Our mission is to improve the health and quality of life of our members
Mommy Steps Program Description

I. Purpose
Passport Health Plan (PHP) has developed approaches to the management of members’ high risk obstetrical condition(s) in order to improve birth outcomes such as prematurity and low (LBW), and very low, birth weight (VLBW). The emphasis of the program is education for targeted members and clinicians to improve the overall health, wellness, and quality of the member’s life. The program will facilitate member understanding and responsibility of the high risk pregnancy process as well as coordination of care between the member and/or caregiver and the clinician. The program focus is on increasing both member and clinician adherence with the American Congress of Obstetricians and Gynecologist (ACOG) guidelines.1

II. Rationale
According to the March of Dimes PeriStats, in 2010, 12% of all live births in the United States were preterm, or 1 in 8.2 In addition, 8.1% were LBW and 1.4% were VLBW.2

According to the March of Dimes PeriStats, in 2010, 13.7% of all live births in Kentucky were preterm, 9.0%, were born LBW and 1.6% were born VLBW.2

Plan rates remain above targeted Healthy People 2020 goals of 11.4% for preterm deliveries, 7.8% for LBW, and 1.4% for VLBW.3 In 2011, Passport noted approximately 9,522 live births with 19.6% preterm delivery rate, a 10.7% LBW rate, and 1.9% VLBW rate. The numbers of deliveries has continued to climb to each year with a noted consistent preterm delivery, LBW, and VLBW rate. Major risk factors for LBW and VLBW include a multiple gestation pregnancy, preterm birth, smoking, inadequate maternal nutrition, maternal age extremes, and short pregnancy interval. Major risk factors for preterm birth include a history of preterm birth, current multiple gestation pregnancy, some uterine/cervical abnormalities, diabetes mellitus, hypertension, late or no prenatal care, smoking, alcohol, and illicit drug use.4

In 2012, the Plan reviewed all of the poor birth outcomes deliveries in 2011 to evaluate what risk factors were the common denominators for our populations. The most common risk factors were a history of, or current, preterm labor or delivery, premature rupture of membranes, incompetent cervix, pregnancy induced hypertension/toxemia/eclampsia/HELLP syndrome, chronic hypertension, Intrauterine growth retardation (IUGR), a multi-fetal pregnancy, or substance abuse with the current pregnancy.

III. Objectives
• Decrease preterm deliveries.
• Decrease LBW and VLBW deliveries.
• Increase early and regular prenatal care as defined per HEDIS® methodology.
• Increase percentage of members who receive a postpartum visit from a clinician within 21 to 56 days after delivery.
• Increase clinician adherence to the ACOG Guidelines.

1 http://www.passporthealthplan.com/pdf/provider/resources/cpg/03.pdf
2 http://www.marchofdimes.com/peristats/
4 Prematurity risk factors compiled by March of Dimes available at http://www.marchofdimes.com/peristats/
IV. Population Identification
Eligible members for the Mommy Steps Program are identified primarily through clinician notification of pregnancy to the Plan but can include the following:
- Claims/encounter data
- Data collected through the Utilization Management (UM) process, examples include, but are not limited to, hospital census report, ER Utilization reports, pre-certification data, embedded UM, and concurrent review data
- Data collected through the Care Connection Program health and wellness outreach representatives
- Referrals from clinicians – This includes, but is not limited to, OB practitioners, Departments of Health, and Teen Pregnancy programs
- Referrals from other PHP departments, examples include, but are not limited to, Case Management, Disease Management, EPSDT, or Member Services
- Referrals from subcontractors – This includes, but is not limited to, 24/7 Nurse Health Information Line
- Self-referrals from members
- Referrals from hospital educators/discharge planners
- Data collected through the Health Risk Assessment Form (HRA)
- Data collected through the Presumptive Eligibility (PE) report

Members who meet the criteria are eligible for the program. This determination of eligible members occurs on a daily basis. In addition to identifying members on a daily basis, members may be adjusted from low risk to high risk based on claims/encounter data or referrals, as needed.

V. Member Participation and Opting Out of the Program
Eligible members are considered enrolled in the program and receive interventions without having to specifically request it. For this reason enrollment is considered passive. Participation, however, is voluntary and the member has the right to “opt out” of the program or decline all or any part of it.

Information on how to “opt out” is provided as part of the welcome packet and the member is advised verbally if questions regarding participation arise during outreach. Members who “opt out” may “re-enter” the program at any time by contacting the Perinatal Case Manager or the Care Connection Program, either verbally or in writing.

VI. Member Contact
Eligible members are identified monthly and receive a welcome packet including:
- Welcome letter (Appendix A), and
- Information on:
  - The importance of early and regular prenatal care
  - Community resources such as WIC, HANDS, Healthy Start
  - Text4Baby program
  - Smoking cessation resources
  - Available treatment for drugs and alcohol, mental health services
  - Domestic violence support line
  - Dental and vision service contacts
  - Legal assistance contacts
  - Support group information for loss of an infant
  - State transportation service contact numbers
• Member incentives

The welcome letter encourages the member to contact the Plan to receive an additional educational book regarding pregnancy and delivery or if the member has any questions about pregnancy. Members who call the Plan are screened for any high risk conditions that could result in poor birth outcomes, demographics are verified, and members are given the Care Connection Program contact numbers to call with any questions or if anything changes during the member’s pregnancy. In addition, the members receive:

• Outreach upon enrollment into the program and at 24-28 weeks gestation to include a psychosocial assessment, verbal education on warning signs of pregnancy complications and their specific risk related diagnosis, signs, and symptoms of preterm labor, good prenatal care, when to call their clinician, education on the screening test for gestational diabetes, and assistance with prenatal classes, community resources, and transportation. Members receive additional telephonic follow-up monthly and as needed.
• Assistance with rescheduling missed OB appointments and overcoming barriers that may contribute to further missed appointments, such as transportation and language barriers.
• Visits from the Maternity On-site Coordinator to provide education and support to hospitalized high-risk antepartum members.
• Postpartum hospital visit in high volume hospitals to educate and assist with scheduling a postpartum visit and newborn follow-up visit.
• Postpartum telephonic outreach to screen for postpartum depression, educate and assist with scheduling a postpartum clinician visit, newborn follow-up visit, assist with newborn enrollment, and answer any questions.
• Annual reminders are sent for flu/pneumonia vaccination.

All written program material sent to members includes contact information for the Perinatal Case Manager, the Care Connection Program, and the 24/7 Nurse Advise Line. Some educational materials are available in other languages, upon request.

All health plan members receive information regarding the Mommy Steps Program and how to contact the Perinatal Case Manager, the Care Connection Program, and the 24/7 Nurse Advise Line via the member handbook and the Plan website.

All identified pregnant members with any of the following with current or previous pregnancy will be considered high risk (Appendix B):
• Pre-term Labor or Delivery < 37 weeks
• Premature Rupture of Membranes (PROM)
• Incompetent Cervix
• Pregnancy Induced Hypertension (PIH) / Toxemia / Preeclampsia / Eclampsia / HELLP Syndrome
• Chronic Hypertension (CHTN)

All identified pregnant members with any of the following with the current pregnancy will be considered high risk:
• Multi-fetal Pregnancy with Current Pregnancy
• Intrauterine Growth Restriction (IUGR) with Last/Latest or Current Pregnancy
• Substance Abuse with Current Pregnancy
Pregnant members identified as **high risk** receive all of the above interventions in addition to outreach from the Perinatal Case Manager. The Perinatal Case Manager:

- Assesses the member’s needs utilizing a maternity specific assessment and develops an individualized plan of care, including the member’s caregiver when possible.
- Performs reassessment of the member’s needs as needed utilizing a maternity specific assessment.
- Coordinates care with the clinician involved in the member’s care and assists with follow up care with a specialist, if appropriate.
- Establishes and maintains contact with the member to evaluate and revise the plan of care as needed.
- Educates the member and/or caregiver on the importance of the clinician’s established treatment plan to include medication adherence, attending scheduled appointments, adherence with self-monitoring activities, and adherence with screenings/lab test ordered by the clinician.
- Educates the member and/or caregiver on lifestyle issues that may improve the member’s birth outcome to include diet/weight management, medication adherence, exercise, smoking cessation, avoidance of drugs and alcohol, and regular clinicians’ visits.
- Conducts the Patient Health Questionnaire (PHQ) 2 as a depression prescreening tool and based on the results completes the Edinburgh Postnatal Depression Scale Assessment, to identify members in need of referral for behavioral health services.
- Provides the member with assistance/information regarding available community resources.
- Provides the member and/or caregiver with additional written and/or verbal information targeted to the member’s specific needs.

**VII. Clinician Notification and Involvement**

Participating clinicians in the health plan are notified of the Mommy Steps Program by the following:

- New Provider Kit distributed to new clinicians with information regarding how the Perinatal Case Manager works with pregnant members and instructions on how to access and utilize the program services (*Appendix C*)
- The PHP Provider Manual
- The PHP Provider Website @ [www.passporthealthplan.com](http://www.passporthealthplan.com)
- Medical Office Notes
- Clinician outreach visits by the Provider Relations Department and/or Perinatal Case Manager

Each participating clinician office is assigned an individual Perinatal Case Manager. The assigned Perinatal Case Manager outreaches to the clinician as needed to coordinate care for the pregnant member and to identify any additional members the clinician feels may be at risk for poor birth outcomes.

The ACOG Guidelines are distributed to all participating clinicians as part of the Provider Manual and are available on the PHP website. Guidelines are reviewed, updated, and posted on the health plan’s website [www.passporthealthplan.com](http://www.passporthealthplan.com) at least every two years and anytime new scientific evidence is published.
VIII. Integrating Member Information

PHP utilizes an integrated documentation system, JIVA, in order to allow all health plan staff access to member information. In JIVA’s Member Centric view all users are able to view information that is specific to the member such as demographics, eligibility, member’s PCP clinician, spoken language, and preferences on receiving educational materials or phone contact. Users also have the ability to enter additional addresses, or phone numbers, which the member may give as an alternative way to reach him/her that is not associated with the state file download that populates the basic demographic fields in JIVA. The Member Centric view may also be utilized to denote a caregiver name and phone number, as needed. In addition, JIVA utilizes widgets to provide quick reference to “open” authorizations, care coordination activities, and appeals. Users can view detail of each “open” item, or view a summary of each, depending on what information is needed. JIVA also has multiple quick-access tabs across the top of the Member Centric view to allow a user the ability to:

- Edit demographic information and preferences, as needed.
- Add an episode or “open” cases.
- Upload documents related to the member and/or the member’s care that need to be visible to all users in order to facilitate seamless care coordination.
- View all the documentation that has been entered as it relates to the member.
- View any correspondence that the member has sent to the Plan, or that the Plan has sent to the member.
- View the member’s established care coordination assessment and plan of care.
- View claims, both pharmacy and medical, related to the member.
- View results of labs/screenings, as available.
- Review care gaps.
- View a clinical summary, of the last 6 months history, of the member regarding tests and services, medical conditions, medications, ER visits, inpatient admissions, office visits, etc.
- View historical data or “closed” cases.

All of this data allows everyone interacting with the member to have to most current and available data in order to make every contact count to its fullest potential and improve coordination of care by all users having the same information.

IX. Member Satisfaction with High Risk OB Care Management

PHP Care Management Programs have a systematic method of evaluating member satisfaction with all areas of Care Management services. The Mommy Steps Member Satisfaction Survey (Appendix D) is distributed to all pregnant members after discharge from the program. Questions address member experiences with the Mommy Steps Program and the Perinatal Case Manager in the areas of:

- The effectiveness in helping the member understanding high risk pregnancy.
- The helpfulness in assisting the member developing a self-management plan.
- The helpfulness in assisting the member adhering with the established self-management plan.
- The usefulness of the educational materials provided.
- The ability of the Perinatal Case Manager to listen to the member.
- The helpfulness of the Perinatal Case Manager to assist the member in care coordination.
Complaints regarding the Mommy Steps Program may also be received by the Member Services Department during routine member contacts. The Member Service staff document the complaint in EXP, a customer service software package that records, tracks, and reports all member inquiries and/or complaints. Each department has a mailbox specific to the department. Member Services forwards the EXP complaint to the Manager of Care Coordination for follow-up.

The Manager of Care Coordination conducts a quantitative and qualitative analysis of complaints regarding the Mommy Steps Program annually. This analysis is used to identify patterns of member complaints and opportunities to improve satisfaction with the Mommy Steps Program. Changes to the Mommy Steps Program are made as needed.

X. Annual Evaluation

The annual evaluation of the Mommy Steps Program is conducted by the Plan’s Perinatal Case Manager, the Manager of Care Coordination, the Director of Medical Management Care Coordination, the Chief Medical Officer, or their designee, and receiving input from the Quality Improvement Department, as appropriate.

Objectives, activities, and outcomes are evaluated at a minimum of annually in order to:
- Measure participation rates.
- Determine whether the Mommy Steps Program has demonstrated improvement in birth outcomes and quality of care provided to pregnant members.
- Evaluate the overall effectiveness of the Mommy Steps Program.
- Allow for exploration of barriers and limitations of the Mommy Steps Program.
- Revise areas as needed to improve effectiveness of the Mommy Steps Program.

Formal measurements of Frequency of Ongoing Prenatal Care, Initiation of Prenatal Care and Postpartum Care are performed annually through HEDIS® reviews using HEDIS® methodology. Program goals for LBW, VLBW, and Preterm Births are based on Healthy People 2020 and are measured on delivery information obtained through facility Notification of delivery. Results are utilized to revise the program and set the program goals for the following year. More frequent barrier analyses are performed on an ongoing basis and adjustments to the Mommy Steps Program are made accordingly.

XI. Program Goals

- Increase percentage of members who receive prenatal care within 42 days of enrollment or within the first trimester.
- Increase average number of prenatal visits to 80% or greater of the expected visits per member to encourage regular prenatal care.
- Increase percentage of members who receive a postpartum clinician visit between 21 and 56 days after delivery.
- Decrease the number of preterm deliveries (≤ 37 weeks).
- Decrease the number of LBW (1,501 grams to < 2,500 grams) babies to 5% or less.
- Decrease the number of VLBW (< 1,500 grams) babies to 1% or less.

HEDIS® is a registered trademark of the National Committee of Quality Assurance (NCQA).
Final approval dates for Quality Medical Management Committee:
June 5, 2007
April 1, 2008
July 7, 2009
March 2, 2010
May 3, 2011
July 20, 2012
June 4, 2013
Appendices

A. Member Welcome Letter
B. Mommy Steps High Risk Stratification Tool
C. New Provider Kit
D. Mommy Steps Member Satisfaction Survey
Dear Member...

Welcome to Passport Health Plan’s Mommy Steps Program! Mommy Steps is here to help you with your pregnancy. We know that becoming a mom is a big step in your life. But, knowing which steps to take can put you at ease and make all the difference!

Our Mommy Steps team will help you take 3 important steps in your pregnancy.

3 Steps to a Healthy Pregnancy:
1. Regular Doctor Visits
2. Healthy Eating
3. Making Good Choices

Our staff is here to answer your questions about:
- How to have a healthy pregnancy.
- How to get free transportation.
- Your benefits and how to get clothes, food and other things you and your baby need.

If you would like to speak with us, call 1-877-903-0082. You may call Monday – Friday from 8 am to 6 pm. TDD/TTY users please call 1-800-691-5566.

Si habla Español, por favor llame Pasos de Mamá: 1-877-903-0082, press 0, then press 8225.

As a Mommy Steps member, you can receive a free pregnancy book. The book tells you how to take care of yourself during and after pregnancy. To receive your book, please call us at the above number so we can check your mailing address.

Sincerely,
Your Mommy Steps Team
As a Mommy Steps member, you can receive free text messages to help you through your pregnancy.

Text4baby offers FREE messages on your cell phone to help you through your pregnancy and baby’s first year.

Signing up is easy!
Text BABY (BEBE in espanol) to 511411
What is text4baby?
If you’re pregnant or a new mom, you can sign up for FREE text messages sent directly to your cell phone through a program called text4baby. With text4baby you’ll receive three text messages each week, timed to your due date or baby’s birthday. Messages start in pregnancy and go through your baby’s first year. You’ll get tips on prenatal and infant care, immunization, postpartum depression, breast feeding, oral health, quitting smoking, infant feeding, car safety and safe sleep.

What people are saying about text4baby:

“Messages and reminders from text4baby help put me at ease. Being relaxed is better for me and my baby.”
– Pregnant Mom

“Text4baby is so empowering…Moms are receiving accurate health information on their cell phones that they can use to start a conversation with their midwives or doctors.”
– Physician

Learn more at www.text4baby.org!

Thanks to the support of: CTIA - The Wireless Foundation and participating cell phone companies. All messages you receive from text4baby are free! Even if you don’t have a text messaging plan, you can get these messages for free. If you have limited texting per month, text4baby won’t take away from your total amount of messages.

Text4baby is a free service of the National Healthy Mothers, Healthy Babies Coalition

Participating providers include: Alltel, Assurance Wireless, AT&T, Bluegrass Cellular, Boost Mobile, Cellular South, Cellcom, Centennial Cellular, Cincinnati Bell, Cricket, Metro PCS, N-Telos, Nex-Tech Wireless, Sprint Nextel, T-Mobile, U.S. Cellular, Verizon, Wireless, Virgin Mobile USA

Text4baby protects your privacy. Information collected from you when you sign up for text4baby is only used to send text4baby messages. Your information is not sold or shared with anyone for any commercial purpose. You won’t get mailings or messages about any products because of text4baby.
Community Resources

As a new mom, there are many things you will need for you and your baby. Our staff has a list of free resources that are available in the community. This includes maternity clothes, baby formula, food and baby equipment. If you would like our help, please call 1-877-903-0082.

Women, Infant & Children (WIC)

WIC offers:
- Help with healthy foods, milk and juices for moms during pregnancy.
- Nutrition education and advice.
- Breastfeeding education and support.

If you are interested, please see listings on the next page.

Health Access Nurturing Development Services (HANDS)

- HANDS is a home visit program for new and expectant parents.
- Trained home visitors will answer your questions about pregnancy or your baby’s first years.

If you are interested, please call your local health department.

Healthy Start (502) 574-6661

- Healthy Start staff can visit you in your home.
- They can help you begin prenatal care during the first 3 months of pregnancy. They can also teach you how to keep up your care during pregnancy.
Smoking Cessation 1-800-QUITNOW (784-8669)
Trained counselors are here to help you quit smoking.

Project Link / Seven Counties (502) 583-3951
- Offers treatment for drugs, alcohol, mental health and developmental disabilities.
- To get priority care, please tell them you are pregnant.
- Services are available to those who live in Jefferson, Bullitt, Henry, Oldham, Shelby, Spencer and Trimble county.

Communicare (270) 769-1304
- Offers treatment for drugs, alcohol, mental health and developmental disabilities.
- To get priority care, please tell them you are pregnant.
- Services are available to those who live in Breckenridge, Grayson, Hardin, Larue, Marion, Meade, Nelson and Washington county.

Domestic Violence 1-877-803-7577
Helps women and children suffering from physical, sexual, mental and/or emotional abuse.

Dental Care 1-800-578-0603
- Passport Health Plan covers 2 dental exams each year.
- We suggest you have a dental exam during your pregnancy.
- Periodontal disease (gum disease) can cause premature labor!

Eye Care - Block Vision 1-800-428-8789
- Passport Health Plan covers 1 vision exam each year.
- We suggest you set up a vision exam after you deliver.

Legal Aid Society 1-800-292-1862
Offers free legal services for those who cannot afford it.

Consoling Parents 1-800-221-0446
Offers support groups for parents who have had a miscarriage, stillbirth or early infant death.
# WIC Sites

<table>
<thead>
<tr>
<th>WIC SITES</th>
<th>ADDRESS</th>
<th>PHONE</th>
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<tbody>
<tr>
<td>Breckinridge County Health Department</td>
<td>220 South Hardin, Hardinsburg, KY 40143</td>
<td>270-756-5121</td>
</tr>
<tr>
<td>Bullitt County Health Department</td>
<td>181 Lees Valley Road, Shepherdsville, KY 40165</td>
<td>502-543-2415</td>
</tr>
<tr>
<td>Oldham County Health Department</td>
<td>1786 Commerce Parkway, LaGrange KY 40031</td>
<td>502-222-3516</td>
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### THREE RIVERS DISTRICT DEPARTMENT

<table>
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<tr>
<th>Member Welcome Letter</th>
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<tr>
<td>Carroll County Center</td>
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</table>

### NORTH CENTRAL DISTRICT DEPARTMENT

| Henry County Health Department | 125 North Property Road, New Castle, KY 40050 | 502-845-2882 |
| Shelby County Health Department | 615 11th Street, Shelbyville, KY 40065 | 502-633-1231 |
| Spencer County Health Department | 88 Spears Drive, Taylorsville, KY 40071 | 502-477-8146 |
| Trimble County Health Department | 138 Miller Lane, Bedford, KY 40006 | 502-255-7701 |

### LINCOLN TRAIL DISTRICT DEPARTMENT

| Grayson County Health Department | 124 East White Oak Street, Leitchfield, KY 42754 | 270-769-1601 |
| Hardin County Health Department | 580 C. Westport Road, Elizabethtown, KY 42701 | 270-765-6197 |
| Larue County Health Department | 215 East Main Street, Hodgenville, KY 42748 | 270-358-3844 |
| Marion County Health Department | 516 North Spalding Avenue, Lebanon, KY 40033 | 270-692-3393 |
| Meade County Health Department | 520 Hillcrest Drive, Brandenburg, KY 40108 | 270-422-3988 |
| Nelson County Health Department | 325 South 3rd Street, Bardstown, KY 40004 | 502-348-3222 |
| Hardin County Health Department – Radcliff | 1463 North Wilson Road, Radcliff, KY 40160 | 270-352-2526 |
| Washington County Health Department | 302 East Main Street, Springfield, KY 40069 | 859-336-3980 |

### LOUISVILLE/JEFFERSON COUNTY

| Louisville Public Health & Wellness Department | 400 East Gray Street, Louisville, KY 40202 | 502-574-6676 |
| Children and Youth Project | 555 South Floyd Street, Louisville, KY 40202 | 502-852-5316 |
| Dixie Health Center | 7219 Dixie Highway, Louisville, KY 40258 | 502-937-7277 |
| Family Health Center – Portland | 2215 Portland Avenue, Louisville, KY 40212 | 502-574-6672 |
| Middletown Health Center | 200 Juneau Drive, Middletown KY 40243 | 502-245-1074 |
| Neighborhood Place – Barrett | 810 Barrett Avenue, Louisville, KY 40204 | 502-574-6680 |
| Neighborhood Place – Fairdale | 1000 Neighborhood Place, Fairdale, KY 40118 | 502-363-1428 |
| Neighborhood Place – L & N Building | 908 West Broadway, 2nd Floor, Louisville, KY 40202 | 502-595-3121 |
| Neighborhood Place – South Central | 4255 Hazelwood Avenue, Louisville, KY 40215 | 502-485-7141 |
| Newburg Health Center | 4810 Exeter Avenue, Louisville, KY 40218 | 502-458-0778 |
| Park DuValle Community Health Center | 3015 Wilson Avenue, Louisville, KY 40211 | 502-774-4401 |
| South Park TAPP | 1010 Neighborhood Place, Fairdale, KY 40118 | 502-485-8946 |
| Westport TAPP | 8800 Westport Road, Louisville, KY 40242 | 502-485-8125 |

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**MommySteps**

Passport Health Plan • 5100 Commerce Crossings Dr. • Louisville, KY 40229 • www.passporthealthplan.com • 1-800-578-0603

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Need A Ride?

As a Passport member, you can get free rides to your appointments. This includes medical visits, dental visits and prenatal classes. When you need a ride, call the company in your area as listed below.

You must call 3 business days before your appointment. To cancel a ride, you must call 1 business day before your appointment.

When you call for a ride, tell them your:
  - Medicaid ID number
  - Appointment date and time, doctor’s name and address
  - Special needs such as a wheelchair lift, escort and car seats for children

If you live in Jefferson, Oldham, Shelby, Spencer, Bullitt, Trimble or Henry county, you must call:
Federated Transportation Services of the Bluegrass (FTSB)
1-888-848-0989

If you live in Breckinridge, Carroll, Grayson, Hardin, Larue, Marion, Meade or Nelson county, you must call:
LKLP
1-800-245-2826

If you live in Washington county, you must call:
Bluegrass Community Action
1-800-456-6588

All counties:
If you are having any problems, you may file a complaint by calling 1-888-941-7433.
### Mommy Steps Program Description

#### Appendix B

#### Mommy Steps High Risk Stratification Tool

<table>
<thead>
<tr>
<th>High Risk</th>
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<tbody>
<tr>
<td>- Pre-term Labor or Delivery &lt; 37 weeks with <strong>ANY</strong> pregnancy</td>
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<tr>
<td>- Premature Rupture of Membranes (PROM) with <strong>ANY</strong> pregnancy</td>
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<tr>
<td>- Incompetent Cervix with <strong>ANY</strong> pregnancy</td>
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<td>- Substance Abuse with <strong>Current</strong> Pregnancy</td>
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<tr>
<td>- Teen Pregnancy</td>
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</tbody>
</table>
• Diabetes Disease Care Manager is available to assist practitioners with achieving positive health outcomes for our members with diabetes. The care manager provides educational in-services for office staff, supplies resources such as the Diabetes Care Tool, and answers practitioners’ questions regarding the care of our members. The Diabetes Disease Care Manager may be reached at (502) 585-7074 or (800) 578-0636, ext. 77074.

The Mommy & Me Program

Assisting Practitioners with the Care of Pregnant Women.

The goal of the Mommy & Me Program is to work with our practitioners and members to improve prenatal, infant and maternal outcomes for pregnant members.

The Mommy & Me Program offers the following:

• The Mommy & Me Provider Report provides practitioners with information regarding their antepartum members’ emergency room, 23-hour observation, and inpatient stays during pregnancy. It also alerts practitioners to other risk factors or co-morbidities, such as diabetes, asthma, smoking, or extreme maternal age (younger or older).

• Member educational materials - accessible via www.passporthealthplan.com, or by contacting the Plan’s Mommy & Me Program staff.

• PHP Perinatal Clinical Practice Guidelines, which are based on the recommendations of the American College of Obstetricians and Gynecologists are also available via www.passporthealthplan.com.

• Mommy & Me Perinatal Care Managers are available to assist practitioners by working one-on-one with their high-risk members, assisting with education and resources for all pregnant members, and answering practitioners’ questions regarding the care of our members. Mommy & Me Perinatal Care Managers may be reached at (502) 585-7908 or (800) 578-0636, ext. 77908.

EPSDT Program for Members Ages Birth to 21 Years

Assisting Practitioners with the Care of Children and Adolescents

The EPSDT Program provides education and outreach to caregivers for members from birth to age 21 to ensure the early diagnosis and treatment of medical conditions which, if undetected, could result in serious medical conditions and to promote preventive health screenings and immunizations. The comprehensive EPSDT benefits include periodic well-child medical, dental, vision and hearing assessments (health screenings), immunizations, laboratory tests, health education, developmental assessment and anticipatory guidance.
Mommy Steps Program Survey

Our records show that [name], our [title], recently worked with you or someone in your family.

At Passport, your opinions matter to us. We want to give you the best service possible and would like to hear from you! Please answer the questions below and tell us what we are doing right and how we can improve.

Please check the best answer.

1.) Were you able to manage your health better with the help of [name]?
   - ☐ Yes, they were very helpful
   - ☐ Yes, they were somewhat helpful
   - ☐ No, they were not helpful

2.) Did [name] listen to you and explain things so you could understand them?
   - ☐ Always
   - ☐ Usually
   - ☐ Sometimes

3.) How would you rate the number of times [name] contacted you?
   - ☐ Too many
   - ☐ Too few
   - ☐ Just enough

4.) Did the [fill-in] Program help you understand your health problem?
   - ☐ Yes, it was very helpful
   - ☐ Yes, it was somewhat helpful
   - ☐ No, it was not helpful

5.) Were the written materials mailed to you (brochures, letters, newsletters) helpful and easy-to-read?
[Yes, they were very helpful] [Yes, they were somewhat helpful] [No, they were not helpful]

6.) How would you rate the overall helpfulness of the [name of program]?
[ ] Excellent
[ ] Good
[ ] Fair

7.) Are there things that would have made the [name] Program more helpful to you? (please explain)

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

8.) May we call you to talk about your survey answers?
[ ] Yes
[ ] No

NAME (optional): __________________________ PHONE NUMBER: ______________________

Month: __________________ Year: __________

Please return this survey in the postage-paid envelope.

Thank you again for your time!

PASSPORT HEALTH PLAN