Attachment A: **TEMPLATE FOR TRANSFORMATION PROJECT SUGGESTIONS**

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Project Title	***Improve prenatal and perinatal care access***

Rationale for the Project

According to the Washington State Department of Social and Health Services[i], Medicaid women continue to see worse health care outcomes compared to non-Medicaid women in the state.

After a stable period during the 1990s, the number of births to Washington women increased by 13% from 2000-2002 to 2008. In 2008, the number of births to Washington residents reached an all-time high of 90,334, with 47.8% (43,163 births) to women with Medicaid-paid maternity care. The largest growth in Medicaid deliveries has occurred among Undocumented Women: in 1989, Undocumented Women accounted for just 2% (405 births) of Medicaid births; by 2008, this figure had increased ten-fold to 20.4% (8,810 births).

Prenatal care access has declined since 2002, reflected by both decreases in first trimester prenatal care entry and increases in late or no prenatal care. Medicaid women continue to have lower rates of first trimester entry than higher-income Non-Medicaid women. The rate of first trimester entry has been decreasing since 2003, especially for low income women and in certain locales, with slight increases in 2008 for both Medicaid and Non-Medicaid women. Late (third trimester) or no prenatal care has continued to rise for both Medicaid and Non-Medicaid.

Evidence-based support:
Prenatal and perinatal care is key to improve the health of both the mother and child after birth. Key initiatives for improving mother and child health are:

- Support breastfeeding initiation, continuation, and baby-friendly practices; Ensure and support best practices to prevent morbidity and mortality associated with obstetrical hemorrhage; Decrease statewide cesarean section rate, and decrease variability in cesarean section rates in hospitals throughout Washington; Improve maternal morbidity and mortality statewide; Ensure women receive comprehensive, evidenced-based, and timely prenatal and postpartum care; Postpartum care should effectively address and support breastfeeding initiation and continuation, contraception, and ensure follow-up and treatment of medical co-morbidities.

The following link provides studies that demonstrate an evidence base for the early provision of prenatal care.
http://www.hrsa.gov/quality/toolbox/measures/prenatalfirsttrimester/part6.html#2

Benefit for Medicaid beneficiaries:
Maternal, infant and child health is a Healthy People 2020 objective for the federal government. Additionally, CMS is particularly interested in increasing quality outcomes for Medicaid patients.[ii] Medicaid covers women during pregnancy and through one year after birth. Pregnant women, children and mothers make up a significant portion of the Medicaid care provided in Washington. These patients would benefit immensely from proactive, preventive care to ensure healthy newborns and maternal health.

Project Description

Which Medicaid Transformation Goals[iii] are supported by this project/intervention?
X Reduce avoidable use of intensive services
X Improve population health, focused on prevention
1. Accelerate transition to value-based payment
X Ensure Medicaid per-capita growth is below national trends

This project links to multiple Medicaid Transformation Goals. Healthy births reduce the need for the use of intensive inpatient services such as the newborn ICU. Additionally, healthy newborns improve population health by improving the health of communities from birth.

Which Transformation Project Domain(s) are involved?
X Health Systems Capacity Building
X Care Delivery Redesign

X Population Health Improvement – prevention activities

Target populations: Pregnant women and newborns – focus on high-risk populations if possible.

Project goals, interventions and outcomes expected during the waiver period, including relationship to improving health equity /reducing health disparities:

1. Implement evidence-based prenatal care models, such as CenteringPregnancy
2. Achieve baby-friendly hospital designation through supporting exclusive breastfeeding prenatally, after delivery, and for 6 months after delivery and using lactation consultants after delivery.
3. Encourage best practice and facilitate provider education to improve cesarean section rates, and decrease inequities among cesarean section rates. Participate, as appropriate, in statewide QI initiatives for first-birth low-risk cesarean births.
4. Coordinate care for women in the post-partum period with co-morbid conditions including diabetes and hypertension
5. Implement initiatives to further the goals in Washington's Safe Deliveries Road Map
6. Expand the use of community health workers through partnership with health department
7. Expansion of maternity support services
8. Expand the nurse family partnership program beyond first time mothers
9. Partner with social services to strengthen supports provided (i.e., WIC providing timely formula, or prioritizing homeless pregnant women for housing)

Links to transformation initiatives: This links to the Safe Deliveries Roadmap and the goals of HCA's First Steps program.

Potential Partners:
Community-based organizations are key to expanding access to prenatal and perinatal care.

Core Investment Components

Proposed activities cost estimates: In 2008, there were 43,163 births to women that were covered by Medicaid. According to an AHRQ report, the mean cost for prenatal care for Medicaid women was $2,142[iv]. A very rough estimate puts providing consistent prenatal care for the state Medicaid population at around $100 million assuming all patients are reached and provided prenatal care. On an individual project level, Rainier Health Network serves approximately 10,000 births per year.

Length of implementation: The implementation time can be relatively short, from a few months to a year depending on ability to hire staff and launch programs effectively.

Return on investment: There is a proven return on investment for prenatal care. Medical costs for a healthy baby are fairly low, costing $4, 551, from birth (including labor & delivery) through the first year[v]. But, for a preterm baby who needs intensive care, the costs average $49,033. Health care payers—employers, health plans, federal and state Medicaid programs, and individuals—all share the cost of caring for premature babies. Preterm births cost the U.S. economy $26.2 billion annually in medical, educational and lost productivity.

Project Metrics

Metric	Measure Steward	Benchmark data
Exclusive Breast Milk Feeding (PC-05)	JNC	Suggest that a state benchmark be set
Baby Friendly Hospital designation	Baby-Friendly USA	n/a
Percentage of Low Birth- weight births	CDC	Suggest that a state benchmark be set
Pre-term birth rates	TBD	Suggest that a state benchmark be set
Cesarean Section (PC-02): Number of nulliparous women with a term, singleton baby in a vertex position delivered by cesarean section	JNC	Suggest that a state benchmark be set
Unexpected Newborn Complications (UNC)	CMQCC	Suggest that a state benchmark be set
Prenatal and Postpartum Care (PPC)	NCQA	Suggest that a state benchmark be set

Timeliness of Prenatal/Postnatal Care	HEDIS	Suggest that a state benchmark be set
Frequency of ongoing prenatal care	AHRQ	Suggest that a state benchmark be set
Infant Mortality	CDC	Suggest that a state benchmark be set

[i] https://www.dshs.wa.gov/sites/default/files/SESA/rda/documents/research-9-98.pdf

[ii] https://www.medicaid.gov/medicaid-chip-program-information/by-topics/quality-of-care/maternal-and-infant-health-care-quality.html

[iv] http://meps.ahrq.gov/mepsweb/data_files/publications/rf27/rf27.pdf

[v] Thomson Reuters. The Cost of Prematurity and Complicated Deliveries to U.S. Employers. Report prepared for the March of Dimes, October 29, 2008.