statements:

Baseline to interim measurement goal: Increase the use of the most and moderately effective contraceptive measure year over year to decrease the premature births by 2%.

Baseline to final measurement goal: Increase the use of the most and moderately effective contraceptive measure from 32.7% at baseline to 50% at final re-measurement. Targets were set outside the 95% confidence interval of the baseline rate. This increase allowed for statistical variability of the target rate by an amount comparable to the variability of the baseline rate a meaningful improvement goal.

3. Methodology

1. Data Collection and Analysis Procedures

Performance Indicators[1]

Indicators should be measurable, objective, clearly defined, and correspond directly to the study aim. The timeframe should be indicated as the measurement year, i.e., the annual timeframe represented by the data, from the start date to the end date of each measurement year, as indicated in the subsection "Timeline", below.

If there is more than one indicator, copy the following headings for each one and complete the relevant information. Note: Meaningful, focused measurement is generally limited to 2-3 indicators.

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. Increase the use of progesterone therapy to reduce recurrent preterm birth in accordance with ACOG recommendations

Data Source(s): The plan may identify the eligible population by obtaining evidence of a previous preterm singleton birth from any one or combination of the following data sources: High Risk Registry, Notice of Pregnancy Form. To identify deliveries, the plan may use evidence of birth from the LEERS vital records, or a delivery on an infant claim (Deliveries Infant Record Value Set) where the organization can link infant and mother eligibility records

Eligible Population:

All pregnant women from the high risk registry receiving 17P, with singleton birth deliveries. The plan may identify the eligible population by obtaining evidence of a previous preterm singleton birth from any one or combination of the following data sources: High Risk Registry, Notice of Pregnancy Form. To identify deliveries, the plan may use evidence of birth from the LEERS vital records, or a delivery on an infant claim (Deliveries Infant Record Value Set) where the organization can link infant and mother eligibility records.

Exclusion Criteria:

Numerator Definition:

Women who had at least one Progesterone injection between the 16th and 21st week of pregnancy.
Number of live births within the measurement period delivered at <39 weeks gestational age that were identified as high-risk by Maximus and reported to UHC from the total of all the high-risk registry files and UHC claims data that received 17P.

Denominator Definition:

The eligible population.
Total of all postpartum women who have a history of preterm birth from the high-risk registry files received from Maximus and from UHC claims data that delivered in the measurement year who received 17P.

Indicator #2, Indicator #3 and Indicator #4

1. Chlamydia: The percentage of women 16 years and older who delivered a singleton live birth and had at least one test for Chlamydia during pregnancy.
2. HIV: The percentage of women who delivered a singleton live birth and had at least one test for HIV during the pregnancy.
3. Syphilis: The percentage of women who delivered a singleton live birth and had at least one test for syphilis during the pregnancy.

Increasing STI screening; Chlamydia, Syphilis, and HIV among pregnant women who delivered in the measurement year that were high risk pregnancies and all deliveries.

Data Source(s): Codes provided by IPRO to UHC and will be used to calculate the Chlamydia, HIV and Syphilis Screening measure. Chlamydia HEDIS® technical specification to be used as follows: the percentage of women 16 years or older who delivered a live birth and had at least one test for Chlamydia during the measurement year.

Eligible Population: All women who delivered singleton births in the measurement year that were screened for Chlamydia, HIV, or Syphilis

Exclusion Criteria:

Numerator Definition:

1. Chlamydia: At least one Chlamydia test (HEDIS® screening in Women [CHL] Chlamydia Tests Value Set) during the 280 days prior to delivery.

2. HIV: At least one HIV test (Table 1-HIV) during the 280 days prior to delivery.
   Two (or more) HIV tests (Table 1-HIV) during the 280 days prior to delivery.

3. Syphilis: At least one syphilis test (Table 2-Syphilis) during the 280 days prior to delivery.
   Two (or more) syphilis tests (Table 2-Syphilis) during the 280 days prior to delivery.

Denominator Definition:

1. Chlamydia: Measure to be reported for two denominators:
   a. The total of all the eligible population
   b. The total of all the eligible high risk subpopulation with a history of prior preterm birth, as identified by the high risk registry.
2. HIV:
   a. The total of all the eligible population
   b. The total of all the eligible high risk subpopulation with a history of prior preterm birth, as identified by the high risk registry.

3. Syphilis:
   a. The total of all the eligible population

Indicator #5, Indicator #6, and Indicator #7
Facilitate uptake of postpartum contraception.
The percentage of postpartum women who:

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

2) Adopt use of a moderately effective method of contraception, i.e., use of injectables, oral pills, patch, ring, or diaphragm.
3) Adopt use of a most or moderately effective method of contraception

NOTE: *This is a modified developmental measure, and feedback obtained from Louisiana Healthy Plans and state Medicaid programs over the first year of its use will lead to refinements and the development of additional guidance for reporting.*

Data Source(s): IPRO disseminated the codes used to identify most effective and moderately effective methods of contraception. Plans agreed to begin testing the measure by developing an extraction module to identify the measure numerators (i.e., use of a most effective FDA-approved method of contraception and use of a moderately effective method of contraception), and denominator (i.e., postpartum women).
Choose an item or manually enter if multiple sources
Click here to enter Indicator 1, Indicators, also known as Performance Measures, evaluate the outcome of the PIP, and thus the overall success of the project. They should be stated as "The percent of ….."

Eligible Population:
Delivered a live birth on or between November 6 of the year prior to the measurement year and November 5 of the measurement year. Include women who delivered in a birthing center.

Exclusion Criteria:
i. Women who are not capable of getting pregnant;
ii. Omit from the data set any woman with a code for hysterectomy/oophorectomy during 60 day postpartum period, per Table 1.
iii. In baseline measurement, UHC will identify barriers to the data

Numerator Definition:
Numerator 1: The eligible population that is using a most effective method of contraception.

Use the codes in Table 4 to identify women who adopted use of either female sterilization or LARC.

Numerator (1a): Female sterilization (if member counted in this numerator, do not include in numerator 1b I, ii or iii)

Numerator (1b): Long-acting reversible method of contraception (LARC), i.e., contraceptive implants, or intrauterine devices or systems (IUD/IUS). Report three numerators:
i. Adoption of LARC during delivery hospitalization (if member counted in this numerator, do not count in numerator 1b ii).
ii. Adoption of LARC in the outpatient setting within 60 days postpartum.
iii. Adoption of LARC total (i + ii)

Numerator 2: The total eligible population that is using a moderately effective method of contraception.

Use the codes in Table 4 to identify women who adopted use of a moderately effective method of contraception, i.e., injectables, oral pills, patch, ring, or diaphragm; among the population of clients identified for the denominator.

Numerator 3: The eligible population that is using either a most effective [per numerator 1a or 1b (i) specifications] or moderately (per numerator 2 specification) effective method of contraception.

Denominator Definition:
Postpartum status as per HEDIS® Hybrid PPC specifications. As high risk registry data matures, separate rates will be reported for the subpopulations of women in the high risk registry.

Indicator #8 Engaging members in postpartum care

Data Source(s): Administrative Claims Data
The percentage of women with a postpartum visit, as per the HEDIS® PPC postpartum measure, in the HEDIS® Volume 2 Technical Specifications.

Eligible Population:
All women who delivered singleton births in the measurement year that had a postpartum visit within 21-56 days after delivery. Refer to the HEDIS® Volume 2 Technical PPC specifications.

Indicator #9 Engaging members in postpartum care
Data Source(s): Hybrid Data
The percentage of women with a postpartum visit, as per the HEDIS® PPC postpartum measure, in the HEDIS® Volume 2 Technical Specifications.

Eligible Population:
All women who delivered singleton births in the measurement year that had a postpartum visit within 21-56 days after delivery. Refer to the HEDIS® Volume 2 Technical PPC specifications.

Exclusion Criteria:

Numerator Definition:
All women who delivered singleton births in the measurement year that had a postpartum visit within 21-56 days.

Denominator Definition:

HEDIS® Hybrid Postpartum Measure (Administrative). The eligible population

Data Collection and Analysis

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

If sampling was employed: N/A
Describe sampling methodology: N/A
Sample Size and Justification: N/A

Data Collection:

To identify women with a Delivery, SMART professional claims that are parsed out by category of service (Vaginal, C-Section) are used. The data source for all metrics is CSP Facets and CareOne data loaded into the SMART data warehouse.

A dedicated reporting server houses a real-time copy of the CSP Facets production database which contains claims, provider and member data. Data is extracted weekly and loaded to the SMART data warehouse. The SMART data warehouse also contains vendor data (RX, dental, lab and vision) loaded weekly and Care Management system data (CareOne, CommunityCare and ICUE) loaded daily. If the report specifications require merging of these data sources the member can be linked across the multiple systems allowing consolidation of the sources. CSP and vendor data in SMART are stamped with a unique member identifier in addition to the CSP Subscriber ID, state Medicaid ID and/or SSN. Care Management data will contain CSP facets Subscriber ID, state Medicaid ID and/or SSN. The independent data sets can be merged using these identifiers common to the systems.

Source code is reviewed by a senior analyst or manager for correctness; comparisons are made to prior period metrics and approval is required from the business owner before the report is placed in the production reporting schedule. Data is reviewed and validated by the assigned analyst and the business owner after requirements have been verified and approved. If at any point during the development cycle the output is not reasonable or meeting the expected outcome, examples of data are isolated and run through the logic to determine the underlying cause of the outcome. If necessary, requirements and SQL logic are modified until the accurate output is achieved.

OB Medical record reviews conducted to comply with contractual requirements according to the Reducing Premature Births PIP

Process-

•Top 10 OB providers were selected by the CPC
•10 charts/ 2 different providers were reviewed to determine compliance with medical record documentation standards
•Reviews were conducted within a timeframe established by the QM Department.
• Five UHC-Community plan medical records were randomly selected per the CPC and per the CPC's top 10 provider
• Chlamydia, Syphilis and HIV testing, LARC Reviews were conducted in accordance with the plans policy.

Members were included in the denominator per performance measure specifications who received treatment or screening in accordance with the performance measure specifications for the numerator.

Validity and Reliability

All members must be identified as a Louisiana member to be included in reporting. Unknown members are not included in any reporting. SQL logic will display a direct filter on the line of business specific to the performance measure health plan thus ensuring only appropriate members are selected. SMART claim, member and vendor data are stamped with a unique member identifier. Care Management and CSP data also contains a system contrived member key. If Care Management data is merged with SMART member/claims/vendor data, the CSP facets Subscriber ID, State Medicaid ID or SSN from the Care Management data is linked to one of these values.

For the PIP reporting measure the Louisiana members are also limited to Female only. From these LA Female members, three months of Claims are pulled. Another one month sweep of claims for LA Female members is done for Delivery claims. Lastly, a one month Claims sweep is done for 17 P injections for these LA Female members.

From these buckets of Claims the data is pivoted out based off of diagnosis and/or procedure codes for STI (HIV, SYP, and CHL) LARC, 17P injections, and Moderately Effective Contraceptives metrics.

Additionally, member tables of HFS and HR Louisiana members are built to be used as reference tables to flag the Female members as HFS or HR for the purposes of the report.

Data validation for non-HEDIS® measures will be done with medical record reviews to ensure data validity and reliability.

Data Analysis:

Attest Health Care Advisors present a final audit statement for the 2016 HEDIS® Compliance Audit for UnitedHealthcare, Community and State covering the 2016 reporting year, in accordance with the Healthcare Effectiveness Data and Information Set (HEDIS®) Standards issued by the National Committee for Quality Assurance (NCQA). Attest examined UHC's submitted measures for conformity with the Healthcare Effectiveness Data and Information Set (HEDIS®) Technical Specifications. These specifications are subject to change and are published annually. Attest audit team is dedicated to a concurrent audit methodology that

permits early detection and correction of problems. The audit team consists of auditors certified by NCQA to perform HEDIS® audits and staff trained to assist with audit tasks. The audit followed the NCQA HEDIS® Compliance Audit standards and policies and procedures. The audit process conformed to Audit planning and testing was constructed to measure conformance to the HEDIS® Technical Specifications for all measures presented at the time of our audit. The auditors performed a review of UHC's transaction systems and data analysis procedures, examined computer programs to confirm adherence to NCQA specifications, interviewed key process representatives, examined select transactions including claims, and benchmarked the performance rates for each measure against normative data. On June 6, 2017 Medical Record Review Validation (MRRV) phase of 2017, where UHC's HEDIS® data is audited to ensure we have met NCQA's high standards for sound process and accuracy proved a 100 percent pass rate for all audits, all HEDIS® measures, all health plans and all lines of business.

HEDIS® FINAL AUDIT STATEMENT

We have examined UnitedHealth Care's submitted measures for conformity with the Healthcare Effectiveness Data and Information Set (HEDIS®) Technical Specifications. This audit followed the NCQA HEDIS® Compliance Audit standards and policies and procedures. Audit planning and testing was constructed to measure conformance to the HEDIS® Technical Specifications for all measures presented at the time of our audit.

This report is UnitedHealthcare management's responsibility. Our responsibility is to express an opinion on the report based on our examination. Our examination included procedures to obtain reasonable assurance that the submission presents fairly, in all material respects, the organization's performance with respect to the HEDIS® Technical Specifications. Our examination was made according to HEDIS® Compliance Audit standards and policies and procedures, and accordingly included procedures we considered necessary to obtain a reasonable basis for rendering our opinion. Our opinion does not constitute a warranty or any other form of assurance as to the nature or quality of the health services provided by or arranged by the organization.

In our opinion, United HealthCare's submitted measures were prepared according to the HEDIS® Technical Specifications and present fairly, in all material respects, the organization's performance with respect to these specifications.

Geo Access

Geo Access is monitored every quarter by the plan and reported to the Quality Improvement Committee. The only deficiency reported in the provider network has been Dermatologist. Current provider access review shows no access issues for OB/GYN providers. The plan continues to monitor to ensure adequate member access to OB/GYN providers and any negative trends or deficiencies.

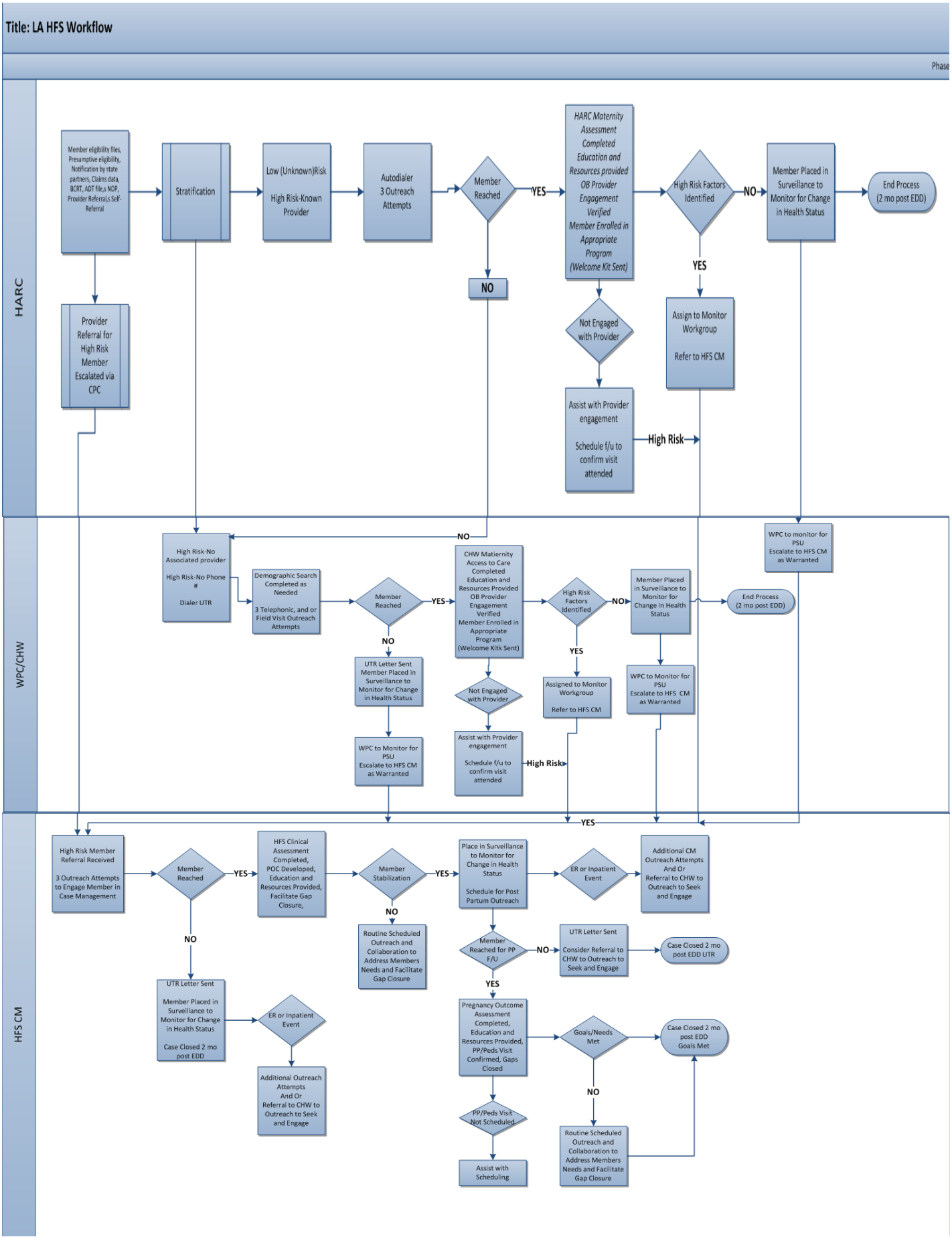

Title: LA HFS Workflow
Phase
HARC
WPC/CHW
HFS CM
Member eligibility files, Presumptive eligibility, Notification by state partners, Claims data, BCRT, ADT file,s NOP, Provider Referral,s Self-Referral
Stratification
Low (Unknown)Risk
High Risk-Known Provider
Autodialer 3 Outreach Attempts
Member Reached
YES
NO
HARC Maternity Assessment Completed Education and Resources provided OB Provider Engagement Verified Member Enrolled in Appropriate Program (Welcome Kit Sent)
High Risk Factors Identified
NO
YES
Member Placed in Surveillance to Monitor for Change in Health Status
End Process (2 mo post EDD)
Provider Referral for High Risk Member Escalated via CPC
Not Engaged with Provider
Assign to Monitor Workgroup
Refer to HFS CM
Assist with Provider engagement
Schedule f/u to confirm visit attended
High Risk
High Risk-No Associated provider
High Risk-No Phone #
Dialer UTR
Demographic Search Completed as Needed
3 Telephonic, and or Field Visit Outreach Attempts
Member Reached
YES
NO
CHW Matiernity Access to Care Completed Education and Resources Provided OB Provider Engagement Verified Member Enrolled in Appropriate Program (Welcome Kitk Sent)
High Risk Factors Identified
NO
YES
Member Placed in Surveillance to Monitor for Change in Health Status
End Process (2 mo post EDD)
WPC to monitor for PSU Escalate to HFS CM as Warranted
UTR Letter Sent Member Placed in Surveillance to Monitor for Change in Health Status
WPC to Monitor for PSU Escalate to HFS CM as Warranted
Not Engaged with Provider
Assigned to Monitor Workgroup
Refer to HFS CM
WPC to Monitor for PSU Escalate to HFS CM as Warranted
Assist with Provider engagement
Schedule f/u to confirm visit attended
High Risk
YES
High Risk Member Referral Received
3 Outreach Attempts to Engage Member in Case Management
Member Reached
YES
NO
HFS Clinical Assessment Completed, POC Developed, Education and Resources Provided, Facilitate Gap Closure,
Member Stabilization
YES
NO
Routine Scheduled Outreach and Collaboration to Address Members Needs and Facilitate Gap Closure
Place in Surveillance to Monitor for Change in Health Status
Schedule for Post Partum Outreach
ER or Inpatient Event
Additional CM Outreach Attempts And Or Referral to CHW to Outreach to Seek and Engage
Member Reached for PP F/U
NO
YES
UTR Letter Sent
Consider Referral to CHW to Outreach to Seek and Engage
Case Closed 2 mo post EDD UTR
UTR Letter Sent
Member Placed in Surveillance to Monitor for Change in Health Status
Case Closed 2 mo post EDD
ER or Inpatient Event
Additional Outreach Attempts And Or Referral to CHW to Outreach to Seek and Engage
Pregnancy Outcome Assessment Completed, Education and Resources Provided, PP/Peds Visit Confirmed, Gaps Closed
Goals/Needs Met
Case Closed 2 mo post EDD Goals Met
NO
PP/Peds Visit Not Scheduled
Assist with Scheduling
Routine Scheduled Outreach and Collaboration to Address Members Needs and Facilitate Gap Closure

Figure 1

Timeline

Report the baseline, interim and final measurement data collections periods below.

Baseline Measurement Period:
Start date: IPRO to pre-populate with date.
End date: IPRO to pre-populate with date.

Submission of Proposal Report Due: IPRO to pre-populate with date.

PIP Interventions (New or Enhanced) Initiated: 1/1/2016

Baseline Measurement Period:
Start date: IPRO to pre-populate with date.
End date: IPRO to pre-populate with date.

Interim Measurement Period:
Start date: IPRO to pre-populate with date.
End date: IPRO to pre-populate with date.

Submission of Interim Report Due: 6/30/2017

Final Measurement Period:
Start date: IPRO to pre-populate with date.
End date: IPRO to pre-populate with date.

Submission of Final Report due: 6/30/2018

4. Barriers and 5. Interventions

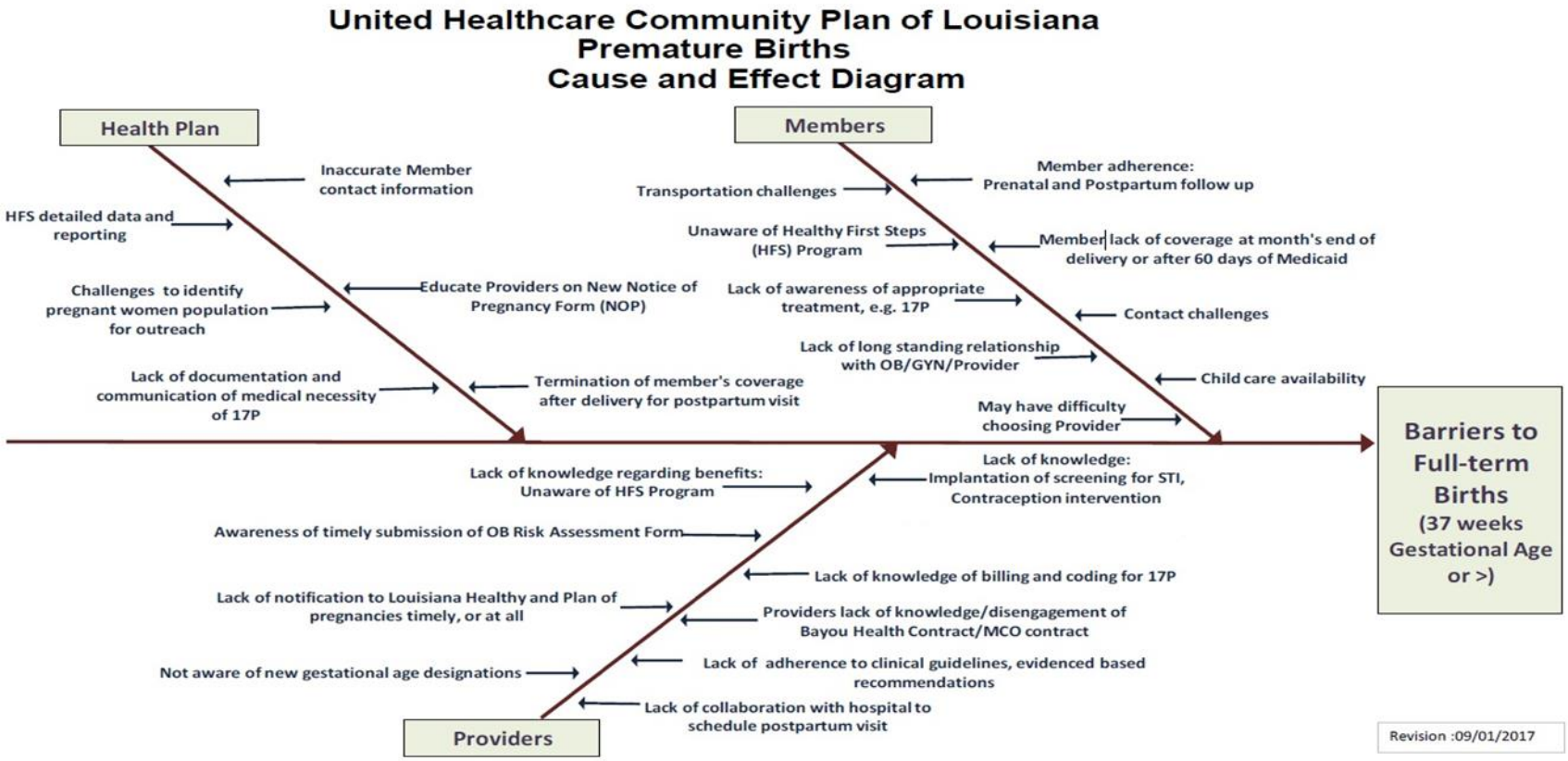
This section describes the barriers identified and the related interventions planned to overcome those barriers in order to achieve improvement.

Barrier Analysis

Barrier analysis was conducted at the Healthcare Quality Management subcommittee held in the 3rd and 4th Quarter 2017, with recommendations reviewed and discussed at the Quality Management Committee held in the 4th Quarter 2017 as described in the PIP.

The Plan conducted a Causal – Barrier Analysis by Ishikawa fishbone to identify the various factors that contribute to pre- term births. This barrier analysis workgroup included Plan and National Quality Management and CPCs. Barriers to preterm births and interventions for improvement, although inter- dependent, were identified and categorized into 3 main groups: Member, Provider, and Health Plan.

Figure 2



Women's Health

A. Postpartum Care

Table 1 **Target locations:**

Parish	# Noncompliant Members 2015	Noncompliance Rate % 2015	# Noncompliant Members 2016	Noncompliance Rate % 2016
East Baton Rouge	**641**	**58.38%**	**464**	**51.50%**
Lafayette	**147**	**71.71%**	**166**	**74.77%**
Jefferson	**238**	**61.34%**	**170**	**50.90%**
Caddo	**317**	**67.16%**	**215**	**48.97%**

1. Ethnicity targets: Black/African-American

2. Gender: Female

3. Age Brackets: 16 – 35 years of age

4. Current Action Items:
   a. Member Quarterly Newsletter Article
   b. Healthy First Steps (HFS): Mailings to pregnant members
   c. Baby Blocks: Members can receive eight (8) incentives for achieving health care goals during the 24–month prenatal and post-partum program ongoing program for new mothers.
   d. Measures addressed at Provider Expositions, including CPC Power Point presentation of "HEDIS® in 30" at the Baton Rouge Expo reaching Baton Rouge and Lafayette providers
   e. CPCs visit high volume OB Practices to discuss Evidenced-Based (HEDIS®) Quality Performance Guidelines, as well as educate providers via the OB toolkit on the importance of the postpartum visit for issues such as postpartum depression and LARC.
   f. Silver links calls to members with appointment made for members was done throughout the year. Women's health calls were done by the local plan.
   g. "Baby Showers" to educate expecting moms occur in geographical areas where high pregnancy and low prenatal care have been identified
   h. Silverlink Live outreach calls to expecting moms (escalated campaign in Q4 2017)
   i. Twitter: @UHCPregnantCare (In Spanish: @UHCEmbarazada) and Text for Baby (English and Spanish) Delivers health and wellness information relating to pregnancy, child birth and general health information applicable to pregnant women.
   j. Participated in Disparities Seminar in March 2017 at Xavier University.
   k. Silver links calls to members with appointment made for members was done throughout the year. Women's health calls were done by the local plan.

l. Quality Management staff called members on the gap list
m. Worked with ACC on the certain HEDIS®® measures to close gaps for ACC practices.

Additional actions/programs have been added that have become available. These will provide equality to all members and the "best practices" that can potentially raise the level of performance equity so all members will receive the best level performance from our providers.

5. Proposed 2018 Action Items

a. Participate in Strong Start Pregnancy Centering Collaborative to determine opportunities to promote pregnancy centering in the Lafayette area.
b. Healthy First Steps (HFS) Mailings to expecting mothers

c. Women's Health Email to member scheduled for deployment on 2018. Women's health email includes STI screenings, Breast cancer screenings and CCS screenings.

Barriers Analysis:

December 2017
After analyses of additional data, it was determined that the initial major barriers identified continue to be the top drivers for preterm births.

Table 2

Barrier Analysis			
Date	Events/Activities Related to Intervention	Successes/Challenges/Confounding Factors	Plans/Next Steps
April 2017	NOP provider to plan communication	We were able to expand our internal project team to include members from Healthy First Steps – our pregnancy care management partner and a pharmacist.	Identify single points of contact to ensure timely processing of NOP received from provider sites.
May 2017	NOP provider to plan communication	Internal process for receipt and processing of form had to reconfigured to achieve goals and time-frames	Ready to start receiving and processing NOP forms
July 2017	NOP provider to plan communication	Provider sending NOP forms monthly	Reeducation and Reinforcement to providers.
September 2017	NOP provider to plan communication	Revisited processing the form in a timely manner to achieve goals – risk stratification, enrolling in CM programs	Collect data on each member for whom a form has been received, making note of needs.

Barrier Analysis			
		and notifying provider,	Assess forms for data quality and communicate back to providers.
November 2017	NOP provider to plan communication	Incomplete or inappropriate member forms received. Received forms with incomplete information – without member due date. Receiving forms from providers for non-Medicaid United Healthcare members (commercial insurance).	Reeducation and Reinforcement to providers. Notifying providers on case by case basis that the form is only required for Medicaid members.
July 2017	17P Receipt Rate	Received notification from provider that member (No demographics) required Progesterone injections.	Notified provider. Provider's office resent NOP form. Member was referred to High Risk Care Management. Communicated back to provider that form was received and that needs have been identified.
August 2017	17P/Prenatal Care	Per some providers, transportation issues is a reason why some members are noncompliant for 17P injections	Education on Optum OB Home Care services, HFS and distribution of resources.
September 2017	LARC	Per some providers, members are unaware that LARC is reversible.	Clinical Practice Guidelines are incorporated into key components of HFS, including member education materials, postpartum care periodicity schedules, clinical management and outreach protocols, and support provided to network providers and practitioners.
December 2017		Returned mail, incorrect contact information.	Throughout her pregnancy, each member receives education through a variety of channels, including mail, email, automated or live calls, mobile apps, and/or materials supplied by her obstetric practitioners including the importance of contraception and birth spacing.

LA HFS results

Table 3

High Risk Pregnant members engaged in CM by region	Q1 2016	Q2 2016	Q3 2016	Q4 2016
LA 1 New Orleans	567=17.03	720=17.34	744=17.16	641=17.6
LA 2 Baton Rouge	777=23.33	948=22.84	1005=23.18	820=22.51
LA 4 Lafayette	417=12.52	552=13.3	610=14.07	562=15.43
LA 7 Shreveport	350=10.51	402=9.69	426=9.83	342=9.39
Total of high risk members engaged in CM	3330	4151	4335	3643

There was not a significant variance in the rate, by region, for each quarter

Table 4

Sum of TOT_PREG_MBRS	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	1-Nov	Dec-17
Total High Risk Engaged with OB	623	603	605	520	483	441	432	404	387	384	387	372
Total High Risk Enrolled in HFS	811	763	745	676	640	591	569	562	532	514	517	475
% High Risk Engaged with OB	77%	79%	81%	77%	75%	75%	76%	72%	73%	75%	75%	78%

The percentage of high risk engaged with an OB did not have a significant variance.
The total number of high risk enrolled members decreased every month. The total number for High Risk Members engaged with an OB had a slight increase from Feb 2017 to March 2017 however decreased in the subsequent months.

Barrier Overall Analysis and Conclusion

We were able learn the following:

- Need to expand our team to be more inclusive – adding our maternal care program partners
- That our internal processes for intake and use of information from providers were inadequate in achieving our intended goals of engaging with our members and ensuring high quality care

- Mapping out the process and identifying failure modes can help identify interventions that can lead to improvement
- Having uniformity (communications form) and consistency (processing of forms) across various providers will ensure higher reliability
- We still have failure points within from providers – late notifications – that need to be resolved.

Documentation was poor and at times difficult to determine pregnancy assessment info. Ongoing discussions with provider practices to get the completed and legible NOP forms submitted timely.

Practices indicated that they made an effort to refer the patients who might be high risk for preterm labor to CM especially if 17-alpha hydroxyprogesterone was indicated. If was difficult to determine by NOP form if patients were referred to CM.

December 2017 Barrier and Intervention conclusion

In 2018, the interventions will continue to be enhanced and developed more fully to meet any additional barriers identified in 2018.

Barrier analysis will be updated and reported annually through the existing Quality Improvement Program and committee reporting structure as part of the ongoing monitoring of the effectiveness of the interventions. Interventions may be modified based on new findings from any additional data collection.

Barriers were reviewed in December 2017 and remain unchanged.

Populate the tables below with relevant information, based upon instructions in the footnotes.

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]
Eligible members not identified appropriately	Completion of Notification of Pregnancy Form	1a	**Implementation of NOP form** Identify pregnant members and conduct live outreach/assist with appointment scheduling and PCP assignments. By contract the timeframes below apply for existing member or new members whose basis of eligibility is pregnancy from the date the MCO or their subcontracted provider becomes aware of the pregnancy through claims, notification of pregnancy form (NOP), and provider visits. • In their first trimester within 14 days; • In the second trimester within 7 days; • In their third trimester within 3 days; • High risk pregnancies within 3 days of identification of high risk by the MCO or maternity care provider, or immediately if an emergency exists	*Planned Start: Q2 2015* *Actual Start: 1/1/2016* *Date Revised: 04/01/2017*
Delay in identifying member or missed identification	Completion of Notification of Pregnancy Form	1b	**Implementation of NOP form** Identify pregnant members and conduct automated calls through a vendor (Silverlink Communications) to educate members on prenatal	*Planned Start: Q2 2015* *Actual Start:*

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]
			visits and care throughout their pregnancies.	*1/1/2016* *Date Revised: 04/01/2017*
Based on feedback from provider sites the NOP form not readily available in provider office. Adequate staffing and availability of time to properly complete NOP	Completion of Notification of Pregnancy Form	1c	**NOP provider to plan communication** Outreach to Provider groups and providers	*Planned Start: Q2 2015* *Actual Start: 1/1/2016* *Date Revised: 04/01/2017*
Plan lacks accurate and complete data to identify pregnant high risk members for active care coordination and identify member-specific barriers to care. Lack of a logical process for the mining of the state file and marrying that to current pregnant members	Review of Internal processes	2a	**Plan to Provider Communication (Health Plan/Member/Provider)** • Work with Healthy First Steps for detailed member information related to full-term due dates. • Work with Healthy First Steps for a more robust tracking and reporting system for Level 3 Case Management data. • Work with Business Intelligence to obtain missing provider, parish, and zip code data. • NOP(Notification of Pregnancy form/OB risk assessment	*Planned Start: Q1 2015* *Actual Start: 1/1/2016* *Date Revised:*
Lack of importance of prenatal care and impact on early deliveries	Review of Internal processes	2b	Baby Blocks (Member)	*Planned Start: Q1 2015* *Actual Start: 1/1/2016* *Date Revised:*
Lack of importance of prenatal care and impact on early deliveries	Review of Internal processes	2c	Healthy Talk (Member)	*Planned Start: Q1 2015* *Actual Start: 1/1/2016* *Date Revised:*
Member lack of knowledge regarding benefits available,	Review of Internal processes	2d	17 P brochure (Member)	*Planned Start: Q1 2015* *Actual Start: 1/1/2016* *Date Revised:*
Member late presentation, lack of relationship with provider, lack of awareness of appropriate treatment	Review of Internal processes	2e	Healthy Pregnancy Care Book (Member)	*Planned Start: Q1 2015* *Actual Start: 1/1/2016* *Date Revised:*
Lack of importance of prenatal care and impact on	Review of Internal processes	2f	Twitter Pregnancy Care (Member)	*Planned Start: Q1 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]
early deliveries				*Actual Start: 1/1/2016* *Date Revised:*
Transportation challenges, Child care availability, Lack of benefit knowledge	Review of Internal processes	2g	• Text4Baby (Member) • Multimedia communications • LDH supported partnerships	*Planned Start: Q1 2015* *Actual Start: 1/1/2016* *Date Revised:*
Lack of knowledge of late trimester availability requirements	Review of Internal processes	2h	Healthy 1st steps (Provider)	*Planned Start: Q1 2015* *Actual Start: 1/1/2016* *Date Revised:*
Lack of knowledge of late trimester availability requirements	Review of Internal processes	2i	OB risk assessment completion (Provider)	*Planned Start: Q1 2015* *Actual Start: 1/1/2016* *Date Revised:*
Lack of adherence to clinical guidelines, evidenced based recommendations	Review of Internal processes	2j	Routine cervical length assessments (Provider)	*Planned Start: Q1 2015* *Actual Start: 1/1/2016* *Date Revised:*
Lack of provider knowledge regarding plan services such as care management and coordination, benefit coverage, billing & coding for progesterone and contraception interventions. Lack of provider knowledge regarding clinical practice guidelines availability. Lack of adequate staff knowledge and training. Lack of Provider knowledge on ordering processes of 17P	Discussion with Providers	3a	**Medicaid 101/ Provider Education Initiative** (Provider/Health Plan): CPC's to deliver face-to-face provider education and distribute educational materials to OB/GYN/Practitioner sites. Educate practitioners on preterm deliveries and efficacy in the use of hormone therapy (17P). OB Tool Kit	*Planned Start: Q1 2015* *Actual Start: 5/1/2015* *Date Revised: 1/1/2016*
Providers do not have the resources within their offices to coordinate care.	Discussion with providers	3b	The CPC's will contact OB/GYN Practitioners sites throughout the year for reinforcement: (Provider) • 37 week delivery • C-section • OB Tool Kit (appendixes)	*Planned Start: Q1 2015* *Actual Start: 5/1/2015* *Date Revised: 1/1/2016*

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]
Physician's schedules are not always flexible to meet with plan.	Observation	3c	Ensure that clinical practice guidelines for antenatal progesterone and ACOG during pregnancy are EASILY available online (Provider)	*Planned Start: Q1 2015 Actual Start: 5/1/2015 Date Revised: 1/1/2016*
Lack of knowledge of Implantation of screening for STI, Most or Moderately effective Contraception intervention.	Discussion with providers	3d	LARC (Provider)	*Planned Start: Q1 2015 Actual Start: 5/1/2015 Date Revised: 1/1/2016*
Providers do not have the resources within their offices to coordinate care.	Discussion with providers	3e	Collaborate with behavioral health resources as needed (Provider)	*Planned Start: Q1 2015 Actual Start: 5/1/2015 Date Revised: 1/1/2016*
Member lack of coverage at month's end of delivery or after 60 days of Medicaid coverage	Analysis of claims	3f	Collaborate with the State to provide PPC visit after Medicaid termination if within delivery to 56 days post-partum with Take Charge program. With Medicaid expansion July 1, 2016 this population was carved into LA Medicaid. Take Charge Plus program auto enrollment into Medicaid expansion July 1, 2016 (Plan, Member)	*Planned Start: Q1 2015 Actual Start: 5/1/2015 Date Revised: 1/1/2016*
Providers do not have the resources within their offices to coordinate care.	Provider Interviews	3g	CPCs delivery and educate Provider on coding and billing updates (Provider)	*Planned Start: Q1 2015 Actual Start: 5/1/2015 Date Revised: 1/1/2016*
Lack of timeliness of data receipt. Difficulty in obtaining current member contact information	Brainstorming	3h	Work with LDH/ULM on enhanced LEERS File in process since April (Plan)	*Planned Start: Q1 2015 Actual Start: 5/1/2015 Date Revised: 1/1/2016:*
Lack of high risk member relationship with provider, Lack of high risk member awareness of appropriate treatment, Lack of high risk	Brainstorming	4	**Prenatal Care Management Outreach and Engagement Program Targeted to High Risk, Pregnant Members and Postpartum Care Management Outreach** (Providers): Reform reimbursement for antenatal progesterone (Member): Continue Healthy First Steps case management program	*Planned Start: Q1 2015 Actual Start: 2/1/2015 Date Revised: -*

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]
member engagement with OB provider and CM coordinator. Lack of high risk members receiving 17P in all geographic regions. Lack in obtaining current member contact information. Lack of members' willingness for ongoing engagement and adherence, Lack of knowledge billing, coding, reimbursement			for pregnant women and incorporate specific education about asking doctors about antenatal progesterone as clinically appropriate Individual Case Management Plan. Care and Case management throughout the pregnancy including PCMH and "backdoor" contact via PCP Concurrent review nurses: • Standardize scheduling prenatal visits • Case Management & Care Coordinators	*1/01/2016*
Lack of knowledge of contract and benefits along with coding and billing that impact incentive reimbursement	Discussion with Providers	5	**Postpartum Care Management Outreach and Engagement Program Targeted to High Risk Members** (Provider): Provider Incentives: VBC-Value Based Contracting OB VBC a. NOP forms submitted STI screening CHL, HIV, Syphilis	*Planned Start:Q1 2015* *Actual Start: 02/01/2015* *Date Revised: 01/01/2016:*
Unaware of HFS Program Unaware of the dangers of an early delivery Unaware of clinical practice guidelines availability Lack of knowledge billing, coding, reimbursement Member late presentation, lack of relationship with provider, lack of awareness of appropriate treatment Accuracy of data Timeliness of data receipt Lack of high risk members receiving 17P in all geographic regions	Brainstorming, Claims Analysis	6	Redesign and continue our existing Maternal Child Health Program known as Healthy First Steps ("HFS"). **Q1 2016** # of high risk members who received initial dose of timely injectable progesterone /#High risk members - **19 / 2455 =0 .77%** LA2 Baton Rouge 3=0.12 LA3 Thibodaux 2=0.08 LA4 Lafayette 5=0.2 LA6 Alexandria 2 =0.08 LA7 Shreveport 5=0.2 LA9 Mandeville 2=0.08 **Q2 2016** # of high risk members who received initial dose of timely injectable progesterone /#High risk members - **20 / 2018 =1.0%** LA2 Baton Rouge 1=0.05 LA3 Thibodaux 3=0.15 LA4 Lafayette 7=0.35 LA7 Shreveport 3=0.15 LA8 Monroe 3=0.15 LA9 Mandeville 3 =0.15	*Planned Start:Q2 2017* *Actual Start: April 1, 2017* *Date Revised:*

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]
Access and availability of OB offices Lack of member awareness of the importance of STI screenings.			**Q3 2016** # of high risk members who received initial dose of timely injectable progesterone /#High risk members - **10 / 1685 =0.59%** LA2 Baton Rouge 4=0.24 LA4 Lafayette 1=0.06 LA7 Shreveport 3=0.18 LA9 Mandeville 2 =0.12 **Q4 2016** # of high risk members who received initial dose of timely injectable progesterone /#High risk members **- 5 / 1971 =0 .25%** LA1 New Orleans 1=0.05 LA2 Baton Rouge 1=0.05 LA4 Lafayette 1=0.05 LA7 Shreveport 1=0.05 LA9 Mandeville 1 = 0.05	
Difficulty in obtaining current member contact information Unaware of the HFS program	Brainstorming	7	• Ongoing Health Education All pregnant women, regardless of risk or engagement with a provider will receive a welcome letter including information pertaining to KidsHealth and MyHealthLine in addition to the information listed in the ongoing interventions table.	*Planned Start:Q2 2017* *Actual Start: April 1, 2017* *Date Revised:*
Inadequate staffing and availability of time to properly complete NOP Lack of staff knowledge and training Eligible members not identified appropriately Provider/ Office manager availability Provider office unaware the member has listed them as there OB	Brainstorming	8	• Collaborate with providers by facilitating care Coordination Leveraging Clinical Practice Consultants and Transformation Consultants to work with ACOs and OB care providers to identify pregnant members with high risk factors including diabetes and hypertension, provide necessary care coordination, educate on UHC processes (i.e. NOP submission), educate on ACOG evidence based care (i.e. 17P and 39 week delivery initiatives), educate on LARC	*Planned Start:Q2 2017* *Actual Start: April 1, 2017* *Date Revised:*
Difficulty in obtaining member current contact information Opposition of community partners	Brainstorming	9	• Expanded Scope of Care and Community Partners Focus resources on longitudinal engagement of highest risk members, integrated with our Whole Person Care model Leverage field-based Community Health Workers to remove social barriers to care and Collaborate with community partners to engage, educate and support members	*Planned Start:Q2 2017* *Actual Start: April 1, 2017* *Date Revised:*

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.

Number of Intervention	Description of Intervention Tracking Measures[6]	Q1 2016	Q2 2016	Q3 2016	Q4 2016
1 NOP provider to plan communication	# OB providers educated about using NOP form/ # OB providers submitting NOP form per Member Residence Num: # of providers that received face-to-face provider education and received educational materials Denom: A distinct count (using Provider ID) of those providers at a single location that have submitted an OB Risk Assessment form for the pregnant members that are assigned to them for obstetric/maternal care in our clinical system (Community Care). Member residence (region) is taken off the member's demographic record in our clinical system (Community Care).	Numerator: 122 Denominator: 502 Rate: 24.3 LA1-63=12.55 LA2-276=54.98 LA3-29=5.78 LA4-22=4.38 LA5-10=1.99 LA6-14=2.79 LA7-31=6.17 LA8-2=0.4 LA9-55=10.96	Numerator: 45 Denominator: 827 Rate: 5.44 LA1-145=17.53 LA2-283=34.22 LA3-104=12.58 LA4-95=11.49 LA5-37=4.47 LA6-20=2.42 LA7-55=6.65 LA8-12=1.45 LA9-76=9.19	Numerator: 17 Denominator: 655 Rate: 2.6 LA1-109=16.64 LA2-200=30.53 LA3-61=9.31 LA4-65=9.92 LA5-17=2.6 LA6-23=3.51 LA7-74=11.3 LA8-27=4.12 LA9-79=12.06	Numerator: 4 Denominator: 932 Rate: 0.42 LA1-69=7.4 LA2-410=44 LA3-95=10.2 LA4-120=12.88 LA5-20=2.15 LA6-20=2.15 LA7-39=4.18 LA8-37=3.97 LA9-122=13.09
2 Plan to provider communication	# plan to provider communications of members at risk for preterm birth, i.e., sharing of high risk registry / # High risk members Num: Female members enrolled in HFS Denom: Female members with High Risk Preg indicator on 834 file[i]	Numerator: 2455 Denominator: 3364 Rate: 72.98 LA1-561=22.85 LA2-382=15.56 LA3-293=11.93 LA4-270=11 LA5-80=3.26 LA6-99=4.03 LA7-374=15.23 LA8-233=9.49 LA9-163=6.64	Numerator: 2018 Denominator: 4213 Rate: 47.9 LA1-469=23.24 LA2-300=14.87 LA3-232=14.5 LA4-217=10.75 LA5-65=3.22 LA6-81=4.01 LA7-320=15.86 LA8-195=9.66 LA9-139=6.89	Numerator: 1685 Denominator: 4389 Rate: 38.39 LA1-403=23.92 LA2-238=14.12 LA3-182=10.8 LA4-187=11.1 LA5-52=3.09 LA6-67=4 LA7-263=15.61 LA8-161=9.56 LA9-132=7.83	Numerator: 1971 Denominator: 3681 Rate:53.54 LA1-443=22.48 LA2-294=14.92 LA3-21711.01 LA4-224=11.36 LA5-67=3.4 LA6-74=3.75 LA7-305=15.47 LA8-199=10.1 LA9-148=7.51
3 Medicaid 101/Provider Education Initiative	# providers who completed educational program / total # providers targeted for education Num: # of providers that received face-to-face provider education and received the OB toolkit Denom: OB Providers who were contacted throughout the year for reinforcement.	Numerator: 122 Denominator: 122 Rate: 100	Numerator: 45 Denominator: 45 Rate: 100	Numerator: 17 Denominator: 17 Rate: 100	Numerator: 4 Denominator: 4 Rate: 100

Number of Intervention	Description of Intervention Tracking Measures[6]	Q1 2016	Q2 2016	Q3 2016	Q4 2016
	# Provider referrals to health plan care management / # High risk members. Num: Female members identified for Healthy Pregnancy Program Denom: Female members with High Risk Preg indicator on 834 file	Numerator: 689 Denominator: 2456 Rate: 28.05	Numerator: 725 Denominator: 2020 Rate: 35.89	Numerator: 944 Denominator: 1686 Rate: 55.99	Numerator: 620 Denominator: 1972 Rate31.44
4 Prenatal Care Management Outreach and Engagement Program Targeted to High Risk, Pregnant Members	# high risk members who are currently pregnant who received timely injectable progesterone initiation / total # high risk eligible members Num: Female members with High Risk Preg indicator on 834 file who had a 17p injection within the month Denom: Female members with High Risk Preg indicator on 834 file	Numerator: 19 Denominator: 2455 Rate: 0.77	Numerator: 20 Denominator: 2018 Rate: 1.0	Numerator: 10 Denominator: 1685 Rate: 0.59	Numerator: 5 Denominator: 1971 Rate: 0.25
	# high risk eligible members who received timely injectable progesterone initiation / # engaged in care management Num: Female members with High Risk Preg indicator on 834 file who had a 17p injection within the month Denom: Female members enrolled in HFS	Numerator: 19 Denominator: 3364 Rate: 0.56	Numerator: 20 Denominator: 4213 Rate: 0.47	Numerator: 10 Denominator: 4389 Rate: 0.22	Numerator: 5 Denominator: 3681 Rate: 0.14
	# high risk eligible members who received timely injectable progesterone initiation / # not engaged in care management Num: Female members with High Risk Preg indicator on 834 file who had a 17p injection within the month Denom: Female members not enrolled in HFS	Numerator: 19 Denominator: 2431 Rate: 0.78	Numerator: 20 Denominator: 1997 Rate: 1.0	Numerator: 10 Denominator: 1663 Rate: 0.6	Numerator: 5 Denominator: 1913 Rate: 0.26
	# members who were screened for HIV [ii]/ # pregnant members in obstetric care management Num: Female members screened for HIV	Numerator: 959 Denominator: 3364 Rate: 28.5	Numerator: 1007 Denominator: 4213 Rate: 23.9	Numerator: 968 Denominator: 4389 Rate: 22.06	Numerator: 567 Denominator: 3681 Rate: 15.4

Number of Intervention	Description of Intervention Tracking Measures[6]	Q1 2016	Q2 2016	Q3 2016	Q4 2016
	Denom: Female members enrolled in HFS # members who were screened for syphilis / # pregnant members in obstetric care management Num: Female members screened for syphilis[iii] Denom: Female members enrolled in HFS	Numerator: 990 Denominator: 3364 Rate: 29.43	Numerator: 1123 Denominator: 4213 Rate: 26.66	Numerator: 1097 Denominator: 4389 Rate: 25	Numerator: 632 Denominator: 3681 Rate17.17
5 Postpartum Care Management Outreach and Engagement Program Targeted to High Risk Members	# of providers who performed an immediate postpartum LARC/# of providers educated about postpartum LARC insertion Num: Providers who performed immediate postpartum LARC on female members who just had a delivery Denom: OB Providers who were contacted throughout the year for reinforcement. # of high risk members who received a LARC/ # of high risk eligible members Num: Female members with High Risk Preg indicator on 834 file who received a LARC Denom: Female members with High Risk Preg indicator on 834 file # high risk members who adopted use of a moderately effective method of contraception during the 60 day postpartum period / # engaged in care management Num: Female members with High Risk Preg indicator on 834 file who adopted this method following delivery Denom: Female members enrolled in HFS	Numerator: 0 Denominator: 122 Rate: 0 Numerator: 16 Denominator: 2456 Rate: 0.65 Numerator: 2 Denominator: 3330 Rate: 0.06	Numerator: 0 Denominator: 45 Rate: 0 Numerator: 12 Denominator: 2020 Rate: 0.59 Numerator: 0 Denominator: 4151 Rate: 0	Numerator: 1 Denominator: 10 Rate: 10% Numerator: 7 Denominator: 1686 Rate: 0.415 Numerator: 3 Denominator: 4335 Rate: 0.07	Numerator: 1 Denominator: 4 Rate: 25% Numerator: 10 Denominator: 1972 Rate: 0.51 Numerator: 1 Denominator: 3643 Rate0.03

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.

Number of Intervention	Description of Intervention Tracking Measures[6]	Q1 2017	Q2 2017	Q3 2017	Q4 2017
1 NOP provider to plan communication	# OB providers educated about using NOP form/ # OB providers submitting NOP form per Member Residence Num: # of providers that received face-to-face provider education and received educational materials Denom: A distinct count (using Provider ID) of those providers at a single location that have submitted an OB Risk Assessment form for the pregnant members that are assigned to them for obstetric/maternal care in our clinical system (Community Care). Member residence (region) is taken off the member's demographic record in our clinical system (Community Care).	Num:9 Denom:415 Rate:2.17 LA1-70=16.87 LA2-67=16.14 LA3-50=12.05 LA4-64=15.42 LA5-27=6.51 LA6-13=3.13 LA7-33=7.95 LA8-29=6.99 LA9-62=14.93	Num: 31 Denom:468 Rate:6.62 LA1-52=11.11 LA2-131=28 LA3-69=14.74 LA4-56=11.97 LA5-20=4.27 LA6-10=2.14 LA7-46=9.83 LA8-29=6.2 LA9-55=11.75	Num:36 Denom:237 Rate:15.19 LA1-42=17.72 LA2-36=15.19 LA3-28=11.81 LA4-34=14.35 LA5-19=8.02 LA6-12=5.06 LA7-19=8.02 LA8-13=5.48 LA9-34=14.35	Numerator:46 Denom:212 Rate:21.7 LA1-31=14.62 LA2-29=13.68 LA3-35=16.51 LA4-33=15.57 LA5-15=7.07 LA6-9=4.24 LA7-19=8.97 LA8-18=8.49 LA9-23=10.85
2 Plan to provider communication	# plan to provider communications of members at risk for preterm birth, i.e., sharing of high risk registry / # High risk members Num: Female members enrolled in HFS Denom: Female members with High Risk Prig indicator on 834 file	Num: 3817 Denom: 12457 Rate: 30.64 LA1-2300=18.47 LA2-2165=17.38 LA3-1421=11.41 LA4-1565=12.57 LA5-395=3.17 LA6-587=4.71 LA7-2030=16.3 LA8-1161=9.32 LA9-833=6.69	Num: 2688 Denom:13090 Rate:20.53 LA1-2391=18.27 LA2-2280=17.42 LA3-1489=11.37 LA4-1651=12.61 LA5-412=3.14 LA6-625=4.77 LA7-2121=16.2 LA8-1222=9.33 LA9-899-6.87	Num:2077 Denom:13812 Rate:15.04 LA1-2494=18.06 LA2-2373=17.18 LA3-1600=11.59 LA4-1685=12.2 LA5-438=3.17 LA6-661=4.79 LA7-2276=16.48 LA8-1290=9.34 LA9-995=7.2	Numerator: 1502 Denom: 13378 Rate: 11.23 LA1-2439=18.23 LA2-2316=17.31 LA3-1562=11.67 LA4-1636=12.23 LA5-417=3.12 LA6-629=4.7 LA7-2195=16.41 LA8-1220=9.12 LA9-964=7.21
3 Medicaid 101/Provider Education Initiative	# providers who completed educational program / total # providers targeted for education Num: # of providers that received face-to-face provider education and received the OB toolkit Denom: OB Providers who were contacted throughout the year for reinforcement.	Num:9 Denom:9 Rate:100	Num:31 Denom:31 Rate:100	Num:36 Denom:36 Rate:100	Numerator:46 Denom:46 Rate:100

Number of Intervention	Description of Intervention Tracking Measures[6]	Q1 2017	Q2 2017	Q3 2017	Q4 2017
	# Provider referrals to health plan care management / # High risk members. Num: Female members identified for Healthy Pregnancy Program Denom: Female members with High Risk Preg indicator on 834 file	Num: 1006 Denom: 12466 Rate: 8.07	Num:650 Denom: 13105 Rate:4.96	Num:414 Denom:13828 Rate:2.99	Numerator: 366 Denom: 13438 Rate: 2.72
4 Prenatal Care Management Outreach and Engagement Program Targeted to High Risk, Pregnant Members	# high risk members who are currently pregnant who received timely injectable progesterone initiation / total # high risk eligible members Num: Female members with High Risk Preg indicator on 834 file who had a 17p injection within the month Denom: Female members with High Risk Preg indicator on 834 file	Num:142 Denom: 12457 Rate: 1.14	Num:222 Denom: 13090 Rate:1.7	Numerator: 209 Denominator: 13812 Rate: 1.51	Numerator: 230 Denominator:13378 Rate: 1.72
	# high risk eligible members who received timely injectable progesterone initiation / # engaged in care management Num: Female members with High Risk Preg indicator on 834 file who had a 17p injection within the month Denom: Female members enrolled in HFS	Num:142 Denominator: 3817 Rate: 3.72	Num:222 Denominator: 2688 Rate:8.26	Numerator: 209 Denominator: 2077 Rate: 10.06	Numerator: 230 Denominator: 1502 Rate: 15.31
	# high risk eligible members who received timely injectable progesterone initiation / # not engaged in care management Num: Female members with High Risk Preg indicator on 834 file who had a 17p injection within the month Denom: Female members not enrolled in HFS	Numerator:142 Denominator:12217 Rate:1.16	Numerator:222 Denominator: 12852 Rate:1.73	Numerator: 209 Denominator: 13608 Rate: 1.54	Numerator: 230 Denominator: 13301 Rate: 1.73
	# members who were screened for HIV / # pregnant members in obstetric care management				

Number of Intervention	Description of Intervention Tracking Measures[6]	Q1 2017	Q2 2017	Q3 2017	Q4 2017
	Num: Female members screened for HIV Denom: Female members enrolled in HFS	Numerator: 1343 Denominator: 3817 Rate:35.18	Numerator:1494 Denominator: 2688 Rate:55.58	Numerator:1351 Denominator: 2077 Rate: 65.05	Numerator: 1248 Denominator: 1502 Rate: 83.1
	# members who were screened for syphilis / # pregnant members in obstetric care management	Numerator:1290 Denominator: 3817 Rate:33.8	Numerator:1369 Denominator: 2688 Rate:50.93	Numerator: 1198 Denominator:2077 Rate: 57.68	Numerator:1089 Denominator:1502 Rate: 72.5
	Num: Female members screened for syphilis Denom: Female members enrolled in HFS				
	#high risk members who received timely injectable progesterone initiation / # injections for the members				Numerator: 230 Denominator: 415 Rate: 55.42
	Num: Female members with High Risk Preg indicator on 834 file who had a 17p injection within the month Denom: 17p injections received by members	Numerator: 142 Denominator: 269 Rate: 52.79	Numerator:222 Denominator:433 Rate:51.27	Numerator: 209 Denominator: 404 Rate: 51.73	
5 Postpartum Care Management Outreach and Engagement Program Targeted to High Risk Members	# of providers who performed an immediate postpartum LARC/# of providers educated about postpartum LARC insertion Num: Providers who performed immediate postpartum LARC on female members who just had a delivery Denom: OB Providers who were contacted throughout the year for reinforcement.	Numerator:9 Denominator:9 Rate:100	Numerator:18 Denominator:31 Rate: 58.06	Numerator:18 Denominator:36 Rate:50	Numerator:31 Denominator:46 Rate:67.4
	# of high risk members who received a LARC/ # of high risk eligible members Num: Female members with High Risk Preg indicator on 834 file who received a LARC Denom: Female members with High Risk Preg indicator on 834 file	Numerator:71 Denominator: 12466 Rate:0.57	Numerator:106 Denominator:13105 Rate:0.81	Numerator:107 Denominator: 13828 Rate: 0.77	Numerator: 99 Denominator: 13438 Rate: 0.74

Number of Intervention	Description of Intervention Tracking Measures[6]	Q1 2017	Q2 2017	Q3 2017	Q4 2017
	# high risk members who adopted use of a moderately effective method of contraception during the 60 day postpartum period / # engaged in care management Num: Female members with High Risk Preg indicator on 834 file who adopted this method following delivery Denom: Female members enrolled in HFS	Num: 16 Denominator: 3779 Rate:0.42	Num:31 Denominator:2662 Rate:1.16	Numerator: 37 Denominator: 2055 Rate: 1.8	Numerator: 59 Denominator: 1488 Rate: 3.96

Number of Intervention	Description of Intervention Tracking Measures[6]	Q1 2017	Q2 2017	Q3 2017	Q4 2017
6 Redesign and continue our existing Maternal Child Health Program known as Healthy First Steps(New, measurement in 2017)	# of pregnant members diagnosed with Diabetes and have a POC/ # high risk pregnant members with diabetes not enrolled in Case Management Num: Female pregnant members with Diabetes and have Plan of care in CM Denom: Female pregnant members with High Risk Preg indicator and have Diabetes but not enrolled in CM	Numerator:18 Denominator:34 Rate:52.94	Numerator: 23 Denominator: 37 Rate: 62.16	Numerator: 20 Denominator: 41 Rate: 48.78	Numerator: 16 Denominator: 36 Rate: 44.44
	# of pregnant members diagnosed with Diabetes and have a POC/ # high risk pregnant members with a Plan of care Num: Female pregnant members with Diabetes and have Plan of care in CM Denom: Pregnant members enrolled in HFS and have a Plan of care	Numerator:18 Denominator:105 Rate:17.14	Numerator: 23 Denominator:146 Rate: 15.75	Numerator: 20 Denominator: 94 Rate: 21.28	Numerator: 16 Denominator: 60 Rate: 26.67
	# of pregnant members diagnosed with hypertension and have a Plan of care / # high risk pregnant members with hypertension not enrolled in Case Management Num: Female pregnant members with Hypertension and have plan of care in CM Denom: Female pregnant members with High Risk Preg indicator and have	Numerator:22 Denominator:23 Rate:95.65	Numerator:23 Denominator:38 Rate: 60.52	Numerator:10 Denominator:62 Rate: 16.13	Numerator: 7 Denominator:65 Rate: 10.77

Number of Intervention	Description of Intervention Tracking Measures[6]	Q1 2017	Q2 2017	Q3 2017	Q4 2017
	Hypertension but not enrolled in CM # of pregnant members diagnosed with hypertension and have a POC/ # high risk pregnant members with a Plan of care Num: Female pregnant members with hypertension and have Plan of care in CM Denom: Pregnant members enrolled in HFS and have a Plan of care # high risk pregnant members with a Plan of care # high risk pregnant members Num: Pregnant members enrolled in HFS and have a Plan of care Denom: Female pregnant members with High Risk Preg indicator	Numerator:22 Denominator:105 Rate:20.95 Numerator:105 Denominator:433 Rate:24.25	Numerator: 23 Denominator:146 Rate: 15.75 Numerator: 146 Denominator: 595 Rate: 24.54	Numerator:10 Denominator: 94 Rate:10.64 Numerator: 94 Denominator: 450 Rate: 20.89	Numerator:7 Denominator: 60 Rate:11.67 Numerator: 60 Denominator: 308 Rate: 19.49
7 Ongoing Health Education (New, measurement in 2017)	#Members who agreed to high risk OB case management with a Plan of care / # high risk pregnant members Num: Female pregnant members in CM with a Plan of care Denom: Female pregnant members with High Risk Preg indicator	Numerator: 105 Denominator: 433 Rate: 24.25	Numerator: 146 Denominator: 595 Rate: 24.54	Numerator: 94 Denominator: 450 Rate: 20.89	Numerator: 60 Denominator: 308 Rate19.49
8 Collaborate with providers by facilitating care Coordination (New, measurement in 2017)	# of providers who were educated about LARC and provided an immediate postpartum LARC / # of providers educated about LARC Num: OB Providers who were contacted throughout the year for reinforcement and billed for immediate postpartum LARC Denom: OB Providers who were contacted throughout the year for reinforcement.	Numerator: 7 Denominator: 9 Rate: 77.78	Numerator: 16 Denominator: 31 Rate: 51.61	Numerator: 15 Denominator: 36 Rate: 41.67	Numerator: 15 Denominator: 46 Rate32.61
9 Expanded Scope of Care and Community Partners (New,	# of pregnant members that have a Maternal age <20 diagnosed with diabetes/ # of high risk pregnant members that have a Maternal age	Numerator: 2 Denominator: 3 Rate: 66.67	Numerator: 3 Denominator: 3 Rate: 100	Numerator: 3 Denominator: 5 Rate: 60	Numerator: 3 Denominator: 3 Rate100

Number of Intervention	Description of Intervention Tracking Measures[6]	Q1 2017	Q2 2017	Q3 2017	Q4 2017
measurement in 2017)	<20 Num: Maternal age <20 Female pregnant members with a High Risk Preg indicator and diagnosed with diabetes Denom: Maternal age <20 Female pregnant members with a High Risk Preg indicator				Numerator: 28 Denominator: 30 Rate: 93.33
	# of pregnant members that have a Maternal age >35 diagnosed with diabetes /# of high risk pregnant members that have a Maternal age >35 Num: Maternal age >35 Female pregnant members with a High Risk Preg indicator and diagnosed with diabetes Denom: Maternal age >35 Female pregnant members with a High Risk Preg indicator	Numerator: 24 Denominator: 53 Rate: 45.28	Numerator: 24 Denominator: 84 Rate: 28.57	Numerator: 23 Denominator: 62 Rate: 37.10	
	# of pregnant members that have a Maternal age <20 diagnosed with hypertension/ # of high risk pregnant members that have a Maternal age <20 Num: Maternal age <20 Female pregnant members with a High Risk Preg indicator and diagnosed with hypertension Denom: Maternal age <20 Female pregnant members with a High Risk Preg indicator	Numerator: 2 Denominator: 3 Rate: 66.67	Numerator: 3 Denominator: 3 Rate: 100	Numerator: 0 Denominator: 0 Rate: 0	Numerator: 0 Denominator: 3 Rate: 0
	# of pregnant members that have a Maternal age >35 diagnosed with hypertension /# of high risk pregnant members that have a Maternal age >35 Num: Maternal age >35 Female pregnant members with a High Risk Preg indicator and diagnosed with	Numerator: 37 Denominator: 53 Rate: 67.92	Numerator: 15 Denominator: 84 Rate: 17.86	Numerator: 15 Denominator: 62 Rate: 24.19	Numerator: 25 Denominator: 30 Rate: 83.33

Number of Intervention	Description of Intervention Tracking Measures[6]	Q1 2017	Q2 2017	Q3 2017	Q4 2017
	hypertension Denom:>35 Female pregnant members with a High Risk Preg indicator				

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[iv]	**Administrative (A) or Hybrid (H) Measure?**	**Baseline Period** 2015 Unable to populate Eligible Population and Exclusions (New Template)	**Interim Period** 2016 Unable to populate Eligible Population and Exclusions (New Template)	**Final Period** 2017	**Final Goal/Target Rate**
[2]Indicator #1 The percentage of women 15-45 years of age with evidence of a previous pre-term singleton birth event (<37	A	Eligible Population = Enter # Exclusions= Enter # If "H", Sample size = Enter # Numerator = 31 Denominator = 1000 Rate = 3.1%	Eligible Population = Enter # Exclusions= Enter # If "H", Sample size = Enter # Numerator = 82 Denominator = 562 Rate = 14.59% .	Eligible Population = Enter # Exclusions= Enter # If "H", Sample size = Enter # Numerator = 168 Denominator = 933 Rate = 18.01	Target Rate: 20.4 Rationale: 95% of CI Calculation of 11.6%, 17.4%

[2] The rate was calculated using the Initiation of Injectable Progesterone for PTB prevention specifications.

weeks completed gestation) who received one or more Progesterone injections between the 16th and 21st week of gestation.					
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	A			Eligible Population = Enter # Exclusions= Enter # If "H", Sample size = Enter # Numerator = 181 Denominator = 1002 Rate = 18.06	Target Rate: 20.4
Indicator #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.	A	Eligible Population = Enter # Exclusions= Enter # If "H", Sample size = Enter # Numerator = 6002 Denominator = 9373 Rate = 64%	Eligible Population = Enter # Exclusions= Enter # If "H", Sample size = Enter # Numerator = 7623 Denominator = 8691 Rate = 87.7%	Eligible Population = Enter # Exclusions= Enter # If "H", Sample size = Enter # Numerator = 8108 Denominator = 9205 Rate = 88.1%	Target Rate: 89.1% Rationale: 95% of CI Calculation of 87.0%, 88.7%

Indicator #3 The percentage of women who delivered a live birth and had at least one test for HIV during pregnancy.	A	Eligible Population = Enter # Exclusions= Enter # If "H", Sample size = Enter # Numerator = 512 Denominator = 9443 Rate = 5.4	Eligible Population = Enter # Exclusions= Enter # If "H", Sample size = Enter # Numerator = 7482 Denominator = 8748 Rate = 85.5	Eligible Population = Enter # Exclusions= Enter # If "H", Sample size = Enter # Numerator = 2033 Denominator = 9240 Rate = 22.0%	Target Rate: 87% Rationale: 95% of CI Calculation of 84.8%, 86.3%
Indicator #4 The percentage of women who delivered a live birth and had at least one test for syphilis during pregnancy.	A	Eligible Population = Enter # Exclusions= Enter # If "H", Sample size = Enter # Numerator = 7662 Denominator = 9443 Rate = 81.1%	Eligible Population = Enter # Exclusions= Enter # If "H", Sample size = Enter # Numerator = 7762 Denominator = 8748 Rate = 88.7%	Eligible Population = Enter # Exclusions= Enter # If "H", Sample size = Enter # Numerator = 7760 Denominator = 9240 Rate = 84.0%	Target Rate:90.1% Rationale: 95% of 88.1%, 89.4%
Indicator #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)	A	Eligible Population = 7358 Exclusions= 57 If "H", Sample size = Enter # Numerator = 709 Denominator = 7301 Rate = 9.7 %	Eligible Population = 8752 Exclusions= 36 If "H", Sample size = Enter # Numerator = 1056 Denominator = 8716 Rate = 12.1%	Eligible Population = 9240 Exclusions= 37 If "H", Sample size = Enter # Numerator = 1151 Denominator = 9203 Rate = 12.5%	Target Rate:25% Rationale: 95% of CI Calculation of 21.50%, 20.42%
Indicator #5a The percentage of postpartum women who adopt use of either a most or	A	Eligible Population = 7358 Exclusions= 57 If "H", Sample size = Enter # Numerator = 88	Eligible Population = 8752 Exclusions= 36 If "H", Sample size = Enter # Numerator = 133	Eligible Population = 9240 Exclusions= 37 If "H", Sample size = Enter # Numerator = 171	

moderately effective FDA-approved method of contraception during delivery hospitalization		Denominator = 7301 Rate = 1.2%	Denominator = 8716 Rate = 1.5%	Denominator = 9203 Rate = 1.9%	
Indicator #5b The percentage of postpartum women who adopt use of either a most or moderately effective FDA-approved method of contraception LARC outpatient within 56 days postpartum	A	Eligible Population = 7358 Exclusions= 57 If "H", Sample size = Enter # Numerator = 621 Denominator = 7301 Rate = 8.5%	Eligible Population = 8752 Exclusions= 36 If "H", Sample size = Enter # Numerator = 923 Denominator = 8716 Rate = 10.6%	Eligible Population = 9240 Exclusions= 37 If "H", Sample size = Enter # Numerator = 980 Denominator = 9203 Rate = 10.6%	
Indicator #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.	A	Eligible Population = 7358 Exclusions= 57 If "H", Sample size = Enter # Numerator = 1676 Denominator = 7301 Rate = 23%	Eligible Population = 8752 Exclusions= 36 If "H", Sample size = Enter # Numerator = 1972 Denominator = 8716 Rate = 22.6%	Eligible Population = 9240 Exclusions= 37 If "H", Sample size = Enter # Numerator = 2011 Denominator = 9203 Rate = 21.9%	Target Rate: 26% Rationale: 95% CI Calculation of 21.60%, 20.52%
Indicator #7 The percentage of postpartum women who adopt use of either a most or moderately effective FDA-approved method of contraception	A	Eligible Population = 7358 Exclusions= 57 If "H", Sample size = Enter # Numerator = 2385 Denominator = 7301 Rate = 32.7%	Eligible Population = 8752 Exclusions= 36 If "H", Sample size = Enter # Numerator = 3028 Denominator = 8716 Rate = 34.7% Most and moderately effective FDA-	Eligible Population = 9240 Exclusions= 37 If "H", Sample size = Enter # Numerator = 3162 Denominator = 9203 Rate = 34.4% Most and moderately effective FDA-	Target Rate:50% Rationale: 95% CI Calculation of 43.13%, 40.97%

			approved method of contraception	approved method of contraception	
Indicator #8 HEDIS® Postpartum Measure	A	Eligible Population = Enter # Exclusions= Enter # If "H", Sample size = Enter # Numerator = 4093 Denominator = 9515 Rate = 43.02 HEDIS® PPC Baseline MY = November 6, 2014-November 5, 2015	Eligible Population = 8752 Exclusions= Enter # If "H", Sample size = Enter # Numerator = 4895 Denominator = 8752 Rate = 55.93 HEDIS® PPC Interim MY = November 6, 2015-November 5, 2016	Eligible Population = Enter # Exclusions= Enter # If "H", Sample size = Enter # Numerator = 5300 Denominator = 9240 Rate = 57.36% HEDIS® PPC MY = November 6, 2016-November 5, 2017	Target Rate: 63.12% as Target/Goal (Per State) Rationale: State Goal
Indicator #9 HEDIS® Postpartum Measure	H	Eligible Population = Enter # Exclusions= Enter # If "H", Sample size = Enter # Numerator = 239 Denominator = 407 Rate = 58.72 HEDIS® Baseline MY = November 6, 2014-November 5, 2015	Eligible Population = Enter # Exclusions= Enter # If "H", Sample size = Enter # Numerator = 260 Denominator = 401 Rate = 64.84 HEDIS® PPC Interim MY = November 6, 2015-November 5, 2016	Eligible Population = Enter # Exclusions= Enter # If "H", Sample size = Enter # Numerator = 265 Denominator = 411 Rate = 64.48% HEDIS® PPC MY = November 6, 2016-November 5, 2017	Target Rate: 63.12% as Target/Goal (Per State) Rationale: HEDIS® 2015MY2014 was 54.99% HEDIS®2016MY2015 hybrid results was 58.72% for an increase of 3.71% QM leadership agreed to meet or exceed the State goal above. HEDIS®2017MY2016 hybrid results was 64.84% for an increase of 6.12% QM leadership agreed to meet or exceed the State goal above. HEDIS®2018MY2017 State Goal 60.98%.

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:
February, March, April 2016
Upon review of the first three months of data, documented interventions, and internal collaboration with our Optum Healthy First Steps/Care Management partners, UHC has identified success and opportunities to improve by the data reported. UHC OBGYN toolkit the comprehensive educational tool to educate providers and their respective offices has proven to be a success. Our OBGYN specialist providers are new to our new prepaid status with the State and were not previously on our provider lists. Our providers have been most receptive to the information that has been disseminated in the past months. Our education NOP form has increased month over month. The new version of LEERS is being communicated along with LARC information, HIV and Syphilis testing, 17P and PPC visits. Our PPC HEDIS® score for HEDIS® 2016 increased by 3.71% points over the previous year.
May, June, July 2016
Upon review of 6 months of data documented interventions and internal collaboration with our Optum Healthy First Steps/Care Management partners, UHC has identified success and opportunities to improve by the data reported. UHC OBGYN toolkit, the comprehensive educational tool, to educate providers and their respective offices has continued to be a success. Our providers have been most receptive to the information that has been disseminated in the past months. Our education and NOP form submission has continued to improve premature births.
August, September, October 2016
Upon review of 9 months of data, UHC has identified success and opportunities to improve by the data reported. Continue to improve the early identification of high risk members and educate members on the importance of prenatal and postpartum care. UHC OBGYN toolkit, the comprehensive educational tool, to educate providers has been enhanced. Our PPC HEDIS® score for November 2016 increased by 6.94% points from the previous year. This data is as of 11-27-2016 prior to Hybrid review and 90 day claims lag and are noted below as TY (this year) and LY (last year) at the same time. PPC TY: 46.33 PPC LY: 39.39
Overall
Upon review of 2016 data, documented interventions, and internal collaboration with our Optum Healthy First Steps/Care Management partners, UHC has identified successes, barriers and opportunities to improve. Continue to collaborate with Alere for engagement of Pregnant Members and work to stratify members using data we have versus waiting for members to self-report. The LA C&S plan has added Makena (Hydroxyprogesterone) under its pharmacy benefits. Now, in addition to the usual Medical benefit options, prescribers can write a prescription and have the member fill it at a retail pharmacy. Of note, not all retail pharmacies are able to order Makena (depends on their contract). 3,054 is the total number of 17P/Makena injections administered in 2016 relating to claims. In 2016, the Louisiana HFS enrollment rate of 82% exceeded the national enrollment rate of 74%. An extra outreach was completed in Q3 & Q4. We distributed our enhanced resources to our providers which resulted in an increase in a few of our Q4 rates Our PPC HEDIS® score for 2016 increased by 6.12% from the previous year. **PPC TY: 64.84% PPC LY: 58.72%**
Timeliness of Prenatal Care TY: 85.54% Timeliness of Prenatal Care LY: 79.85%
Our Timeliness of Prenatal Care HEDIS® score for 2016 increased by 5.69% from the previous year

Final
The UHC Quality team has included key stakeholders that included new team members from our Maternal and Infant engagement and outreach program, known as Healthy First Steps (HFS), LA field based Clinical Practice Consultants (CPCs), LA field based Clinical Transformation Consultants (CTCs), as well as our local pharmacists. These disciplines enhance the expertise represented by other team members including quality, care management, and medical. After reviewing and discussing the process flow chart identifying the steps necessary for the early identification and medical management of high risk pregnant mothers with a history of preterm delivery, the key stakeholders came to consensus that two sub-processes in particular were the most critical to achieve success. First, the completion of the Notification of Pregnancy Form (NOP) must be accurately completed. Without the completed NOP, proper and timely identification for a mother at risk is greatly reduced. On account of this critical step being so early in the process, it is a high priority. Second, since the proper initiation of progesterone therapy for at risk mother's is the ultimate goal (SMART AIM), failure to begin such therapy was considered as well to be a primary breakdown in the process. In summary, the two primary sub-processes considered to be most critical in achieving success for the PIP were 1) the completion of the NOP, and 2) once the at risk member was identified utilizing the NOP, the initiation of timely progesterone therapy. Balanced measures that produce meaningful outcomes are part of a strategic management system for achieving long-term performance goals. Specifying balanced measures involves taking into consideration all stakeholders.

Our PPC HEDIS® score for 2017 was above the state goal PPC TY: 64.48
Our Timeliness of Prenatal Care for HEDIS® 2017: TY- 82.24

Our performance indicator goals, with the exception of indicator 5, 6 and 7, were increased during the interim and the final measurement year.

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: 3 out of the 5 intervention Categories have not shown improvement for year 2016. The intervention categories that have not shown improvement are as follows: NOP provider to plan communication, plan to provider communication and Prenatal Care Management Outreach and Engagement program.

- NOP provider to plan communication - Most OB's were educated in the first and second quarter of 2016 which produced lower provider education in the third and fourth quarter.
- Plan to provider communication- The number of members on the registry decreased throughout the first three quarters and increased marginally in Q4. The rate steadily decreased and climbed in Q4.
- Prenatal Care Management Outreach and Engagement Program- The high risk members who received timely injectable progesterone decreased throughout the duration of year 2016 which ultimately affected the rate. The STI screening rate also declined. Some members have transportation challenges or childcare availability issues which causes missed appointments and the lack member adherence with the course of treatment and engagement in the case management program.

System level changes have been made to support with the process measures. The HFS program is now at the local plan level and the focus is Louisiana Specific. One of the goals of the HFS program is to significantly improve the member experience and operational effectiveness in ways that will create sustained improvement in the health and well-being of moms and babies.

UHC is looking at adding the Notice of Pregnancy (NOP) form as an electronic access process within UHC's internal database with providers submitting directly into member electronic record. HFS is looking to automate the Mining of the state file and marrying that to current pregnant members.
Keep track of any events and/or activities related to the intervention as they occur. In addition, keep a record of challenges and/or confounding factors as they occur throughout the intervention period.

UHC quality has restructured the postpartum outreach report & activity tracker to comply with the portion of the HEDIS® measure, PPC.

UHC has redesigned the HFS OB case management for pregnant women going forward. HFS has incorporated specific education about asking doctors about antenatal progesterone as clinically appropriate Individual Case Management Plan.

The goals of our redesigned program include, but are not limited to:

- Increase member and provider engagement
- Increase prenatal and postpartum visits/care
- Decrease pre-term births and NICU admissions by reducing the barriers to 17P utilization
- Improve access to obstetrical care, family planning, and social services
- Outreach to members including education on STI screenings
- Expand the scope of care and service delivery for pregnant members.
- Monitoring of members who are stratified as high risk and are consistently engaged in maternity care with an obstetric practitioner that is not part of Practice Support will be monitored closely by the health plan's maternal child health program coordinator (MCH-PC)
- Engage high risk members in the Whole Person Care Program if not receiving maternity care from any source.
- The new program is continuing the work of the former program that will use the state registries as well as current claims mining to "tag" a member as having a previous high risk pregnancy. This allows the member tag to stay with the member and if in the future she is identified as pregnant, outreach will be prioritized and previous high risk reasons can be seen earlier and more transparently in the documentation system.

Best Practices that were identified in the following intervention tracking measures: Medicaid 101/Provider Education Initiative and Prenatal Care Management Outreach and Engagement program. The following best practices have been identified:

- Data Quality- Increasing access to data, Data mining for Earlier Identification in Pregnancies... Using Data from process measures to identify opportunities for improvement.
- Whole Person Care program improving outcomes for individuals that have high risk pregnancies by improved care coordination
- Provider Education- OB toolkits- Ongoing process of revisions
- Improved Risk Stratification- proactive health management to improved members' clinical outcomes and quality of life
- Addressing Social determinants of health & helping members navigate available healthcare and community resources

Upon review of the 10 intervention categories in 2017, 50% intervention categories have not shown tremendous improvement. The intervention categories that have not shown improvement are as follows: Plan to provider communication, Provider Education Initiative, Redesigning of the HFS program, Collaboration with providers by facilitating care coordination and collaboration with partners.

- Plan to provider communication, - Members enrolled in HFS declined from quarter to quarter and the # of members with a preg indicator on 834 file increased from quarter to quarter. No all members with a preg indicator on 834 file are pregnant.
- Provider Education Initiative- Female members identified for healthy pregnancy program declined throughout 2017.
- Redesigning of the HFS program – Pregnant members with a POC declined throughout 2017.
- Collaboration with providers by facilitating care coordination – Both the numerator and denominator increased for this intervention, however the rate continued to decline.
- Collaboration with partners –The high risk members who had a diagnosis of Hypertension or diabetes that received timely injectable progesterone remained low throughout the year.

3 out of the 5 intervention categories that have not shown improvement for year 2017 are new intervention categories.

System level changes will continue to be monitored and if not productive, will be modified. Development and implementation of revised tracking measures that will produce meaningful outcomes will take place.

Best Practices:

- For HFS, the clinical practice consultants, who are field-based registered nurses, work with high volume obstetric practitioners and the local HFS plan resources to identify members, manage risk, care coordination, engage members in care, and close care gaps.
- Based on medical, behavioral, and/or social risk factors and conditions as well as obstetric care status and affiliation with a supported provider or practitioner, the members receive outreach and are evaluated for case management needs and open gaps in care and will receive the associated targeted interventions.
- Data shared through provider portals, registries, or other methods assist the practitioner in identifying potential new and ongoing risk factors, open gaps in care based on evidence-based guidelines, and other data and information to help manage care.

What factors were associated with success or failure? Some confounding factors that contributed to the rates being low during the intervention period include: Received NOP forms with incomplete information – without member due date. This led to inability to process the request. QM Department outreach team challenged with finding accurate phone numbers to provide outreach to members.

Our Training materials/resources were redesigned and updated. Some of our resources include UHC's OB Toolkit and Brochures on Optum homecare OB services.
An effective infrastructure to support quality improvement efforts includes a culture of quality throughout the UHC from leadership on down which has resulted in an increase of the NOP provider to plan communication rate.
UHC's infrastructure includes multidisciplinary teams of SMEs, clinicians, and data analysts.

Limitations

As in any population health study, there are study design limitations for a PIP. Address the limitations of your project design, i.e., challenges identified when conducting the PIP (e.g., difficulty locating Medicaid members, lack of resources, etc.)

- **Were there any factors that may pose a threat to the internal validity the findings? 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. Increase the use of progesterone therapy to reduce recurrent preterm birth in accordance with ACOG recommendations **Study Limitations:** Validity of the High Risk pregnancy file received from the State that has notable claims lag and transfer of members from MCO to MCO. The State is doing a review to enhance report as requested by MCOs and adding additional elements to the current report.
  Performance Indicator #2: Increasing STI screening; Chlamydia, Syphilis, and HIV among pregnant women who delivered in the measurement year that were high risk pregnancies and all deliveries. **Study Limitations:** UHC will use the specifications for the 2015 HEDIS® Chlamydia Screening, HIV and Syphilis Screening in Women during Pregnancy measures specifications and the IPRO code specifications to identify Chlamydia, HIV and Syphilis. Exclude non-live births (Non-live Births Value Set).
  Performance Indicator #3: Engaging members in postpartum care. **Study Limitations:** PPC rate for total population vs PPC rate for study population thus far. UHC will present the 2015 HEDIS® rates (for all members who delivered) during the June meeting as the baseline. Using the administrative method may result in underreporting until postpartum visits are "unbundled" and providers can bill for the visits. UHC will use

the final HEDIS® rate for the measurement year using the administrative and hybrid review. The periodic rates that will be reported will be the administrative rate only until hybrid review for 2016 is completed.
Performance Indicator #4: Facilitate uptake of postpartum contraception. **Study Limitations:** As high risk registry data matures, separate rates will be reported for the subpopulation of women in the high risk registry.

- **Describe any data collection challenges.** Overall chart collecting for the 2016 HIV/LARC/Contraception/Syphilis/Chlamydia/Postpartum Medical record Review was satisfactory. Performance was high for the first STI screenings and almost 50 % for 2nd STI screenings. Out of the charts selected, there were not any LARC (immediate postpartum).
  •Barriers to provider implementation of and member adherence to screening for STI, and postpartum contraception counseling and uptake.
  •Lack of adherence to clinical guidelines and evidenced based recommendations.

HIV/LARC/Contraception/Syphilis/Chlamydia/Postpartum Medical record Review
2016

BACKGROUND:

5-10 charts per Clinical Practice Consultants (CPCs) were obtained for an OB Medical Record Review from an UHC OB office. The charts were randomly selected. The charts were postpartum and at least 57 days after delivery. Review was onsite or fax/mail.

RESULTS AND ANALYSIS

55 Charts Total:	**Numerator**	**Rate**
# of Chlamydia test (Prenatal)	48	87.27%
# of Syphilis test (Prenatal)	50	90.90%
# of HIV test (Prenatal)	54	98.18%
# Female Sterilization	7	12.72%
# of LARC: Immediate postpartum	0	0
# of LARC during Postpartum period 21-56	9	16.4%
# of Moderately effective Contraception	22	40%

2nd Chlamydia test (Prenatal)	22	40%
2nd Syphilis test (Prenatal)	26	47.27%
2nd HIV test (Prenatal)	16	29.09%

Member Participation

No member participation

Describe methods utilized to solicit or encourage membership participation: N/A

Dissemination of Findings

- **Describe the methods used to make the findings available to members, providers, or other interested parties:** The findings have been disseminated to the PAC (Provider Advisory Committee) and internally.

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 beyond the PIP timeframe.

Description of Intervention	Lessons Learned	System-level changes made and/or planned	Next Steps
NOP provider to plan communication	Accuracy of data for timely identification. Not all NOPs are submitted timely resulting in a delayed delivery of 17-P to member	NOP report now monthly. Providers needing educatior on the importance of submission and accuracy of data.	Plan looking into adding a NOP incentive for 2019
Plan to provider communication	Limited staffing in provider offices Additional training or oversight needed Staff turnover	Continue collaborating with c partners. Continue provider outreach and case management engagement	Monitor interventions and process measures quarterly. Report internally. Devise a plan if the results are not meaningful. Collaborate with key stakeholders by discussing approaches for long term engagement. Current process tracking measure will be discontinued. Tracking measure 2 listed under Medical 101 #of providers referrals to health plan care management will be added to Plan to provider communication.

Medicaid 101/Provider Education Initiative	Provider trust is a key part to develop sustainability	Top OB provider visits changed from quarterly to monthly	Provider education will include continued monthly visits from UHC quality staff to educate and distribute member/provider educational materials. Some of the materials to be distributed will include the Healthy First Steps brochure, smoking cessation information, Nurse Family Partnership information, hormone therapy information, practitioner specific data about preterm deliveries and other relevant materials to be developed.
Prenatal Care Management Outreach and Engagement Program Targeted to High Risk, Pregnant Members	We must attain our practices for the monitoring, analysis, and evaluation of the quality and appropriateness of healthcare provided to our members in the areas of underutilization or high risk conditions. This will allow us to continue to impro our ability to assist members to change their health behaviors.	Top OB provider visits changed from quarterly to monthly	Incentivize providers that close gaps in care opportunities related to PPC
Postpartum Care Management Outreach and Engagement Program Targeted to High Risk Members	We must attain our practices for the monitoring, analysis, and evaluation of the quality and appropriateness of healthcare provided to our members in the areas o underutilization or high risk conditions. This will allow us to continue to improve our ability to assist membe to change their health behaviors.	Top OB provider visits changed from quarterly to monthly	Incentivize providers that close gaps in care opportunities related to PPC
Redesign and continue our existing Maternal Child Health Program known as Healthy First Steps(New, measurement in 2017)	Use Outcomes to focus on the initiatives and results; not just the outputs. Align the outcomes by prioritizin Regular evaluation of the PIP is a component to success	Continue to streamline our processes to produce meaningful outcomes.	Monitor interventions and process measures quarterly. Report internally. Devise a plan if the results are not meaningful. Collaborate with key stakeholders by discussing approaches for long term engagement.

Ongoing Health Education (New, measurement in 2017)	Assess the needs and priorities of the providers and provide them with updated resources often.	Top OB provider visits changed from quarterly to monthly	Continued communication, telephonic, fax blast and face to visits to educate providers. Facilitate increased member awareness of pregnancy management, compliance with prescribed plan of care
Collaborate with providers by facilitating care Coordination (New, measurement in 2017)	Assess the needs and priorities of the providers and coordinate with them.	Continued provider educatio to increase awareness of LARC and birth spacing whi is related to a reduction in preterm births	Monitor interventions and process measures quarterly. Report internally. Devise a plan if the results are not meaningful. Collaborate with key stakeholders by discussing approaches for long term engagement.
Expanded Scope of Care and Community Partners (New, measurement in 2017)	Engage all stakeholders in the process – especially if the initiative crosses departments. This process is critical for ensuring good results alon with strong executive support.	Continue High risk case management by monitoring and coordinating care for those members at greatest r for pre-term labor, pre-term delivery or other adverse perinatal outcomes. The ultimate goal of Healthy Firs Steps is to attain the healthi pregnancy outcome possible from both the maternal and infant perspective.	Monitor interventions and process measures quarterly. Report internally. Devise a plan if the results are not meaningful. Collaborate with key stakeholders by discussing approaches for long term engagement.
ITM #1 Identification and Risk Stratification of Pregnant Women	During our workflow analysis, we were not identifying some high-risk members early due to incomplete information of NOP forms which led to untimely enrollment in appropriate care management programs.	Internal process for receipt and processing of NOP form was reconfigured to achieve stated goals and time-frames.	Continue education to providers on the importance of accurately completing NOP forms. Automation of the NOP forms process.

ITM #2 Monitor Face-to-Face Care Management	We identified the lack of regular, structured communication between our health plan and vendor as a failure mode. The other identified failure mode that this intervention would address is making sure members contact information is updated.	The chosen intervention will allow us to communicate effectively both internally and externally with our partners.	To create a secure shared fax mailbox that several Internal team members can access when contact is missed by the vendor.
ITM #3 Monitor 17P intervention	We noted that our encounter claims is comparable to the data in our CM software. Using the encounter claims, the data was adequate in achieving our intended goals of viewing our members. Inaccurate member contact information was noted as a barrier.	Project team within the health plan meeting to identify internal processes and resources to identify, seek and engage with high risk members.	Redesigning our internal work flows and staff alignment to ensure consistent process.
ITM #4 Monitor Most/Moderately Effective Contraception intervention	During our analysis we noted a possibility of a delay in identifying members or missed identification if member is enrolled late in the 3rd trimester.	Project team within the health plan meeting to identify internal processes and resources to identify, seek and engage with high risk members.	To create a secure shared fax mailbox that several Internal team members can access, thus creating an added safeguard to avoid missed notification.
ITM #5 Outreach for preeclampsia risk reduction/low dose aspirin education	Communication of pregnancy status and identified needs to the appropriate provider will decrease the likelihood that a member will inappropriately lose her Medicaid eligibility during her pregnancy and will attend visits. Communication with the treating providers' offices will enhance our ability to address any other social and medical needs of the member that may be barriers to care.	In the process of updating our system to include when a need for care alert report has been disseminated to providers. This way we will be able to capture the accuracy of the report once delivered.	Identify single points of contact in provider offices. Notifying providers on case by case basis once the need for care alert report is generated and making note of the needs. Having a uniform process across all providers will make this reliable and sustainable. Create a letter to providers for communication and coordination of care.
ITM #6 Primary care/ inter-conception care referral	There are few barriers to sustainability – primarily related to missed notifications that need to be resolved. We need to continue to capture an initial missed notification of delivery in a timely manner.	Automating some processes in order to improve efficiency.	Attempt automation of notification of deliveries in our CM software.

AIM statements	Change Ideas-Summary
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 30%	Optimum management of pregnancy labor and delivery by increasing awareness regarding potential and abrupt risk factors of preterm birth and ensuring adherence to best practices. We are building on the follow drivers for this AIM statement: • Timely notification of pregnancy • Accurate identification of progesterone candidates [pre-pregnant & non-pregnant (prior pregnancy or not)] • Timely identification of progesterone candidates [pre-pregnant & non-pregnant (prior pregnancy or not)] • Patient engagement, education, and adherence
Reduce preterm births before 32 weeks gestation by 10% in women who have experienced a prior preterm singleton birth	Optimum management of overall general health by communicating and coordination of care for any pertinent medical/OB between the member and all

	providers involved in care and treatment. Drivers below are Hypothesized to Impact the AIM statement: • Data feedback loop- connectivity to physicians • Assuring high-risk pregnant women have access to care • Postpartum Counseling on progesterone for those eligible in next pregnancy

Appendix A

Submission Date	SUBMISSION TITLE	SUBMISSION CONTENT
June 2018	Final Submission PIP	This submission includes the barrier analysis that was piloted on the 17P receipt rate, NOP and LARC. There were not any significant changes in the rate for members who received an initial dose of 17P. No additional barriers were found.
October 2018	Resubmission of the Final PIP	Added 17 Incentive rates. Added Signatures to attestation page Revised Next steps by including ITMs

Appendix B
Citations

(Also see endnotes below).

[i] 834 file includes all high risk members... Members may not be pregnant. Possible previous or current high risk pregnancy
[ii] Numerator includes all members that have an encounter claims for HIV. Tracking measure is different from the performance indicator HIV measure.
[iii] Numerator includes all members that have an encounter claims for Syphilis. Tracking measure is different from the Syphilis performance indicator measure.
[iv] Definitions for performance indicators are listed on pages 10-13.
http://www.cdc.gov/nchs/data/nvsr/nvsr63/nvsr63_02.pdf
http://www.cdc.gov/reproductivehealth/maternalinfanthealth/pretermbirth.htm
http://www.state.nj.us/health/news/2012/approved/20121003a.html
https://www.marchofdimes.org/materials/premature-birth-report-card-louisiana.pdf
http://ldh.la.gov/index.cfm/page/1456
http://www.nichd.nih.gov/KnowYourTerms