PASSPORT HEALTH ★ PLAN
5100 COMMERCE CROSSINGS DRIVE
LOUISVILLE, KY 40229
502-585-7900 / 800-578-0603
WWW.PASSPORTHEALTHPLAN.COM

Mommy Steps

Complex Case Management

Diabetes Management

Healthy Heart Program

2016
Mommy Steps

Program Evaluation

Obesity Management

Chronic Respiratory Management

Congestive Heart Failure Management

Our mission is to improve the health and quality of life of our members

EPSDT Program

Rapid Response Outreach Team

Approved - May 16, 2017

2016 Mommy Steps Program Evaluation

Program Title: Mommy Steps Program

Evaluation Period: January 1, 2016 – December 31, 2016

Introduction: The Mommy Steps Program is designed to improve prenatal, infant, and maternal outcomes for pregnant members through improved compliance of both Obstetric (OB) clinicians and members with Passport Health Plan's (Passport) Perinatal Care Clinical Practice Guidelines which are based on the American Congress of Obstetricians and Gynecologists (ACOG) Guidelines. Perinatal Management is the process of coordinating health care interventions and communications for pregnant members and recently delivered members in which patient self-care efforts are significant; supporting OB clinician/member relationships and the plan of care; emphasizing prevention of complications by providing support and care coordination to increase compliance with Passport's Perinatal Care Clinical Practice Guidelines utilizing patient empowerment strategies; and evaluating clinical, humanistic and economic outcomes on an ongoing basis with the goal of improving overall health.[1]

2016 Program Goals:

- Increase percentage of members who:
  - Receive prenatal care within 42 days of enrollment or within the first trimester.
  - Receive a postpartum OB clinician visit between 21 and 56 days after delivery.

- Increase the average number of prenatal visits to 80% or greater of the expected visits per member to encourage regular prenatal care.

- Decrease the number of:
  - Preterm deliveries (≤ 37 weeks).
  - Low birth weight (LBW) (1,501 grams to < 2,500 grams) babies to 5% or less.
  - Very low birth weight (VLBW) (< 1,500 grams) babies to 1% or less.

2016 Program Objectives:

- To decrease:
  - Preterm deliveries.
  - LBW and VLBW deliveries.

- To increase:
  - Early and regular prenatal care (as defined per HEDIS® methodology).
  - Percentage of members who receive a postpartum visit from an OB clinician within 21 to 56 days after delivery.
  - To improve OB clinician compliance/adherence with Passport's Perinatal Care Clinical Practice Guidelines.

Approved - May 16, 2017

[1] "Medicare Direct Contracting for Disease Management." *Disease Management Association of America,* March 2003

- To increase Healthy Kentuckians (HK) results.

Measurements: Overall effectiveness of the Program is measured through annual participation rates, *Healthy People 2020*, audited HEDIS®[2] results, HK, and compliance with Passport's Perinatal Care Clinical Practice Guidelines.

Approved - May 15, 2017

Annual Participation Rate

Eligible members are identified and passively enrolled in the Mommy Steps Program. Members may "opt-out" of the Program and elect not to receive services by notifying a Mommy Steps representative or the Care Connector Program, either telephonically or in writing. Participation Rates are tracked and reported annually.

	Deliveries	Opt Out	Participation Rate
2016	6,020[3]	24	99.99%
2015	6,653[4]	4	99.99%
2014	5,731	7	99.99%
2013	4,649	2	99.99%
2012	6,837	0	100%

HEDIS® Results

The 2016 HEDIS® Results are based on measurement year 2015 data.

The Mommy Steps Program uses the following HEDIS® measures to assess Prenatal and Postpartum Care:

1. **Prenatal and Postpartum Care (PPC)[5]**
   The percentage of deliveries that are live births between November 6 of the year prior to the measurement year and November 5 of the measurement year. For these women, the measure assesses the following facets of prenatal and postpartum care.
   - *Timeliness of Prenatal Care.* The percentage of deliveries that received a prenatal care visit as a member of the organization in the first trimester *or* within 42 days of enrollment in the organization.
   - *Postpartum Care.* The percentage of deliveries that had a postpartum visit on or between 21 and 56 days after delivery.

   Findings: In a sample of 453 women with live birth deliveries, 389 (86.83%) had a timely prenatal care visit and 297 (66.29%) had a postpartum care visit within the 21 to 56 day time frame.

[2] The source for data contained in this publication is Quality Compass® 2016 (Medicaid) and is used with the permission of the NCQA. Any data display, analysis, interpretation, or conclusion based on these data is solely that of the authors, and NCQA specifically disclaims responsibility for any such display, analysis, interpretation, or conclusion. Quality Compass is a registered trademark of NCQA**.**

[3] The number of deliveries reflects claims for delivery services provided during 2016 and reported through 3/31/2017.

[4] The number of deliveries were modified due to the exclusion of miscarriages and stillbirths from the collected data.

[5] PPC for both measures will be looked at for NCQA Accreditation for 2016

Measure	MY 2011	MY 2012	MY 2013	MY 2014	MY 2015
Prenatal Care	86.83%	85.91%	91.61%	86.89%	86.83%
Postpartum Care	72.77%	69.35%	67.33%	68.67%	66.29%

The goals to meet or exceed the 2016 Quality Compass® 90th Percentile for Timeliness for Prenatal Care (91%) and Postpartum Care (73.61%) were not met.

For measurement year 2015, both PPC indicators met the 2016 Quality Compass® 66.67th Percentile.

2. Frequency of Ongoing Prenatal Care (FPC)[6]

The percentage of Medicaid deliveries between November 6 of the year prior to the measurement year and November 5 of the measurement year that had ≥ 81% or more of the excepted number of prenatal visits.

Findings: In a sample of 432 women with live birth deliveries, 321 (74.48%) had ≥ 81% or more of expected prenatal visits.

Measure	MY 2011	MY 2012	MY 2013	MY 2014	MY 2015
Frequency of Prenatal Care ≥ 81%[7]	79.46%	78.08%	78.37%	75.12%	74.48%

The goal to meet or exceed the 2016 Quality Compass® 90th Percentile for FPC (75.77%) was not met.

For measurement year 2015, Frequency of Prenatal Care ≥ 81% met the 2016 Quality Compass® 75th Percentile.

2016 Birth Outcomes: *Healthy People 2020*: Goals for LBW, VLBW, and Preterm Deliveries are based on Passport's Corporate Goals and *Healthy People 2020*[8]

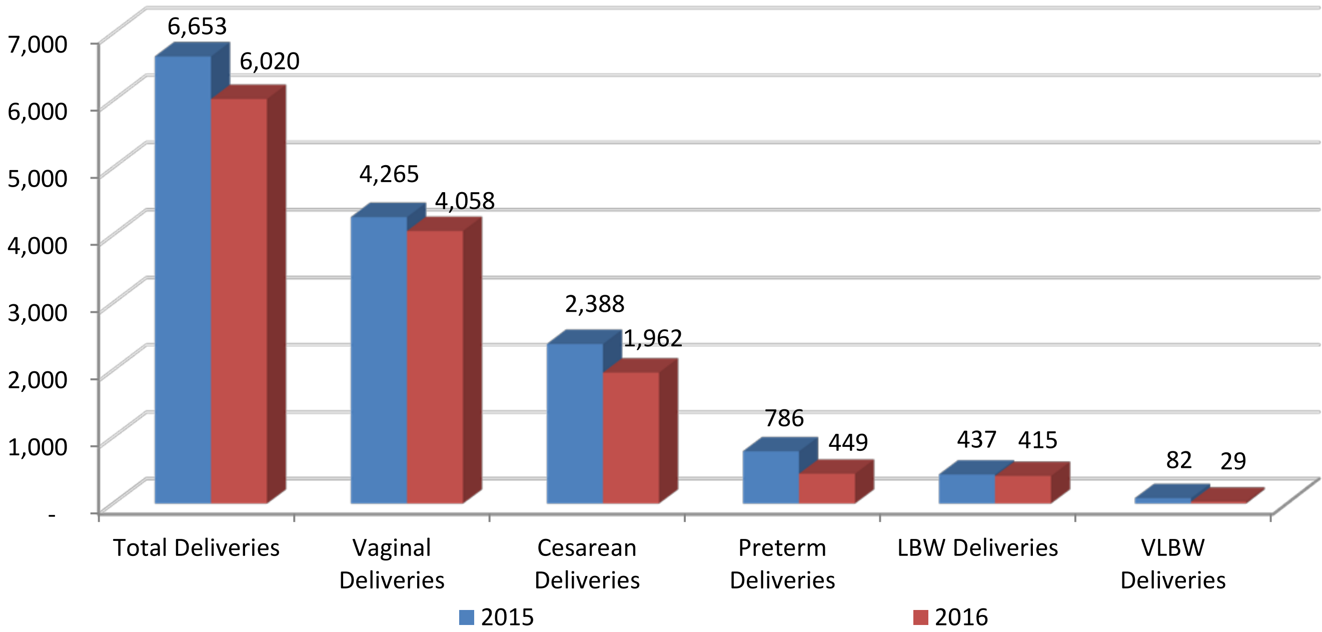
Measure	*Healthy People 2020* Goal	2016 Passport Goal	2012[9]	2013[9]	2014[9]	2015[10]	2016[11]
LBW (1,501 grams to < 2,500 grams)	**7.8%**	**5.0%**	7.0%	6.4%	7.0%	6.65%	6.90%
VLBW (< 1,500 grams)	**1.4%**	**1.0%**	1.5%	1.2%	1.2%	1.2%	0.5%
Preterm Deliveries (≤ 37 weeks)	**11.4%**	**7.6%**	11.2%	9.9%	10.9%	11.81%	7.5%

NOTE: 2015 Birth Outcomes data was based on an eight month claims runout; 2016 Birth Outcomes data was based on a three month claims runout, which may have resulted in an artificially low rate of premature and VLBW babies.

Approved - May 16, 2017

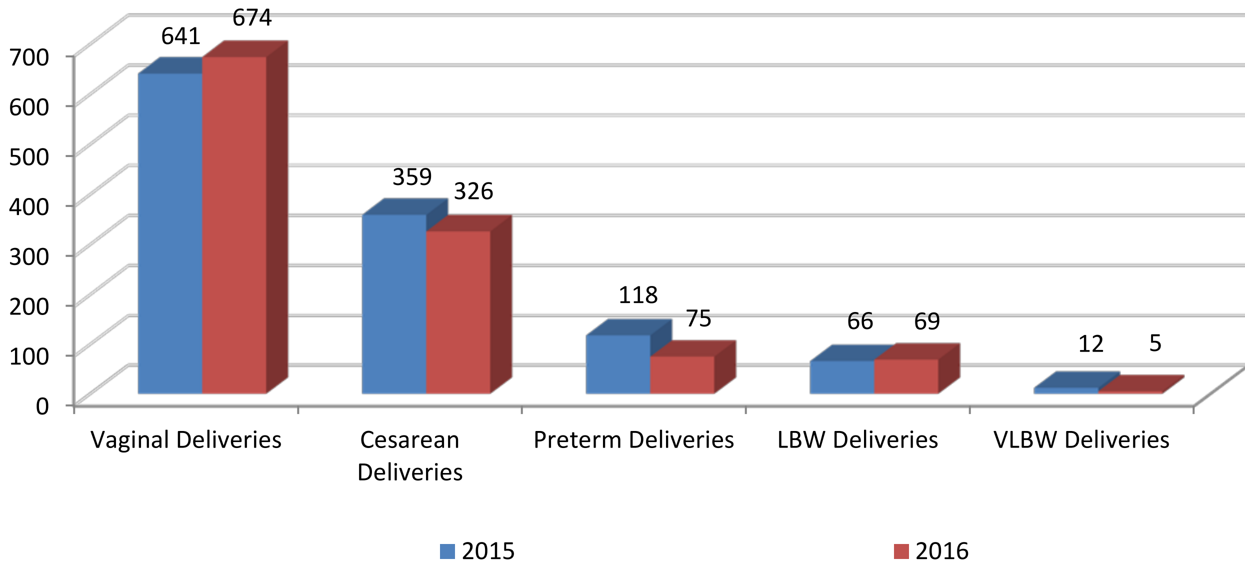
[6] HEDIS® Measure FPC also includes < 21%, 21%-40%, 41%-60%, and 61%-80% of expected visits.
[7] FPC ≥ 81%will be looked at for NCQA Accreditation for 2016
[8] http://www.healthypeople.gov/2020/topicsobjectives2020/objectiveslist.aspx?topicId=26
[9] The figures reflect better outcomes because rates were modified due to the exclusion of miscarriages and stillbirths from the collected data.
[10] Birth Outcomes are based on delivery information obtained through Utilization Review of delivery inpatient stays.
[11] Methodology has revised to look at revenue nursery codes

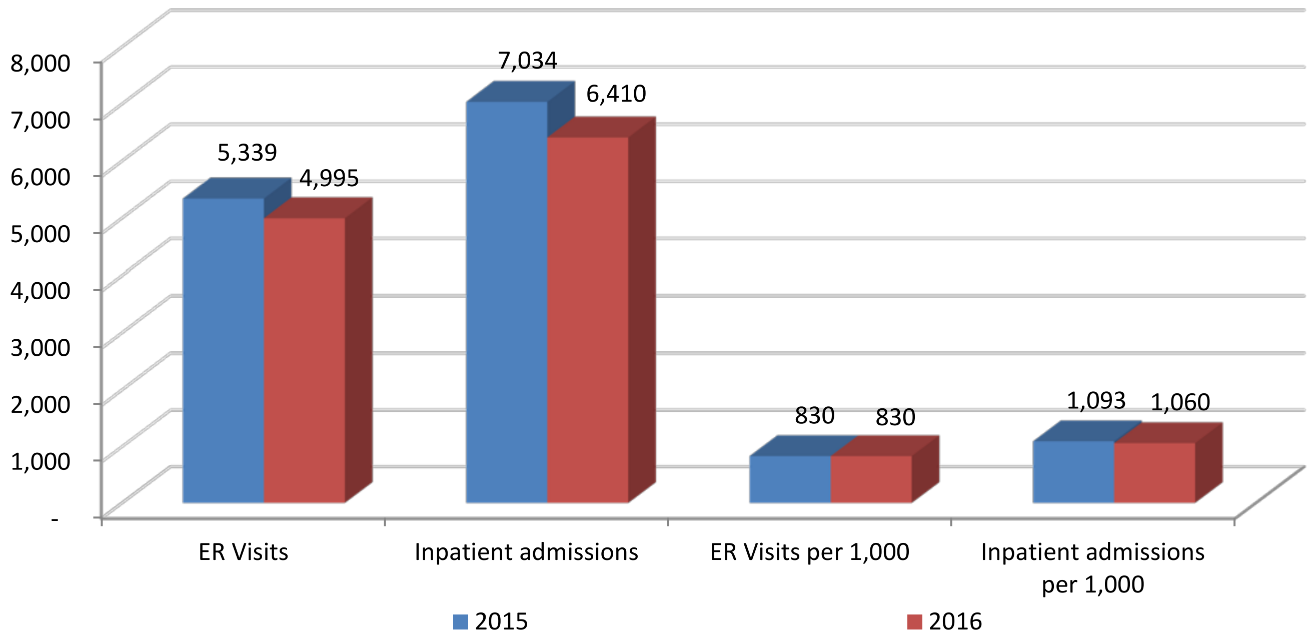
Hospital Utilization with a Diagnosis of Pregnancy



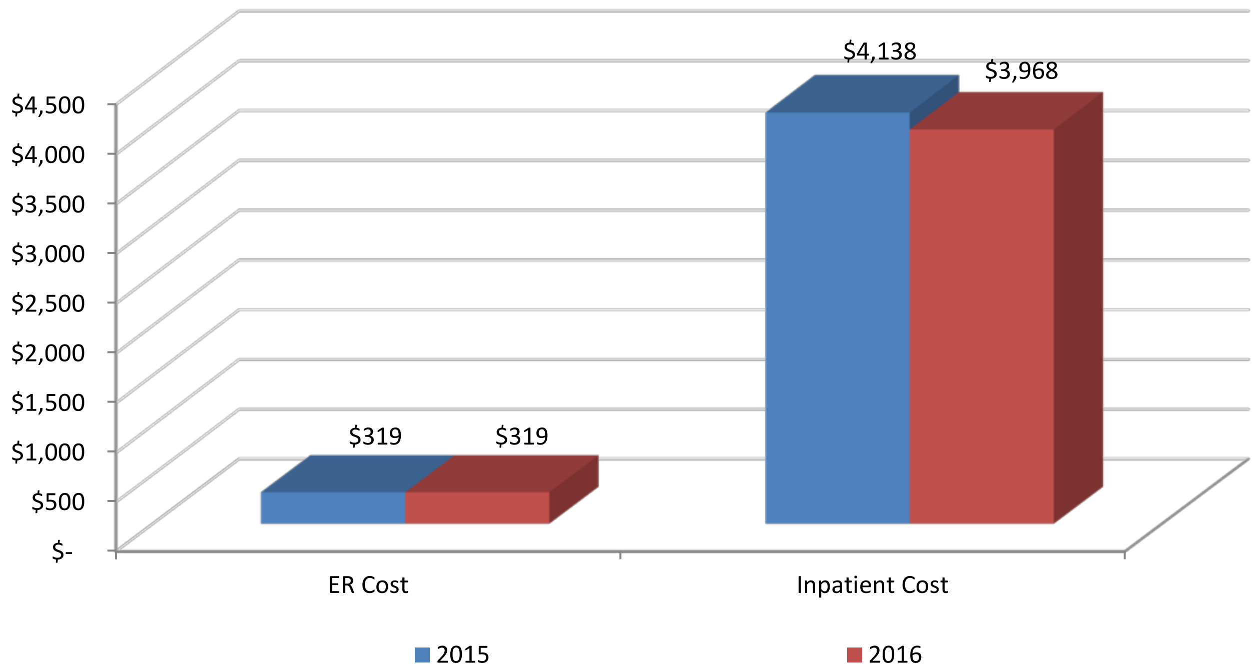
May

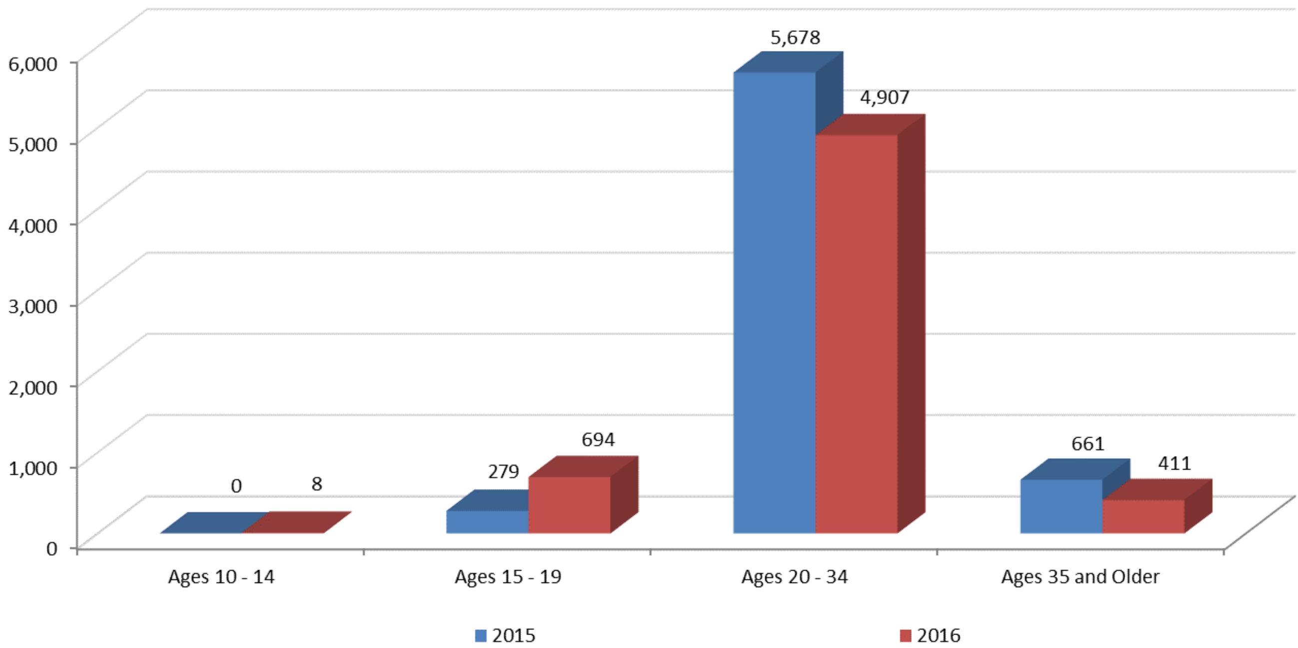
Utilization for Pregnant Members (per 1,000)



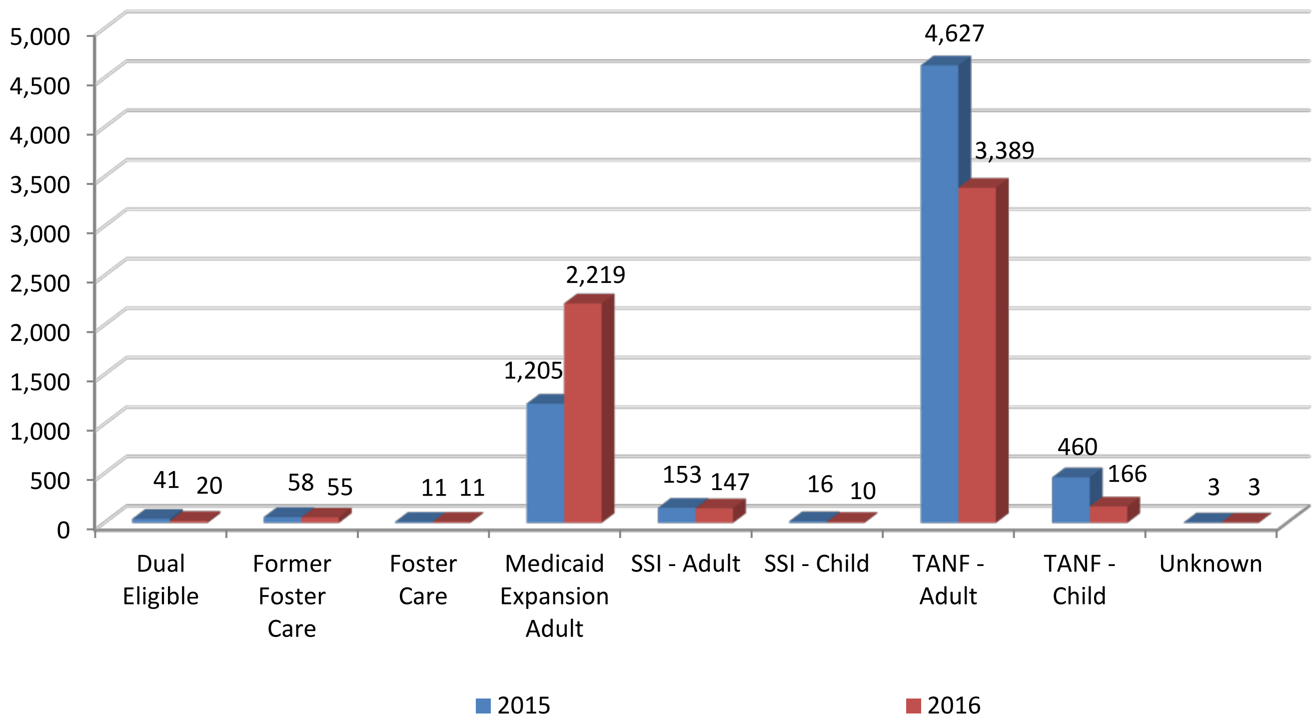


May





Pregnant Members by Age
6,000
5,000
4,000
3,000
2,000
1,000
0
0
8
279
694
5,678
4,907
661
411
Ages 10 - 14
Ages 15 - 19
Ages 20 - 34
Ages 35 and Older
2015
2016



Pregnant Members by Category of Aid
5,000
4,500
4,000
3,500
3,000
2,500
2,000
1,500
1,000
500
0
41
20
58
55
11
11
1,205
2,219
153
147
16
10
4,627
3,389
460
166
3
3
Dual Eligible
Former Foster Care
Foster Care
Medicaid Expansion Adult
SSI - Adult
SSI - Child
TANF - Adult
TANF - Child
Unknown
2015
2016

Healthy Kentuckian Prenatal Risk Assessment Counseling and Education

The percentage of pregnant members who delivered a live birth between November 6 of the year prior to the measurement year and November 5 of the measurement year, whose medical record contains the following:

- Documented Tobacco Use – evidence of screening for tobacco use during one of their first two prenatal care visits or during one of their first two prenatal care visits following enrollment
- Documented Alcohol Use – evidence of screening for alcohol use during one of their first two prenatal care visits or during one of their first two prenatal care visits following enrollment
- Documented Drug Use – evidence of screening for substance/drug use during one of their first two prenatal care visits or during one of their first two prenatal care visits following enrollment
- Assessment and/or Education/Counseling for Nutrition – evidence of assessment of and/or education/ counseling for nutrition during one of their first two prenatal care visits or during one of their first two prenatal care visits following enrollment
- Assessment and/or Education/Counseling for OTC/Prescription Medication – evidence of assessment of and/or education/ counseling for OTC/prescription medication during one of their first two prenatal care visits or during one of their first two prenatal care visits following enrollment
- Screening for Domestic Violence – evidence of screening for domestic violence during one of their first two prenatal care visits or during one of their first two prenatal care visits following enrollment
- Screening for Depression – evidence of screening for depression during one of their first two prenatal care visits or during one of their first two prenatal care visits following enrollment
- Screening for Postpartum Depression – evidence of screening for depression during a postpartum visit

	MY 2011	MY 2012	MY 2013	MY 2014	MY 2015
Tobacco Use	76.24%	87.76%	61.37%	75.39%	84.81%
Alcohol Use	68.53%	86.46%	61.37%	72.51%	81.77%
Drug Use	64.51%	85.94%	61.50%	70.95%	82.04%
Nutrition	58.04%	50.00%	28.26%	39.69%	44.75%
OTC/Prescription Medication	46.43%	84.11%	61.15%	88.47%	27.62%
Domestic Violence	61.83%	45.05%	19.87%	25.28%	42.27%
Depression	65.63%	70.83%	37.09%	39.47%	82.32%
Postpartum Depression	-	58.39%	39.02%	60.52%	82.86%

Findings: During 2015, the percentage of members who received prenatal risk assessment counseling and education for the specific areas listed in the table above showed an increase in seven (7) of the eight (8) areas.

Counseling and education for Tobacco Use increased by 9.42 percentage points, counseling and education for Alcohol Use increased by 9.26 percentage points, counseling and education for Drug Use increased by 11.09 percentage points, counseling and education on OTC/Prescription Medication substantially decreased by 60.85 percentage points, counseling and education for Domestic Violence increased by 16.99 percentage points, counseling and education for Depression substantially increased by 42.85 percentage points and counseling and education for Postpartum Depression substantially increased by 22.34 percentage points.

Approved - May 16, 2017

Analysis

HEDIS®: Results for HEDIS® 2016 (MY2015) indicated Timeliness for Prenatal Care remains relatively the same with a slight decrease of 0.06 percentage points, met the 2016 Quality Compass® 66.67th Percentile. There was a decrease of 2.38 percentage points for Postpartum Care which met the 2016 Quality Compass® 66.67th Percentile. There was a slight decrease of 0.64 percentage points for Frequency of Prenatal Care - ≥ 81% which met the 2016 Quality Compass® 75th Percentile.

Healthy People 2020: LBW, VLBW, and Preterm Deliveries are below the *Healthy People 2020* goals. According to the most recent statistics, Passport's LBW rates are below state and national rates.[12] For LBW it should be noted there was a slight increase of 0.25 percentage points, VLBW had a slight decrease of 0.70 percentage points and Preterm Deliveries ≤ 37 weeks had a decrease of 4.71 percentage points in 2016. 2015 Birth Outcomes data was based on an eight month claims runout; 2016 Birth Outcomes data was based on a three month claims runout, which may have resulted in an artificially low rate of premature and VLBW babies.

Community and Clinician Engagement: Clinicians received status updates on members enrolled in the Mommy Steps Program and provided reference information on the Passport's Perinatal Care Clinical Practice Guidelines, which are based on the ACOG Guidelines located on Passport's website. Community activity involvement included collaboration with March of Dimes, the Kentucky Section ACOG, the Healthy Mothers, Healthy Babies Coalition, Passport's Women's Health Committee, and the Kentuckiana Perinatal Infant Mortality Review Committee, interaction with Freedom House, and the Safe Sleep program in association with Lincoln Trail's Health Access Nurturing Development Services (HANDS), among others.

Member Incentive Program: Passport utilized our Member Incentive Program targeted toward increasing clinician and member awareness of the importance of prenatal and postpartum care. Members who attended all six (6) prenatal visits and return their incentive form received $50. Members who had a C-Section and return their incentive form received $10. Members who kept their postpartum check-up within three (3) to eight (8) weeks after delivery and returned their incentive form received $50. For 2016, a total of 1,790 members took advantage of these rewards. There were 953 members who had at least six (6) prenatal visits, 604 members who had a postpartum screening and 233 members who had their C-Section incision checked. Through the use of member incentives we increase the members' compliance with postpartum examinations, as well as increasing their access to timely prenatal care.

Risk Stratification: In 2016, Passport had an average of 2,739 members per quarter enrolled in the Mommy Steps Program, with an average of 1,210 members per quarter that were identified as new members, a 10% increase from 2015. There was an average of 405 members per quarter identified as high risk. They are selected to be both high risk and most likely to be assisted by active Case Management. This required a reassessment of our triage protocol to ensure that our efforts were being increasingly directed toward those members most likely to benefit from active Case Management. Because of this change in criteria, there was a 66% decrease in the number of actively managed patients in the Mommy Steps Program's compared to 2015, with an increased emphasis on more frequent contacts with the members most likely to benefit from active case management, Care Coordination, and support[13].

Approved - May 16, 2017

[12] National Center for Health Statistics. "*March of Dimes – Peristats*," www.marchofdimes.com/peristats. 2011.

[13] This decrease is due from a change of member stratification for what is considered high risk for the Mommy Steps Program

An average of 781 high risk members per quarter were actively engaged and received one-on-one telephonic contact and educational materials from a High Risk OB Case Manager, a 57% increase from 2015. There was an average of 471 members per quarter who received postpartum outreach calls, an 82% increase from 2015. An average of 377 referrals per quarter was made to WIC, HANDS and Healthy Start, a 6% decrease from 2015. New members received individual educational mailings. The Mommy Steps High Risk OB Case Managers collaborated with Utilization Management (UM) OB Embedded Case Managers to ensure members needs and resources were provided.

Member Complaints: During 2016, there were no complaints received regarding the Mommy Steps Program or the High Risk OB Case Managers.

Program Materials

Member materials:

- Welcome Letter
- Text4Baby and SafeLink Phones
- Helpline Phone Numbers
- Statewide Community Resources
- Statewide Transportation
- Asthma and Pregnancy
- Anemia and Pregnancy
- Diabetes and Pregnancy
- Gum Disease and Pregnancy
- High Blood Pressure and Pregnancy
- Kick Counts
- Nausea and Vomiting
- Preterm Labor
- Urinary Tract Infection
- Warning Signs of Preterm Labor
- March of Dimes: My Pregnancy, Month by Month Book
- When You Smoke… So Do I
- You Can Quit Smoking
- Safe Sleep Education for Your Grandbaby
- Secondhand Tobacco Smoke and the Health of Your Family
- Safe Sleep Contract with Parents
- Safe Sleep for Your Baby
- What does a Safe Sleep Environment Look Like
- Getting Support from Mommy Steps
- Mommy Steps Program Brochure
- HANDS Brochure
- Secondhand Tobacco Smoke
- NIH: Safe Sleep Environment
- CDC: Think Before You Drink
- Postpartum Postcard
- Getting Ready for Pregnancy
- Infant-Toddler Safe Sleep Checklist
- Commonwealth of Kentucky: Breastfeeding: Baby's Best Start
- Commonwealth of Kentucky: Getting Started with Breastfeeding
- Commonwealth of Kentucky: Is My Baby Getting Enough
- Commonwealth of Kentucky: Managing Basic Problems (Milk Supply, Jaundice and Yeast Infection)
- Commonwealth of Kentucky: Breastfeeding Helpful Hints for Nipple Care
- Commonwealth of Kentucky: Breastfeeding Planning Ahead During Pregnancy
- Regional WIC Sites
- Parents Guide to Safe Sleep
- Safe Sleep During Winter

Clinician Materials:

- Care Coordination: Your Connection to Disease and Case Management Programs Brochure
- No-Show Reimbursement Request Letter
- Pregnancy Notification Form

Approved - May 16, 2017

Barriers and Opportunities

Barrier: Initiation of prenatal care continues to be a difficult measure to increase as members must first have a positive pregnancy test with an estimated date of confinement (EDC) to apply for benefits. Meanwhile, Passport is not able to outreach to non-members due to contractual and/or regulatory restrictions.

Opportunity:

- Increase member identification and engage in OB care by:
  - Providing written and telephonic communication to members who miss appointments and assist with rescheduling and assess barriers to care.
  - Performing weekly review of the new member Health Risk Assessment (HRA) to identify pregnant members new to Passport, and outreach to encourage early and regular OB care.
  - Performing daily review of the 24/7 Nurse Advice Line Report, and conduct telephonic outreach to members that think they might be pregnant or have a pregnancy question.
  - Develop new stratification and identification tools by identifying pregnant members through other medical claims, pharmacy, claims, etc.

- Community Outreach: Increase community awareness of the Mommy Steps Program through:
  - Collaborating with community partners, such as Healthy Start, HANDS, and local Departments of Health.
  - 1-800-QUIT-NOW Program for pregnant members who want to quit smoking.
  - Providing education and assisting with pregnancy questions/issues via the 24/7 Nurse Advice Line.
  - Distributing educational materials at health fairs and community baby shower events.
  - Educating members about available resources (*i.e.*, transportation) to assist with keeping appointments.

Barrier: Lack of member awareness of the importance of regular prenatal care, and the importance and availability of the Mommy Steps Program and Services.

Opportunity: Member Outreach:

- Providing written and telephonic communication to members who miss appointments, assist with rescheduling and assess barriers to care.

- Educating members on:
  - The importance of prenatal care to identify complications early at every successful outreach.
  - The warning signs during pregnancy and when to call the OB clinician.

- Leveraging the usage of auto-dialer technology in order to educate more members regarding the importance of regular prenatal care and postpartum visits.

Approved - May 16, 2017

- Continuing member engagement rewards in an effort to encourage early and regular prenatal care as well as timely postpartum care.

- Improve identification and coordination of behavioral health issues, and other social determinants of health to improve care management protocols.

Barrier: Difficulty in identifying modifiable risk factors resulting in a poor birth outcome for the member.

Opportunity: Provider Outreach:

- Collaborating with OB clinicians to notify the Mommy Steps Program of members identified with modifiable risk factors.

- Collaborating with Provider Relations to educate OB clinicians during all site visits to promote a relationship with both the OB clinicians and office managers.

- Requesting the ACOG or "ACOG like" form utilized by participating OB clinicians on each member after the first visit.

- Continuing to educate OB clinicians on the importance of notifying the Mommy Steps Program when a member becomes high risk.

- Continuing collaboration with clinicians to embed High Risk OB Nurse Case Managers in high volume offices in 2016.

- Work to improve compliance, interest on part of member.

- Active participation in provider organizations, such as the Louisville Obstetrical and Gynecological Society, the Kentucky Section ACOG, the Kentucky Perinatal Society, and others.

Approved - May 16, 2017

Interventions completed in 2016:

- Collaborated with Care Message vendor to provide healthy, helpful information to members through Passport sponsored cell phones.

- Collaborated with UM OB Embedded Case Managers to reach, support and educate pregnant and postpartum members.

- Participated in the Women's Health Committee to review, discuss, and create criteria, policies and interventions to improve the health and well-being of pregnant members and birth outcomes.

- The Crib Program provided Pak-N-Play cribs to Passport members in need. The Lincoln Trail Health District is partnered with Passport to split the costs. This program promoted "Safe Sleep" and educated members on the ABCs of Safe Sleep to lessen the number of infant deaths that occur due to co-sleeping or other unsafe sleep habits.

- Participated in activities of Kentucky Section ACOG, Kentucky Perinatal Society, the Louisville OB/GYN Society, and other clinician organizations related to maternal and newborn health care.

- Participated in community coalitions such as Healthy Mothers, Healthy Babies, the March of Dimes, the Fetal and Infant Mortality Review (FIMR) Committee, and others.

- Outreached to members affected by substance use disorder such as the Freedom House.

Prenatal member outreach:

- Educated members regarding the importance of early and regular prenatal care through:
- Telephonic outreach
- Member newsletters
- On-hold SoundCare messages
- Passport's website
- Member educational materials
- Distributed weekly new member packets to 4,841 newly identified pregnant members, a 10% increase from 2015.

- Distributed 605 March of Dimes "My pregnancy month by month" booklet to pregnant members. English and Spanish versions were mailed as appropriate.

Postpartum member outreach:

- Administered the Patient Health Questionnaire (PHQ) 2 to 1,197 pregnant members with 3% of the members scoring a positive result. Further depression screenings were conducted using the Edinburgh Postnatal Depression Scale (EPDS) Assessment with those members. There were 39 members referred for Behavioral Health (BH) services.

Approved - May 16, 2017

Interventions completed in 2016 (Continued):

- Distributed 5,259 weekly postpartum reminder postcards, a 10% increase from 2015.
- Performed 1,883 telephonic outreach calls to postpartum members, an 8% increase from 2015.
- Increased community initiatives related to the identification of members and promotion of healthy pregnancies by:
  - Participated in fundraising and walking in the local March of Dimes.
  - Participated in educational programs of the Kentucky Perinatal Association, March of Dimes, Kentucky Hospital Association, and Passport Webinars and Symposia.
- Updated "Special Health Programs, Just for You!" brochure for member education on support programs available for them.
- Developed new Member Satisfaction Survey Postcard directing members to the Passport website to fill out their survey. There is a specific survey number based on the program the member was enrolled in. If the member would prefer to have a hard copy mailed to them, they can call into our Care Connector line and they will mail one to them to fill out and return.
- Continued to improve integration and collaboration with BH to improve overall coordination of care for members with co-existing medical and BH diagnoses/conditions via bi-monthly meetings and case discussions.
- Distributed the Mommy Steps Member Satisfaction Survey to members enrolled in the Mommy Steps Program, reviewed surveys as received and conducted outreach to those members who indicate "fair" or "poor" responses on their survey (if the member completes contact information section of the survey tool) and monitored surveys for trends. Provided feedback to individual staff when appropriate and addressed any identified areas that needed improvement, none identified.

Approved - May 16, 2017

Planned Interventions for 2017:

- Preterm Birth Prevention Initiative: The goal is to improve birth outcomes by continuing to educate clinicians and support best practices related to clinical evidence for the use of progesterone therapy and universal cervical length screening to reduce preterm delivery.

- Smoking Cessation: The goal is to reduce preterm births, LBW, and VLBW babies via the implementation of OB clinician education to increase screening and education for pregnant members about tobacco use and second-hand smoke exposure.

- Substance Abuse Referral & Treatment: The goal is to reduce preterm births, LBW, and VLBW babies resulting from substance abuse via the implementation of processes to ensure that the counseling and treatment for pregnant women contain no gaps in care from detox to inpatient/residential care and throughout outpatient services to increase recovery rates.

- Enhanced Data Management Systems: Through partnering with Lucina in the creation and implementation of the Firefly system interventions can be monitored and processes re-tooled in a timely manner to improve the health and well-being of high risk pregnant members.

- Enhanced Transportation Services: The goal is to provide high risk pregnant members with enhanced transportation that is more flexible in the notification timeline when requesting transportation services. Enhanced transportation services will assist members traveling to medical appointments and meetings for substance abuse treatment.

- Continue collaboration with Care Message vendor to provide healthy, helpful information to members through Passport sponsored cell phones.

- The Women's Health Committee is comprised of OB clinicians and Passport staff and meets quarterly to collaboratively review, discuss, and create criteria, policies and interventions to improve the health and well-being of pregnant members and birth outcomes.

Performance Improvement Project (PIP):

- Passport aims to improve postpartum care and reduce readmissions for our members post-delivery. Member interventions include:
  - Educate about the warning signs of postpartum complications.
  - Educate on the importance of postpartum visits.
  - Educate on adherence on postpartum visit 21-56 days after delivery.
  - Educate on adherence on C-section incision check 7-14 days after cesarean delivery.
  - Mommy Steps OB Nurse Case Managers placed 2-4 Day postpartum discharge calls to all members who had a C-section and to any member having a vaginal delivery at risk for readmission. During the calls the nurses reviewed the member's health status and provided guidance to the member when they needed to seek care from their OB clinician.

Approved - May 16, 2017

Planned Interventions for 2017 (Continued):

- OB clinician interventions include:
  - o Educated OB clinicians on Passport's Perinatal Care Clinical Practice Guidelines to increase compliance and postpartum visits.
  - o Increase adherence and documentation of postpartum visits between 21-56 days post-delivery.
  - o Decrease postpartum readmissions occurring between 1-14 and 15-30 days post-delivery.

- Member Incentive Program offers rewards to members who have an incision check following a Cesarean delivery and for a postpartum visit between 21 and 56 days.

- Improve transition care of hospitalized obstetrical members by coordination of inpatient and outpatient transition of care services by Embedded Care Managers in high volume obstetrical facilities.

- Increase role of Embedded Case Managers in Region 3 in high volume OB facilities to ensure care coordination transition care is maximized for members at high risk for readmission or adverse outcomes.

- Continue member outreach by:
  - o Distributing weekly member welcome packets to newly identified pregnant members.
  - o Distributing the March of Dimes "My pregnancy month by month" booklet to those members who call in and request a copy.

Postpartum member outreach:

- Educate members regarding the importance of postpartum follow-up through:
  - o Face-to-face outreach
  - o Member newsletters
  - o On-hold SoundCare messages
  - o Passport's website
  - o Care Messaging
  - o Member educational materials

Prenatal member outreach:

- Continue prenatal member outreach by educating members regarding the importance of early and regular prenatal care through:
  - o Face-to-face outreach
  - o Telephonic outreach
  - o Member newsletters
  - o On-hold SoundCare messages
  - o Passport's website
  - o Care Messaging
  - o Member educational materials

Approved - May 16, 2017

Planned Interventions for 2017 (Continued):

- Continue member outreach by:
  - Distributing weekly postpartum reminder postcards.
  - Performing telephonic outreach to all postpartum members.
- Continue collaboration with UM OB Embedded Case Managers. This collaboration presents additional opportunities to reach, support and educate pregnant and postpartum members. The two programs will coordinate their efforts and materials to expand the Mommy Steps Program.
- Screen all postpartum members for depression using the PHQ-2 and EPDS Assessment, during the postpartum period and refer to the BH team as indicated.
- Evaluate the Mommy Steps Program interventions to establish which are the most productive and re-organize resources, as needed.
- Maintain member engagement/incentive rewards to encourage early and regular prenatal care with an OB clinician.
- Increase community outreach initiatives related to the identification of members and promotion of healthy pregnancies by:
  - Continue fundraising and walking in the local March of Dimes.
  - Continue additional opportunities to engage members in early and regular prenatal care.
  - Continue collaboration with clinicians to improve birth outcome and infant mortality.
  - High Risk OB Care Advisor will attend community baby showers to provide member education on pregnancy, delivery, and postpartum topics to improve birth outcomes.
- Review surveys as received and conducted outreach to those members who indicate “fair” or “poor” responses on their survey (if the member completes contact information section of the survey tool).
- Monitor for trends, provide feedback to individual staff and address any identified areas that needed improvement.
- Improve integration and collaboration with BH to enhance overall coordination of care and case management for members with co-existing medical and BH diagnoses/conditions via the addition of a social worker to the Mommy Steps.

Approved - May 16, 2017

Overall the Mommy Steps Program noted improvements in 2016. Based upon the 2016 evaluation, Passport will continue to strive towards the overall goal to improve the health, quality of life and birth outcomes for our pregnant members.