Brief Notes about Technology

Audio

• Audio is available through your computer.
• For assistance, contact cmccoy@amchp.org
• To submit questions throughout the webinar, type your question in the chat box at the lower left-hand side of your screen.
  – Send questions to the Chairperson (AMCHP)
  – Be sure to include to which presenter/s you are addressing your question.
Technology Notes Cont.

Recording

• Today’s webinar will be recorded

• The recording will be available in a week on the AMCHP website at [www.amchp.org](http://www.amchp.org)
Objectives

1) Provide an overview of coverage for women's and reproductive care currently in the United States.

2) Briefly describe and define preconception health and its importance on improving birth outcomes and lowering disparities in the United States.

3) Highlight how health reform, both at the state and national level, can contribute to improving preconception care for women.

4) Share successes, challenges, and lessons learned from a state that offers various levels of coverage for preconception health.
Featuring:

• **Usha Ranji**, Associate Director for Women's Health Policy at the Henry J. Kaiser Family Foundation

• **Kay A. Johnson**, President, Johnson Group Consulting, Inc.

• **Jill Nobles-Botkin**, Director, Perinatal & Reproductive Health Division, Oklahoma Department of Health

• **Shelly Patterson**, Director of Child Health, Oklahoma Health Care Authority
Reproductive Health Care and the Affordable Care Act

Usha Ranji, M.S.
Associate Director, Women’s Health Policy
The Henry J. Kaiser Family Foundation

Opportunities and Strategies for Improving Preconception Health through Health Reform Webinar
AMCHP

January 8, 2013
ACA Implementation Moving Forward

To Date
• Dependent coverage to age 26, no lifetime caps
• Prohibition on denying coverage to children with pre-existing conditions
• Pre-existing condition insurance plan for current uninsured
• Small business tax credits
• Premium review and rebates
• No cost-sharing for preventive services in new private plans and Medicare as well as for new women’s preventive services

In Progress and In 2014:
• Coverage becomes mandatory
• State decisions about health insurance exchanges
• State decisions about Medicaid Expansion – states can decide any time
• Federal regulations on many aspects of ACA operations, including exchange rules, plans rules, Medicaid eligibility
Expansion Could Cover Many Young Women

Insurance Status, by Type

- Employer, 54%
- Medicaid, 14%
- Individual, 7%
- Uninsured, 22%
- Other, 2%

Income Distribution

- <139% FPL: 58%
- 139-399% FPL: 34%
- ≥ 400% FPL: 7%

12.5 Million Uninsured Women

55.9 Million Women Ages 18-44

“Other” includes programs such as Medicare and military-related coverage. The federal poverty level for a family of four in 2010 was $22,050.

Impact Will Vary Across the Country

Uninsured Rates Among Nonelderly Women by State, 2009-2010

Figure 4

Supreme Court Ruling

• In June 2012, the Supreme Court ruled on the constitutionality of the ACA and its provisions, specifically the Individual Mandate and the Medicaid Expansion

• All ACA provisions remain in effect BUT Medicaid expansion is vulnerable:
  – The Court constrained the Secretary’s enforcement power while leaving the Medicaid expansion intact;

• States have financial incentive to expand Medicaid through federal financing, but the penalty for states who do not expand Medicaid is loss of expansion funds, not all Medicaid funds
Two-Thirds of Adult Women on Medicaid Are in Reproductive Years

Distribution of Adult Medicaid Enrollees, by Sex

- Men: 32%
- Women: 68%

Distribution of Adult Women Enrollees, by Age Group

- 85+: 5%
- 75-84: 6%
- 65-74: 8%
- 45-64: 18%
- 18-44: 63%

SOURCE: Kaiser Commission on Medicaid and the Uninsured and Urban Institute analysis of FF Y2009 MSIS.
Medicaid Plays Major Role in Reproductive Health for Low-Income Women

- **Prevention**
  - Screenings- breast and cervical cancer, STI screening, and chronic condition prevention and screening
  - Mandatory coverage for family planning services, but states determine specific benefits
  - Enhanced FMAP (90%) for family planning services. Single largest public payer (75%) for family planning
  - Cost sharing prohibited for family planning services and to pregnant women
  - “Freedom of choice” allows most beneficiaries to seek family planning from any participating provider

- **Maternity Care**
  - Funds almost half of births nationwide
  - Typically covers prenatal care, screenings, delivery, and postpartum care up to 60 days
  - Guaranteed coverage for newborns up to age 1

- **Abortion**
  - Federal financing of abortion is limited to cases of rape, incest, and life endangerment through the Hyde Amendment
Most States Routinely Cover Contraceptives as Family Planning, but More Variation for Other Benefits

Number of States (out of 44) that Always Consider Service as Family Planning

- IUDs: 41
- Oral Contraceptives: 40
- Contraceptive Counseling: 30
- Emergency Contraception Pill: 26
- Gyn Exams: 10
- Preconception Counseling: 7
- Infertility: 4

Notes: Out of 44 states that responded to survey.
Medicaid Family Planning Programs Have Extended Services to Many Uninsured Women

Figure 9

SOURCE: Guttmacher Institute, Medicaid Family Planning Eligibility Expansions, State Policies in Brief, July 2012.
Medicaid Improves Women’s Access to Care

Percentage of non-elderly women reporting:

- No MD visit in past year:
  - Uninsured: 33%*
  - Private Insurance: 10%
  - Medicaid: 11%

- No usual source of care:
  - Uninsured: 34%*
  - Private Insurance: 6%
  - Medicaid: 9%

- No breast exam in past two years:
  - Uninsured: 49%
  - Private Insurance: 16%
  - Medicaid: 33%*

- No Pap test in past two years:
  - Uninsured: 35%*
  - Private Insurance: 18%
  - Medicaid: 24%

*N: Data from 2008. Includes women 18 to 64. *Significantly different from Private Insurance, p<.05.

Insurance Market Regulations Will Provide Additional Protections

Market Reforms

– Modified community rating for insurance premium charges
  • Prohibit insurers from charging people more based on gender, health status, or occupation
  • Variations in premiums based on age (3 to 1) and tobacco use (1.5 to 1) would be limited
– Bans on pre-existing condition exclusions
– Prohibits annual and lifetime limits on coverage
– Guarantee issue and renewability (regardless of health status)
– Medical Loss Ratio
– Summary of Benefits and Coverage (SBC) - with standardized information about benefits, coverage limits, and cost sharing
Essential Health Benefits

• **Insurance Plans are required to cover 10 categories of benefits**
  - Ambulatory patient services
  - Emergency services
  - Hospitalization
  - Maternity and newborn care
  - Mental Health and substance use disorder services, including behavioral health treatments
  - Prescription drugs
  - Rehabilitative and habilitative services and devices
  - Laboratory services
  - Preventive and wellness services and chronic disease management
  - Pediatric services including dental care

• **Selection of “benchmark” plans for insurance exchanges and Medicaid expansion population**
ACA Preventive Services

Covered without cost-sharing in new private plans and Medicaid for newly eligible beneficiaries:

- **U.S. Preventive Services Task Force (USPSTF) Recommendations** rated A or B
- **ACIP** recommended immunizations
- **Bright Futures** guidelines for preventive care and screenings
- **“With respect to women,”** evidence-informed preventive care and screenings not otherwise addressed by USPSTF recommendations

Incentive for Medicaid programs to cover for all beneficiaries – 1% increase in FMAP

**SOURCE:** Patient Protection and Affordable Care Act. Public Law 111–148
Preventive Services to be Covered Without Cost Sharing by New Private Plans and Women Newly Eligible for Medicaid

<table>
<thead>
<tr>
<th>Cancer</th>
<th>Chronic Conditions</th>
<th>Immunizations</th>
<th>Healthy Behaviors</th>
<th>Pregnancy-Related**</th>
<th>Reproductive Health</th>
</tr>
</thead>
<tbody>
<tr>
<td>✓ Breast Cancer</td>
<td>✓ Cardiovascular health</td>
<td>✓ Td booster, Tdap</td>
<td>✓ Alcohol misuse screening and counseling (all adults)</td>
<td>✓ Tobacco and cessation interventions</td>
<td>✓ STI and HIV counseling</td>
</tr>
<tr>
<td>- Mammography for women 40+*</td>
<td>- Hypertension screening</td>
<td>✓ MMR</td>
<td></td>
<td>- (adults at high risk; all sexually-active women)</td>
<td></td>
</tr>
<tr>
<td>- Genetic (BRCA) screening and counseling</td>
<td>- Lipid disorders screenings</td>
<td>✓ Meningococcal</td>
<td></td>
<td></td>
<td>✓ Screenings:</td>
</tr>
<tr>
<td>- Preventive medication counseling</td>
<td>- Aspirin</td>
<td>✓ Hepatitis A, B</td>
<td></td>
<td></td>
<td>- Chlamydia (sexually active women &lt;24y/o, older women at high risk)</td>
</tr>
<tr>
<td>✓ Cervical Cancer</td>
<td>✓ Type 2 Diabetes screening (adults w/ elevated blood pressure)</td>
<td>✓ Pneumococcal</td>
<td>✓ Intensive healthy diet counseling (adults w/high cholesterol, CVD risk factors, diet-related chronic disease)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Pap testing (women 18+, - High-risk HPV DNA testing</td>
<td>✓ Depression screening (adults, when follow up supports available)</td>
<td>✓ Zoster</td>
<td>✓ Tobacco counseling and cessation interventions (all adults)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>✓ Colorectal Cancer</td>
<td>✓ Osteoporosis screening (all women 65+, women 60+ at high risk)</td>
<td>✓ Influenza, Varicella HPV (women 19-26)</td>
<td>✓ Interpersonal and domestic violence screening and counseling (women 18-64)</td>
<td>✓ Screenings</td>
<td></td>
</tr>
<tr>
<td>- One of following: fecal occult blood testing, colonoscopy, sigmoidoscopy</td>
<td>✓ Obesity Screening (all adults) Counseling and behavioral interventions (obese adults)</td>
<td>✓</td>
<td></td>
<td>- Hepatitis B</td>
<td></td>
</tr>
<tr>
<td>✓ Well-woman visits (women 18-64)</td>
<td></td>
<td>✓</td>
<td></td>
<td>- Chlamydia (&lt;24, hi risk)</td>
<td></td>
</tr>
</tbody>
</table>

Includes Many Pregnancy-Related Services

Pre-pregnancy
- Preconception care in well woman visit♀
- Folic acid supplements
- Contraceptive services and supplies♀
- HPV vaccine
- Counseling on nutrition and healthy lifestyles
- Screenings for HIV, Chlamydia, Gonorrhea, Syphilis, Chronic Illnesses

Pregnancy
- Prenatal visits
- Alcohol misuse screening and counseling
- Tobacco counseling and cessation interventions
- Screenings for pregnant women - Rh incompatibility, Hepatitis B, Chlamydia, Gonorrhea, Syphilis, Bacteriurea, Iron deficiency, Gestational diabetes♀- 24-28 weeks gestation, first prenatal visit for high risk

Post Partum
- Breastfeeding supports- Counseling, Consultations w/ trained provider♀, Equipment rental
- Contraception♀
Many State Medicaid Programs Covering Services Without Cost Sharing

- States that cover these services and charge co-pays
- States that cover these services without co-pays

<table>
<thead>
<tr>
<th>Service</th>
<th>States with Co-pays</th>
<th>States without Co-pays</th>
<th>Total States</th>
</tr>
</thead>
<tbody>
<tr>
<td>HIV Screening</td>
<td>13</td>
<td>35</td>
<td>48</td>
</tr>
<tr>
<td>STI counseling</td>
<td>14</td>
<td>25</td>
<td>39</td>
</tr>
<tr>
<td>Chlamydia Screening</td>
<td>13</td>
<td>34</td>
<td>47</td>
</tr>
<tr>
<td>Cervical Cancer Screening</td>
<td>13</td>
<td>35</td>
<td>48</td>
</tr>
<tr>
<td>HPV Vaccine*</td>
<td>9</td>
<td>28</td>
<td>37</td>
</tr>
</tbody>
</table>

Note: Out of 48 states that completed survey. Hawaii, Wisconsin and DC are not included.
Source: KCMU/HMA Survey of State Medicaid Coverage of Adult Preventive Services.
Affordability of Care is KEY for Women

Percentage of women reporting in past year they:

- **Delayed or went without care due to cost**
  - Private: 14%
  - Medicaid: 31%
  - Uninsured: 55%*

- **Did not fill prescription medicine due to costs**
  - Private: 18%
  - Medicaid: 30%
  - Uninsured: 34%*

- **Skipped or took smaller doses of prescription medicines to make them last longer**
  - Private: 13%
  - Medicaid: 28%*
  - Uninsured: 27%*

All Will Not be Insured...

- Who are they?
  - Immigrants who are not legal residents
  - Eligible for Medicaid but not enrolled
  - Exempt from the mandate (most because can’t find affordable coverage)
  - Choose to pay penalty in lieu of getting coverage

- How SCOTUS ruling will affect Medicaid in many states to be determined

- A robust health care safety net will be essential
  - Public Hospitals
  - Federally Qualified Health Centers/Rural Health Centers
  - Family Planning Providers
  - Impact of drop in funding for Disproportionate Share Hospitals (DSH)
Looking Ahead - Reproductive Health Care and ACA

- States have some crucial decisions to make, including whether they will expand Medicaid, who will operate their exchanges, what benefit packages will look like, the costs, and how they will monitor key provisions.
- Many details remain for Medicaid and Exchange:
  - What steps will states take to improve outreach and enrollment? Many are unaware of ACA’s benefits.
  - What are the out-of-pocket costs that women will face?
  - Maintain expanded family planning coverage through SPA especially to undocumented women?
  - What will plans cover as preventive services? What will be included in well woman visits?
  - Will provider networks include a range of providers with experience in women’s health, such as family planning clinics?
- How to serve those who remain uninsured and strengthen the safety-net providers that serve them?
- What choices will policymakers make in broader discussions about the economy?
PRECONCEPTION AND INTERCONCEPTION CARE POLICY UPDATE

Presentation by
Kay Johnson
For
AMCHP Webinar
January, 2013
What is not happening that should be?

• In the current US health care system:
  • Millions of uninsured women.
  • The quality of primary care for millions of women of childbearing age is inadequate.
  • Many providers not focused on reproductive risks, preconception health, or recurring pregnancy outcomes.
  • Prevention messages not reaching women
Prevalence of Risk, Medicaid and Total, PRAMS, 26 Reporting Areas, 2004

<table>
<thead>
<tr>
<th></th>
<th>Percent of Women in Medicaid</th>
<th>Percent of All Women</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Preconception (Pre-pregnancy) Risks and Protective Factors</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tobacco use</td>
<td>36.0</td>
<td>23.2</td>
</tr>
<tr>
<td>Alcohol use</td>
<td>37.7</td>
<td>50.1</td>
</tr>
<tr>
<td>Multi-vitamin use</td>
<td>21.4</td>
<td>35.1</td>
</tr>
<tr>
<td>Stress</td>
<td>33.8</td>
<td>18.5</td>
</tr>
<tr>
<td>Overweight</td>
<td>14.4</td>
<td>13.1</td>
</tr>
<tr>
<td>Obesity</td>
<td>32.7</td>
<td>21.9</td>
</tr>
<tr>
<td>Nonuse of Contraceptives</td>
<td>54.9</td>
<td>53.1</td>
</tr>
<tr>
<td><strong>Interconception/Postpartum (PP) Risks and Protective Factors</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prior LBW</td>
<td>15.6</td>
<td>11.6</td>
</tr>
<tr>
<td>Prior Preterm</td>
<td>13.7</td>
<td>11.9</td>
</tr>
<tr>
<td>Use of Contraceptives</td>
<td>85.1</td>
<td>85.1</td>
</tr>
<tr>
<td>Tobacco use</td>
<td>26.8</td>
<td>17.9</td>
</tr>
<tr>
<td>PP Depression</td>
<td>22.5</td>
<td>15.7</td>
</tr>
</tbody>
</table>

National Preconception Health and Health Care (PCHHC) Initiative Goals

1. To improve the knowledge, attitudes, and behaviors of men and women related to preconception health.

2. To assure that all U.S. women of childbearing age receive preconception care services – screening, health promotion, and interventions -- that will enable them to enter pregnancy in optimal health.

3. To reduce risks indicated by a prior adverse pregnancy outcome through interventions in the interconception period.

4. To reduce the disparities in adverse pregnancy outcomes.
The ACA provides an opportunity to assure that women (and men) attain good health in childhood and adolescence, maintain it during their reproductive years, and age well as seniors.

to improve health across the life span requires our action.
What does ACA health reform bring?

• Coverage for millions of women currently uninsured
• Greater affordability and improved benefit packages
• Changes in the delivery system
• More emphasis on prevention – clinical and community
  • As of Aug. 1, 2012, estimated 47 million insured women enrolling in new health plans or renewing their existing policies will have coverage for clinical preventive health services without cost-sharing:
    • Well-woman visits (annual preventive visit including preconception care and prenatal care)
    • Gestational diabetes screening; HPV DNA testing; STI counseling; HIV Screening and counseling; Contraception and contraceptive counseling; Breast-feeding support, supplies, and counseling; Interpersonal and domestic violence screening and counseling.
      • Plus immunizations and other services recommended by the U.S. Task Force on Clinical Preventive Services.
Maximizing ACA Opportunity in Preventive Services

• Focus on preventive services a centerpiece of the Patient Protection and Affordable Care Act (ACA)
  • IOM charged by HHS to review and recommend what preventive services are important to women’s health
    • Recommendation 5.8: At least one well-woman preventive care visit annually for adult women to obtain the recommended preventive services, including preconception and prenatal care. The committee also recognizes that several visits may be needed...
  • Adopted by HHS as preventive benefit without cost sharing in new (not “grandfathered” plans) (Effective 8/1/2012)

• How can states support the change in provider knowledge, attitudes and practices, along with consumer awareness to assure that women receive covered services?

www.iom.edu/preventiveserviceswomen
## Recommendations for Risk Assessment and Health Promotion In Preconception Care

(Adapted from Moos et al, 2008)

### Family planning counseling and use of reproductive life plan
- Screen women about intentions to become or not become pregnant and their risk of conceiving.
- Encourage use of a reproductive life plan and educate on how it effects contraceptive and medical decisions.
- Provide information and counseling about all forms of contraception.

### Physical activity
- Assess weight-bearing and cardiovascular exercise and offered recommendations.

### Nutrition
- Calculate BMI calculated at least annually.
- When BMI > 26 kg/m², counsel about risks to their own health, the risks for exceeding the overweight category, and the risks to future pregnancies, including infertility. Offer behavioral strategies and support for enrolling in structured weight loss programs.
- When BMI < 19.8 kg/m² should be counseled about the short- and long-term risks to their own health and the risks to future pregnancies, including infertility. Assess for eating disorders and distortions of body image.

### Nutrient intake
- Advise to ingest 0.4 mg of folic acid daily from food and/or supplements and to consume diet of folate-rich food.

### Immunizations
- Assess and update immunization status for tetanus, diphtheria, pertussis; MMR; and varicella.
- Assessed for health, lifestyle, and occupational risks for other infections and offered indicated immunizations.

### Infectious Disease
- Assess STI risks, provide counseling and preventive interventions, and provide STI testing and treatment.

### Parental Exposures
- Assess for the use of tobacco, and those who smoke should be counseled, using the 5 As, to limit exposure.
- Assess alcohol use patterns and risky drinking behaviors and provided with appropriate counseling.
- Advise of risks to the embryo/fetus of alcohol exposure in pregnancy and that no safe level of consumption has been established.
PEER-TO-PEER (P2P) LEARNING PROJECT: HELPING STATES ADDRESS WOMEN'S HEALTH THROUGH MEDICAID

A year of sharing among seven states: CA, FL, IL, LA, NC, OK, TX

A checklist of questions to identify opportunities for states to improve preconception and interconception care using Medicaid
Starting questions: How many…

• What percentage of births financed by Medicaid?
• How many of women with Medicaid financed birth have billing for postpartum visit?
• What proportion of women with a Medicaid-financed birth lose coverage after 60 days?
• What proportion of women transition to a family planning eligibility category 60 days following a Medicaid-financed birth?
• How many women have repeated LBW or preterm birth financed by Medicaid? What are the direct Medicaid costs for medical care to mother and infant?
Other Checklist Questions

- How can state improve the quality of primary care and postpartum visits for Medicaid-covered women to increase use of evidence-based preconception care?
- How can evidence-based pre/interconception screening assessments be encouraged by Medicaid?
- How can state use Medicaid managed care arrangements to improve women’s pre/interconception health?
- How might state use interconception care to serve women who experienced a Medicaid-financed pregnancy with an adverse outcome?
HRSA- MCHB COLLABORATIVE IMPROVEMENT & INNOVATION NETWORK (COIIN) TO REDUCE INFANT MORTALITY

Extracted with permission from presentation by:
Reem M. Ghandour, DrPH, MPA
COIIN Coordinator / Senior Public Health Analyst
Office of Epidemiology and Research
Maternal and Child Health Bureau
Health Resources and Services Administration
U.S. Department of Health and Human Services
COIN concept from Gloor *

- A COIN is a team of self-motivated people with collective vision, enabled by the Web to collaborate in achieving a common goal by sharing ideas, information, and work.

- In a COIN:
  - Collaborate & communicate directly rather than through hierarchies
  - Innovate and work toward common goals.
  - Work in patterns characterized by: meritocracy, transparency, and openness to contributions from everyone.
  - Have “swarm intelligence” or “swarm creativity”.
  - Work within ethical code and a small-world network of trust.

- HRSA-MCHB adapted the COIN approach to reflect focus on both innovation and improvement

**Collaborative Improvement & Innovation** Network to Reduce Infant Mortality = COIIN

Infant Mortality CoILIN: History and Vision

- Developed and implemented in ongoing partnership with ASTHO, AMCHP, March of Dimes, CityMatCH, CMS, and CDC and other public and private partners.

- Team driven and designed to address stated needs:
  - Support collaborative learning, innovation, and quality improvement efforts to reduce infant mortality and improve birth outcomes;
  - Apply evidence-based strategies to reduce infant mortality;
  - Stimulate action across states, among many partners.

- Started in Southern states:
  - Born out of January 2012 Infant Mortality Summit in New Orleans, LA for Regions IV and VI as well as previous state-level work by ASTHO and March of Dimes.

- Nation-wide expansion planned.
CoINN Design

State Teams
- State Health Officials
- MCH staff
- Medicaid staff
- Private partners
  - Average 7-15 people

Strategy Teams
- Strategy Leads (2-3 topical experts)
- Data and/or Methods Experts
- Staff support (MCHB & Partner Organizations)
- State Representatives
  - Average 30-35 people

Common Strategies for Regions IV and VI
- Promote smoking cessation
- Expand Interconception Care in Medicaid
- Reduce elective deliveries
- Enhance perinatal regionalization
- Promote safe sleep

Contract Team with expertise in quality improvement + Advisory Panel
Interconception Care and Medicaid Strategy Team Leadership

ICC and Medicaid Strategy Team Support

• Stephen Cha, MD, MHS
  • Chief Medical Officer, Center for Medicaid and CHIP Services

• Rebekah E. Gee, MD MPH MSHPR FACOG
  • Director, Louisiana Birth Outcomes Initiative

• Alfred W. Brann, Jr., MD
  • Professor of Pediatrics, Emory University School of Medicine

ICC and Medicaid Strategy Team Support

• Kay Johnson, Johnson Group Consulting, Inc.

• Debra Wagler, Division of State and Community Health, MCHB/HRSA

• Brent Ewig, Association of Maternal and Child Health Programs

• Cheryl Robbins, Division of Reproductive Health, CDC
Concept of Interconception Care (ICC)

• The 2006 CDC Recommendations for Improving Preconception Health and Health Care gave a specific and focused definition to interconception care (ICC).
  • Distinct from preconception care, ICC is designed to be follow up to an adverse pregnancy outcome.
  • One of CDC goals was to: “reduce risks indicated by a previous adverse pregnancy outcome through interventions during the interconception period, which can prevent or minimize health problems for a mother and her future children.”

• Widespread expert consensus that ICC is a concrete and effective way to take action on what research tells us about improving the health of women prior to conception.
  • Building on knowledge that the single best predictor of preterm birth is a prior preterm birth.
  • Reflecting published literature, evidence base.
Pregnancy Outcomes Associated with Future Adverse Pregnancy Outcomes

• Fetal mortality (stillbirth) and infant mortality
• Preterm birth ($\leq$37 weeks gestation)
• Low birthweight and very low birthweight
• Maternal complications (prevalence and predictive value for future health)
  • Diabetes (gestational diabetes and/or Type II diabetes)
  • Hypertension (essential and/or pregnancy induced hypertension)
  • Postpartum depression/mood disorders
Medicaid ICC Project Pathways

Waiver eligibility OR Women currently eligible

Risk characteristics of woman to qualify for interconception care
- Adverse pregnancy outcome: Fetal/infant mortality;
  Low birthweight / very low birthweight / preterm birth
- Maternal risks: Hypertension, Diabetes, Depression/mood disorders

Case Management Opportunities
- Targeted (medical assistance) case management or Administrative case management
- Primary care case management / care coordination in health home
- Chronic disease management

Delivery system opportunities
- Managed care and primary care case management -- Integrated delivery systems
- Chronic care model and/or disease management
- Medical home

Focus, main strategy
Define criteria to qualify for enhanced services
Select strategy for case management
Determine health care delivery system opportunities
What could Medicaid do now?

“Almost shovel ready” projects that do not require a waiver!!!

- Postpartum visit as gateway to ICC
- Case management/targeted case management
- Screening/assessment pilot or QI projects
- Integrated care models (e.g., ACO)
- Medical/health home for individuals with chronic conditions/mental health conditions
- Billing codes & provide manual changes
A. (Between January and December 2013), State A will extend prenatal case management for one year to women with continuing coverage who experienced (since October 2012) an adverse outcome of a Medicaid financed birth.

B. (Between January and December 2013), State B will finance intensive, targeted case management for one year to women with continuing coverage who experienced (since October 2012) an adverse outcome of a Medicaid financed birth.
More Project Ideas in a Nutshell: Postpartum Visits

C. *(Between January and December 2013)*, State C will convene a **provider learning collaborative** to increase the utilization and quality of the postpartum visits among women who had a Medicaid financed birth *(since October 2012).*

D. *(Between January and December 2013)*, State D will **monitor utilization and give feedback to providers regarding postpartum visits** among women who had a Medicaid financed birth *(since October 2012).*
More Project Ideas in a Nutshell: Health homes for chronic conditions

E. (Between January and December 2013), State E will designate providers and finance health homes to better coordinate and manage the health of women with continuing eligibility who have chronic conditions and a Medicaid financed birth with an adverse outcome (since October 2012).

- State option became effective on January 1, 2011, done through SPA
- Like medical home model, encompasses all the medical, behavioral health, and social supports and services needed by a beneficiary with chronic conditions
- Chronic conditions described in ACA include a mental health condition, a substance use disorder, asthma, diabetes, heart disease, and being overweight
- States may elect to target individuals with higher numbers or severity (waives comparability)
- Only health home services qualify for the 90% FMAP, including:
  - Comprehensive care management;
  - Care coordination and health promotion;
  - Comprehensive transitional care from inpatient to other settings, including appropriate follow-up;
  - Individual and family support, which includes authorized representatives;
  - Referral to community and social support services, if relevant; and
  - Use of health information technology to link services, as feasible and appropriate
RECOMMENDATIONS FOR HHS ACTION IN A NATIONAL STRATEGY TO REDUCE INFANT MORTALITY

Secretary’s Advisory Committee on Infant Mortality (SACIM)

Summary from November 14, 2012
Strategic Directions: 6 Big Ideas

1. Improve the health of women.
2. Ensure access to a continuum of safe and high-quality, patient-centered care.
3. Redeploy key evidence-based, highly effective preventive interventions to a new generation.
4. Increase health equity and reduce disparities by targeting social determinants of health through investments in high-risk communities and initiatives to address poverty.
5. Invest in adequate data, monitoring, and surveillance systems to measure access, quality, and outcomes.
6. Maximize the potential of interagency, public-private, and multi-disciplinary collaboration.
Oklahoma Partnership

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Oklahoma

- Overall Population: 3,751,351
- Racial/Ethnic:
  - White (72.1%)
  - Black (7.4%)
  - American Indian (8.5%)
- Age:
  - <18 (24.8%)
  - 18-24 (10.2%)
  - 25-44 (25.8%)
  - 45-64 (25.8%)
  - 65+ (13.5%)
- Women of Reproductive Age:
  - 736,629 females aged 15-44 years
  - 19.6% of population

Source: U.S. Census Bureau, 2010 Census.
Maternal and Child Health (MCH)

- Child and Adolescent Health
- MCH Assessment
- Perinatal and Reproductive Health

In 2011:
Those served under Title V:
- 79,930 pregnant women
- 64,796 infants less than one year old
- 621,819 individuals one to 22 years old
Those served under Title X:
- 59,452 males and females
“SoonerCare”
Oklahoma’s Medicaid Program

- Serves 1 in 4 Oklahomans
- Over 1 million members in SFY2012
- 58% female
- 73% of kids under 5 were enrolled at some point during SFY2012
SoonerCare Population by Age

- Children Age 18 and Younger: 57%
- Adults Age 19 to 64: 36%
- Adults Age 65 and Older: 7%
SoonerCare Population by Race

- Caucasian: 68.25%
- African American: 12.76%
- American Indian: 11.26%
- Hawaiian or Other Pacific Islander: 0.04%
- Multiple or Other Races: 5.91%
- Asian: 1.53%
SoonerCare & Pregnant Women

More than 64% of pregnant women delivering in Oklahoma receive health care services reimbursed by SoonerCare.
Oklahoma Births Compared to SoonerCare Deliveries for Calendar Year

- SoonerCare Deliveries
- Oklahoma Births

Oklahoma Births figures are from OSHD and SoonerCare Deliveries figures are from OHCA

* 2009, 2010, and 2011 Oklahoma Births data are preliminary figures.

4/2/2012
Partnership

• Agencies established a joint Perinatal Advisory Task Force in 2005

• Assists both agencies in developing improved policies and services for Oklahoma’s low income women
Perinatal Advisory Taskforce
Member Organizations

- OU Department of Obstetrics & Gynecology
- OU Medical Center Women’s Services
- OSU Department of Obstetrics & Gynecology (Tulsa)
- American College of Nurse-Midwives (OK Chapter)
- American Congress of Obstetricians and Gynecologists
- American Academy of Pediatrics (OK Chapter)
- Association of Women’s Health, Obstetric, and Neonatal Nurses
- Oklahoma Institute for Child Advocacy
- Oklahoma Family Network
- Oklahoma Academy of Family Physicians
- Oklahoma Hospital Association
- Oklahoma Nurses Association
Perinatal Advisory Taskforce
Member Organizations

• Oklahoma Osteopathic Association
• Oklahoma Primary Care Association
• Oklahoma State Medical Association OB/GYN
• Oklahoma City Indian Clinic
• Office of Perinatal Quality Improvement
• Central Oklahoma Integrated Network System
• Central OK Perinatal Coalition
• Community Services Council of Greater Tulsa
• March of Dimes
• Maternal Fetal Medicine
• Family Representative
• Private Insurance Providers
• Fetal & Infant Mortality Review – OKC and Tulsa
Leadership Team

• Maternal and Child Health
• Oklahoma Health Care Authority
• Office of Perinatal Quality Improvement
• March of Dimes
• Oklahoma Hospital Association
• Oklahoma Family Network
Accomplishments in Policy Change & Additional Benefits

• Prenatal risk assessment
• First trimester ultrasounds
• Perinatal dental
• Maternal and infant health social work services
• Lactation consultation services
• Genetic counseling services
• Soon-to-be-Sooners
• Tobacco cessation counseling
• Support for hospital R/T quality care
• Title V needs assessment/priorities
• Movement from 1115a Family Planning Waiver to State Plan Amendment (SPA)
Looking to the Future
Time for Change

• Task forces intended for targeted, short term projects
• Transition from task force to state level perinatal coalition
• Challenges
  – Identifying physician champions
  – Coordinating administrative support with change in leadership
  – Listening to the needs of individual members
Preparing for a Lifetime, It’s Everyone’s Responsibility

- Preconception/Interconception
- Tobacco Cessation
- Prematurity (Every Week Counts)
- Breastfeeding
- Postpartum Depression
- Infant Safe Sleep
- Infant Injury Prevention
- Data
- Communications
Collaborative Improvement & Innovation Network (COIIN) Groups

- National groups working on similar focus areas:
  - Preconception/Interconception Care
  - Smoking Cessation
  - Prematurity – elective deliveries prior to 39 weeks
  - Perinatal Regionalization
  - Safe Sleep
Preconception/Interconception Activities

• Tools
  • Women’s Health Assessment
  • Reproductive Life Plan
    • Adolescents
    • Males
• Public Service Announcements/Media
• Family Planning
• OHCA Quality Initiative
  —Adolescent Well-Child Visits
Women’s Health Assessment
Adolescent Reproductive Life Plan
Related Activities

• Shared Data Workgroup
• High Risk Infant Mortality Project (10 rural counties with highest infant mortality rates)
• Tobacco cessation activities:
  • SoonerQuit Prenatal Initiative
  • SoonerQuit for Women Campaign
SoonerQuit for Women

Bridgette Hennings, 26 | Smoked 10 years | Smokefree 2 years

“I picked a date, and I said, I’m gonna do it. I’m gonna take this day to change my life. And I did. You can quit smoking. Just believe in yourself.”

Mary Trail, 28 | Smoked 9 years | Smokefree 2

“When I said no to the urge to smoke, I was proud. It was like giving myself a pat on the back.”

Kendra Flanagan, 27 | Smoked 8 years | Smokefree 3 years

“Don’t give up on quitting smoking. I am healthier. My family is healthier.”
SoonerQuit for Women

Taryn Goodwin, 26 | Smoked 8 years | Smokefree 3 years

“It starts today. You don’t have to wait. You can quit smoking now.”

Seiglinde Owens, 35 | Smoked 13 years | Smokefree 3 years

“I had to quit for my kids. So they could have a mom around. If I can do it, you can do it.”

Sonny Mac, 35 | Smoked 10 years | Smokefree 4 years

“Live your life. Enjoy your life. There are so many other things that you can enjoy besides picking up a cigarette. Life is so much more than that.”
Opportunities & Challenges

• Expand OHCA FIMR Initiative
• Tobacco Cessation Counseling (Well Child Visit)
• Postpartum Depression Screening (Well Child Visit)
• Pregnancy Medical Home
• Member Incentives
• Other opportunities
Lessons Learned

• Reach out – take the initiative
• Identify common problems/needs
• Relationships, Relationships, Relationships
• Listen to one another
• Be open to change
• Understand that it cannot always be a group hug; you will not always agree
• Do not be static, constantly assess needs
Questions or Comments?
Thank you for attending “Opportunities and Strategies for Improving Preconception Health through Health Reform”

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The recording will be posted on www.amchp.org