

Advancing Preconception Wellness: Health System Learning Collaborative

Webinar #3

September 15, 2016 | 4PM EST

Dial in : 1-800-371-9219

Participant Code: 6080761

Agenda

- Welcome and Introductions
- Learning Collaborative Goals & Format
- Presentation from Mission Health Partners(ACO)
- Presentation from Health Share of Oregon (CCO)
- Samaritan Health Services (CCO)
- Group Discussion
- PCHHC Conference



Preconception health Show Your Love supporters

Engaged Organizations: Check –in

1. Alabama State Department of Health, Title V
2. The Providence Community Health Centers (FQHC), RI
3. Ohio State Hospital Association and Ohio Perinatal Quality Collaborative
4. Washington State Hospital Association
5. County Care Health + Cook County Health System, Illinois
6. New York State Department of Health
7. The VA Health System
8. The Shiprock Service Unit (Navajo)
9. Health Share of Oregon
10. Samaritan Health Services, Oregon
11. Mission Health Partners, NC
12. UC Davis

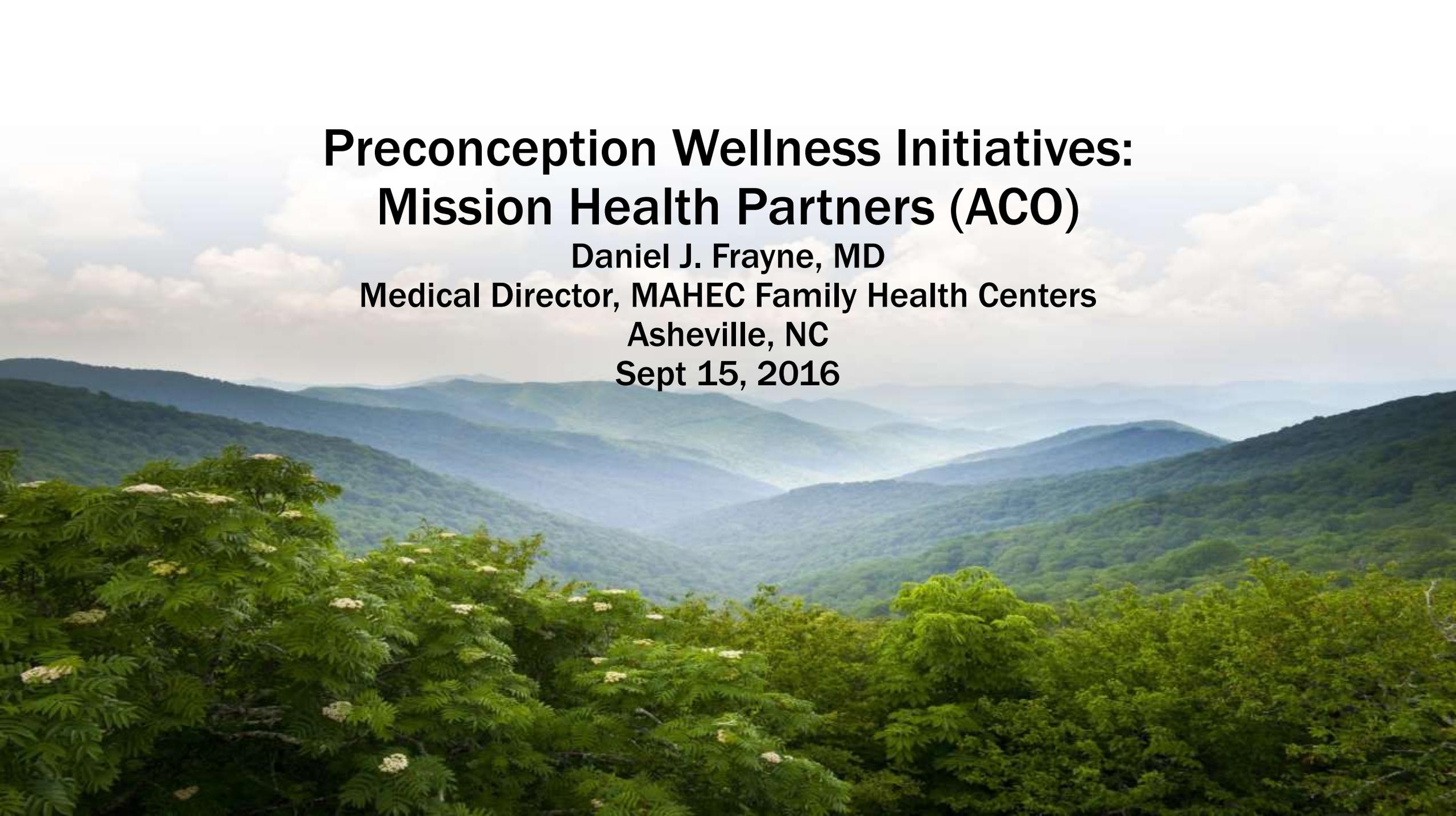
Learning Collaborative Goals

- Share ideas
- Develop and disseminate best practices and strategies
- Define barriers and challenges
- Develop solutions
- **Ultimate goals:**
 - Develop a series of recommendations for system level integration of preconception health
 - At an in person meeting, draft results for publishing

Webinar Structure:

System level preconception health

- Five 30-45 minute sessions
- 1-3 Individual Site Briefs
 - For Preconception Health, share
 1. Your organization's goals regarding preconception health– what are you trying to accomplish?
 3. What do you plan to measure?
 4. What concrete strategies are using to collect the data?
 5. What are the biggest challenges you face to move forward?
- Facilitated Discussion
 - All collaborative members participate in ideas or solutions
 - Results will be recorded and tabulated



Preconception Wellness Initiatives: Mission Health Partners (ACO)

Daniel J. Frayne, MD

Medical Director, MAHEC Family Health Centers

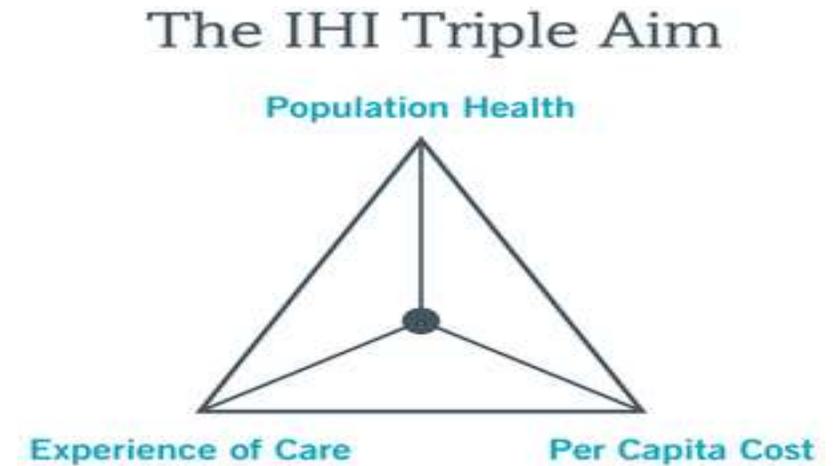
Asheville, NC

Sept 15, 2016

Objectives

- Overview of MHP ACO
- Care Process Models
 - Diabetes
 - Preconception Care
- Piloting PCW measures at MAHEC OB
 - Process
 - Challenges

What is an Accountable Care Organization?



- Group of physicians, hospitals and other healthcare entities that network together to achieve higher quality and efficiency
- Standardize evidence based practice
- Organize resources around team based care, care management, technology to take care of the population

ACO: The Business Model



- The most common program is the Medicare Shared Savings Program
 - Share in the cost savings CMS receives by providing this care
 - NC Medicaid *may* follow suit
- MHP initial efforts concentrate on the highest utilizers and highest cost patients

Western North Carolina Medical Facilities



-  Hospitals
-  Urbanized Areas *
* 2000 U.S. Census Bureau Urban Areas



8 Hospitals
78 Primary Care Practices
120 Specialty practices



WHAT IS A CARE PROCESS MODEL (CPM)?

- Care Process Models ensure that all care delivered by a hospital and its caregivers is medically necessary, the leading edge in medical science and the appropriate treatment intensity.
- Put into effect, these models will systemize treatment processes across all hospitals and practices, improving consistency as well as effectiveness.

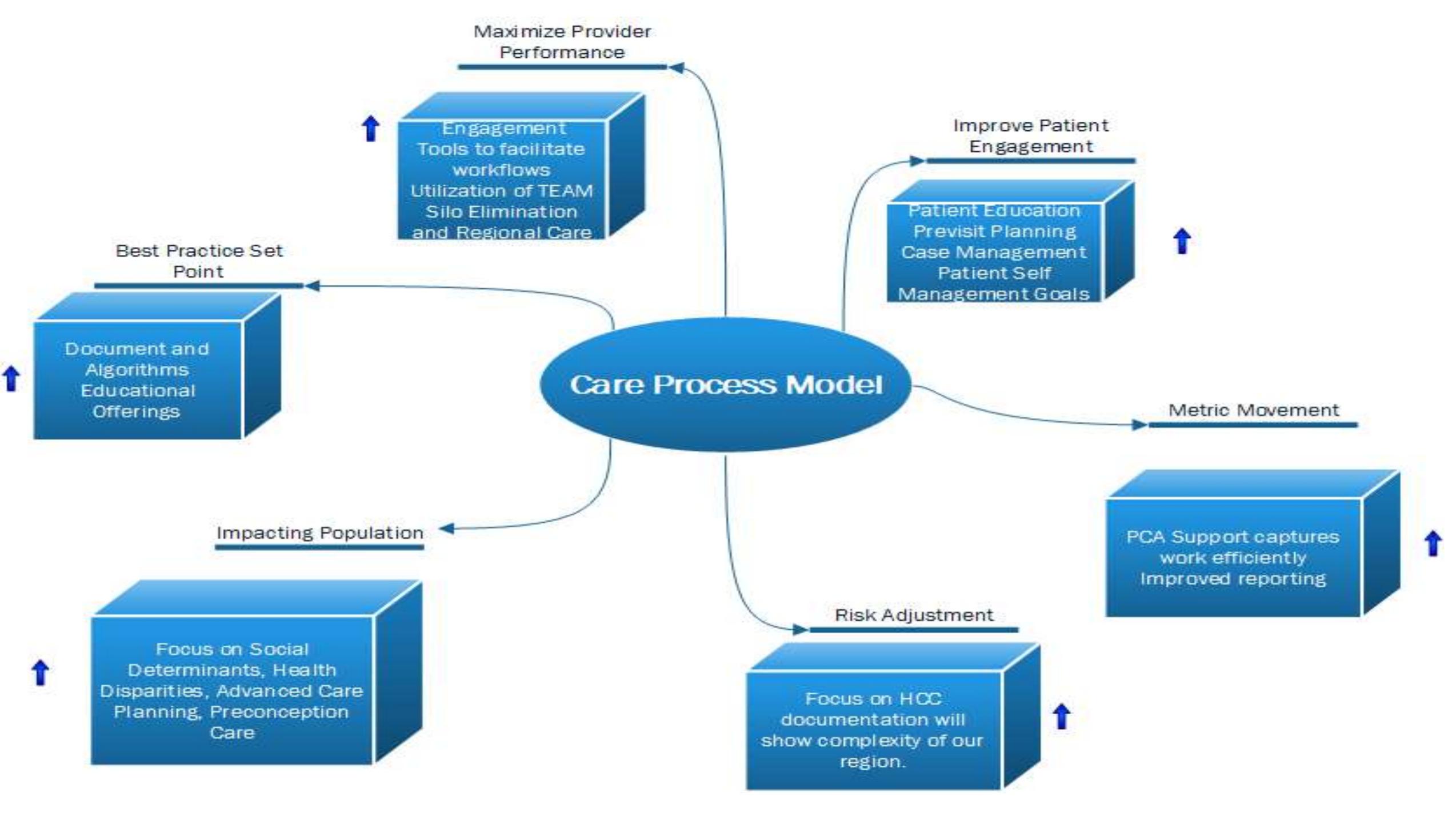
WHAT ARE THE BENEFITS OF A CPM?

- Reduces variation
- Utilizes the best practice from literature and expert opinion
- Improves care delivery repetition
- More readily exposes errors
- Variation study informs revisions to CPMs

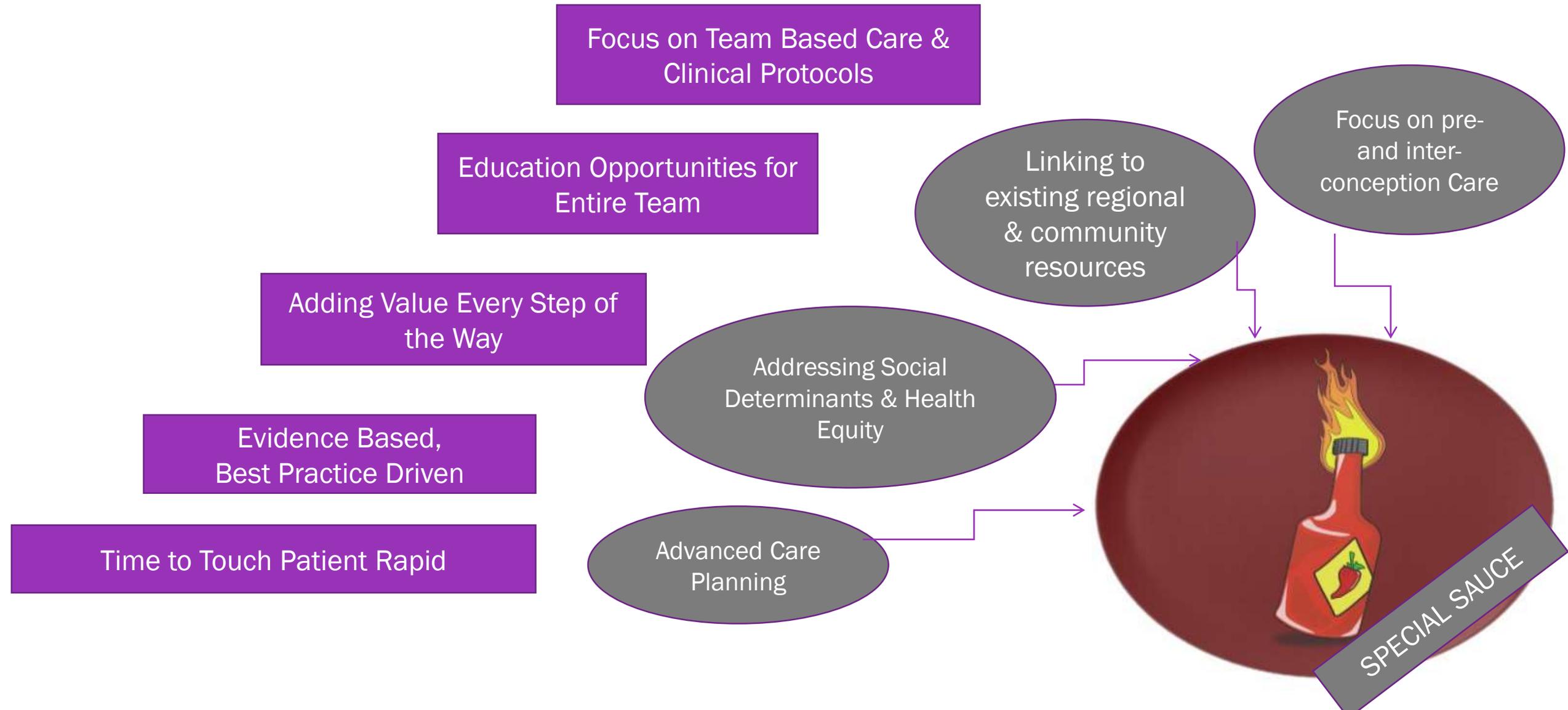
Achieving Our BIG(GER) Aim



Mission Health's BIG(GER) Aim is *to get every person to their desired outcome, first without harm, also without waste and always with an exceptional experience for each person, family and team member.*



What makes a Mission CPM Special?





Care Process Model

*Newly Diagnosed
Diabetes and Prediabetes*



CPM Key Features: Targeting New Diabetes and Pre-diabetes

- Multidisciplinary team approach across the continuum of care
- Evidence-based individualized treatment
- Patient engagement and shared-decision making
- Actionable goal setting
- Preconception counseling

Why Target New Diabetes?

- Highly prevalent: Western NC 13% (US average 9.3%)
 - 63% of western NC adults overweight or obese
- Early diagnosis & treatment prevents complications
 - DM2 asymptomatic early in course
 - Early recognition and treatment DM and cardiovascular risks reduces macro- & microvascular complications.

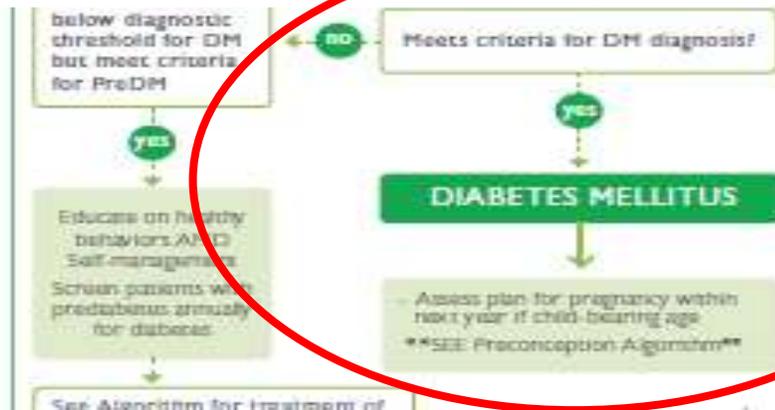
Why Target New Prediabetes?

- Recognition of prediabetes can prevent or delay progression to diabetes.
 - Adoption healthy behaviors and/or medicine reduces risk of progression by as much as 58% at 3 years

ALGORITHM: SCREENING AND DIAGNOSIS OUTPATIENT



- Consider screening every 3 years for adults ≥ 45 years without risk factors
- Diagnostic test for diabetes:
 - Fasting plasma glucose (FPG) with reflex to hemoglobin A1c (A1C) test if > 100
 - A1C Test
 - 2-hour 75-gram oral glucose tolerance test (OGTT)*
- Criteria for diabetes (DM) diagnosis:
 - Two HbA1c values ≥ 6.5
 - Two FPG values ≥ 125 mg/dl
 - Two 2-hour OGTT values ≥ 100 mg/dl
- Criteria for prediabetes (PreDM) diagnosis:
 - Two FPG of 100-125 mg/dl OR
 - Two 2-hour OGTT of 140-199 mg/dl OR
 - Two A1C of 5.7-6.4



INITIAL DIAGNOSIS OF DIABETES RECOMMENDATIONS FOR PRECONCEPTION CARE

All women with a diagnosis of diabetes should receive counselling regarding the risks of her disease for future pregnancies and potential offspring. Providers should work with patients to develop an effective reproductive life plan including highly effective contraceptive methods (such as long acting reversible contraception) with all women with diabetes. Women desiring pregnancy should be counselled on the importance of optimal glycemic control and specialty consultation to decrease maternal and fetal risks.

Strategies for Preconception Care at Initial Diagnosis of Diabetes

- Ask the One Key Question: "Would you like to become pregnant in the next year?"(32)
- Deliver a bundle of educational resources and create a follow-up plan to discuss a reproductive life plan. This should include:
 - o Contraceptive options and local resources
 - o Effect of diabetes on her health and the health of future pregnancies and children
 - o What to do if she desires pregnancy – resources for maternal-fetal medicine (MFM) consultation
 - o Importance of a daily multivitamin with 400 mcg of folic acid (include on med list)

**INPATIENT
FEMALE AGE 18 TO 44 WITH INITIAL
DIAGNOSIS OF DIABETES**

Consult DM Educator

Recommend multivitamin with
400 mcg of folic acid

Ask: "Would you like to
become pregnant in the
next year?"

no

yes

Patient Education
Handouts
- What Is Preconception
Planning – Healthier
Me Plan

Patient Education
Handouts
- What is Preconception
Planning – Healthier
Baby and Me Plan

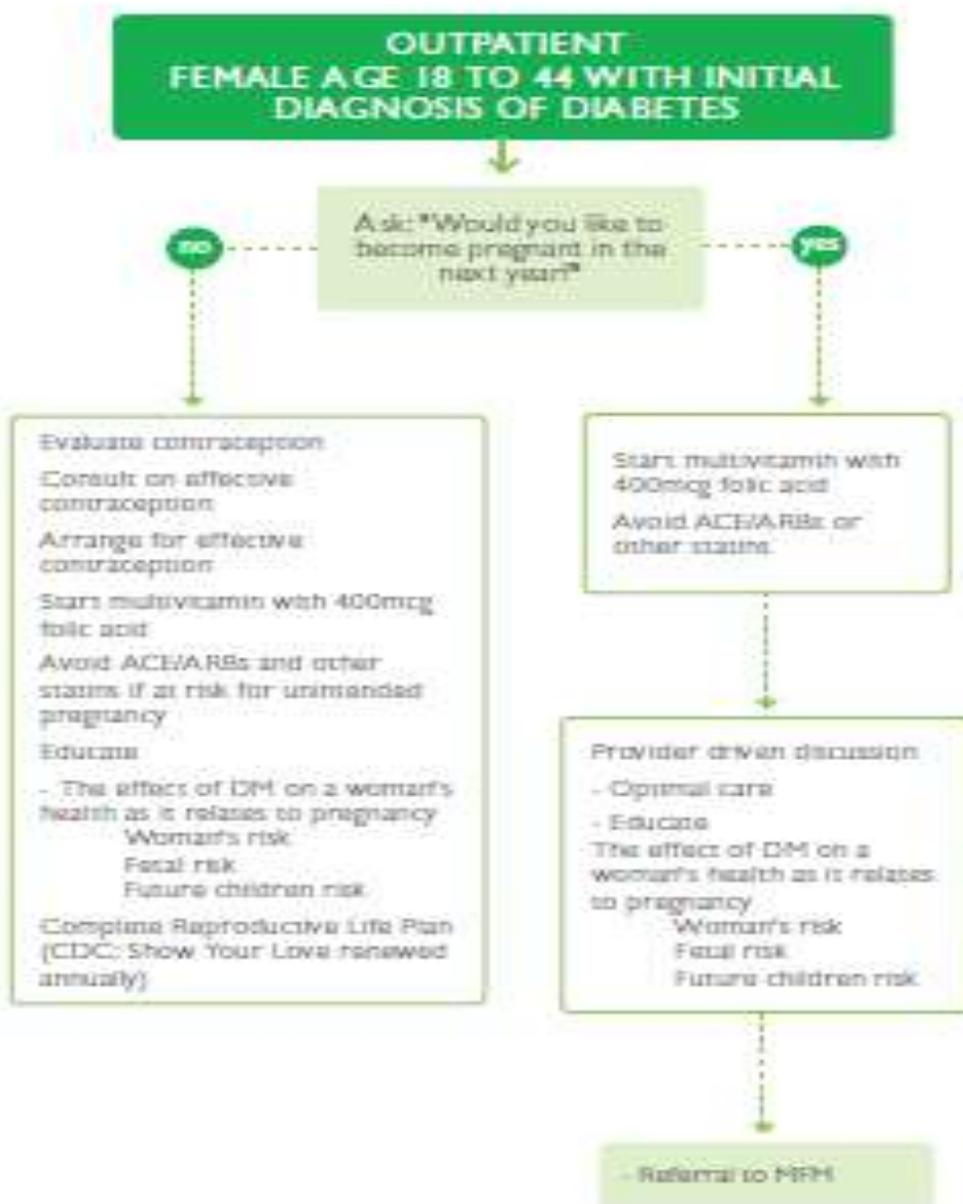
- Referral to PCP:
DM follow up and
Preconception planning

- Referral to MFM
- Referral to PCP:
DM follow up and
Preconception planning

ALGORITHM: INITIAL DIAGNOSIS OF DIABETES RECOMMENDATIONS FOR PRECONCEPTION CARE

WE RECOMMEND THE FOLLOWING:

- Pre-pregnancy goal A1C is < 6.5%. A goal of < 6% is ideal if able to achieve without hypoglycemia
- Recommend multivitamin with at least 400mcg folic acid daily
- Insulin is treatment of choice in woman planning pregnancy
- Avoid statins, ACE inhibitors, and angiotensin receptor blockers (ARBs) in woman who are planning pregnancy or at risk for unintended pregnancy due to teratogenic potential
- Assess other co-morbidities (e.g., CVD, Renal, Retinal, obesity, PCOS, etc.)
- Be aware that control of DM may enhance fertility (i.e., metformin could regulate the menstrual cycle and increase chance for ovulation)
- Pre-gestational DM significantly increases risks for both mother, her pregnancy, as well as the future child's health
- Maternal-Fetal Medicine (MFM) consultation is recommended for all women to discuss future reproductive planning
- Risk factors for unintended pregnancy:
 - On no birth control—and specifically decline of birth control after conversation about risks of unintended pregnancy (!)
 - Prior unintended pregnancy
 - Substance use
 - Young age
 - Mental health issues/depression



DM CPM Metrics - Outpatient

- Reproductive Life Plan:
 - Percentage of female patients age 18-44 with a diagnosis of diabetes who have a documented Reproductive Life Plan
- Use of Multivitamin with Folic Acid:
 - Percentage of female patients aged 18-44 years with a diagnosis of diabetes with a potential for pregnancy who are taking a multivitamin with 400 mcg of folic acid
- MFM Referral:
 - Percentage of female patients aged 18-44 years with a diagnosis of diabetes and who desire to become pregnant in the next 12 months who have a referral to MFM

DM CPM Metrics - Inpatient

- Preconception Care:
 - Percentage of patients aged 18 years and older with a new diagnosis of diabetes who were asked the One Key Question: “Would you like to become pregnant within the next year?”
- MFM Referral:
 - Percentage of female patients age 18-44 with a new diagnosis of diabetes who desire to become pregnant within the next 12 months who were referred to MFM at hospital discharge

Preconception Wellness CPM **(in development)**

**Opportunity for engagement across the continuum of
care**

Will focus on the 9 PCW measures

AND

include IPV screening

(Maybe combine OKQ and IPV screening?)

System Indicators for Preconception Wellness (Obtained at 1st prenatal assessment)*

- PCW#1: Pregnancy Intention
- PCW #2: Access prenatal care in 1st trimester
- PCW #3: Preconception folic acid/multivitamin use
- PCW #4: Tobacco use
- PCW #5: Depression screen/control
- PCW#6: BMI
- PCW#7: Sexually transmitted infection rate
- PCW#8: Optimal blood sugar control in pregestational DM
- PCW#9: Teratogenic medication avoidance

* [Obstet Gynecol.](#) 2016 May;127(5):863-72



OB-GYN Residency

- 4:4:4:4 Ob-GYN Residency with the only MFMs in the region
- Average 52,500 encounters per year with ~2100 deliveries per year
- New patients – average 155 new OB patients per month
 - trending up, 207 per month in the last 3 months
- 85% Caucasian, 10% African American, 5% Latino
- 65% Medicaid (34,125 encounters/year), 20% BCBS, 10% commercial Ins, 5% self pay
- Allscripts EHR
- CCWNC Pregnancy Medical Home Risk screening incentive





PCW Measure Pilot

- **What data was easy to focus on? Where was it obtained?**
 - Healthy Weight – documented in EHR – extractable data
 - Optimal Glycemic Control- documented in EHR – extractable data
 - Tobacco avoidance- documented in EHR – extractable data
 - Absence of STI- documented in EHR – extractable data
 - Entry to Care- CCWNC data (only Medicaid patients)
 - Pregnancy Intention – CCWNC data on risk form (only Medicaid patients)
- **What data was chosen to be too hard for the first round and why?**
 - Preconception Folic Acid use- Not capturing when folic acid was started by woman, not a clear process for documenting in the EHR
 - Teratogen avoidance in chronic conditions – not easily extractable in EHR
 - Absence of depression- not documenting PHQ2/9 on every patient—and not documenting in capturable field
 - currently working to change



PCW Measure Pilot

Challenges:

- We have not begun collecting yet....
 - we weren't able to change what we couldn't extract-- Data team did not want to merge data (CCWNC and EHR) until questions were clarified
- CCWNC data 6 months behind
- QI meetings halted, competing priorities



Comments, Questions, Discussion

Thank you!

Preventive Reproductive Health

The Innovative Work in Oregon

Helen K. Bellanca, MD, MPH

September 2016

One Key Question[®]

*“Would you like to become pregnant
in the next year?”*

Oregon Foundation for Reproductive Health
www.onekeyquestion.org

Contraception Quality Metric in Oregon Medicaid

**Effective contraception use
among women at risk of unintended pregnancy**

Proportion of women 15-50 who are physiologically capable of becoming pregnant and who are using a Tier 1 or Tier 2 method of contraception

(tubal ligation, IUD, implant, shot, pill, patch, ring, diaphragm)

OPHRAC

- Oregon Preventive Reproductive Health Advisory Council
- Convened by state public health partners, Office of Reproductive Health
- Technical Advisory Group for metrics and standards for contraception and preconception care

Contraception Quality Checklist

- Based on CDC guidance documents
- Clinic self-assessment of contraception care
- Domains
 - Competencies
 - 0-1-2 point scoring system
- Total scoring qualifies clinic as “quality family planning provider” or “expert family planning provider”
- Certification process will likely be managed through our state PCPCH system

Counseling guides



Providing Quality Family Planning Services
Recommendations of CDC and the U.S. Office of Population Affairs



QFP: Guide to family planning, infertility, STIs

<http://www.cdc.gov/mmwr/pdf/rr/rr6304.pdf>

<http://www.cdc.gov/reproductivehealth/UnintendedPregnancy/USSPR.htm>

<http://www.cdc.gov/reproductivehealth/UnintendedPregnancy/USMEC.htm>



U.S. Selected Practice Recommendations for Contraceptive Use, 2013
Adapted from the World Health Organization Selected Practice Recommendations for Contraceptive Use, 2nd Edition



SPR: Management issues around initiation and use of contraception



U.S. Medical Eligibility Criteria for Contraceptive Use, 2010
Adapted from the World Health Organization Medical Eligibility Criteria for Contraceptive Use, 4th edition

MEC: Guidance on safety of each method with various health conditions

Contraception Domains

- Access
 - Timeliness of care
 - Affordability
 - Special populations/diversity
 - Language, health literacy, communication
- Service provision
 - Assess for pregnancy intentions
 - Counseling and Education
 - Services for males, youth, postpartum and breastfeeding women
 - Contraception supplies
 - Contraception procedures
 - Contraception management
- Community collaborations
 - Referrals and linkages

2.6 Contraceptive Supplies

- a. Access to oral emergency contraception (EC) onsite.
 - 0 = EC not available onsite.
 - 1 = Administer EC, including Plan B and ella, for immediate use onsite (according to efficacy guidelines for weight and BMI).

- b. Access to broad range of contraceptive methods onsite.
 - 0 = No contraceptive methods available onsite.
 - 1 = Broad range of FDA-approved methods dispensed onsite.
 - 2 = When clinically indicated, up to 1-year supply of broad range of FDA-approved methods dispensed onsite AND LARCs continuously stocked onsite for easy and timely access.

2.7 Contraceptive Procedures: LARC Insertion and Removal/Diaphragm Fitting

- a. IUD insertions/removals.
 - 0 = IUD insertions/removals not offered onsite.
 - 1 = Routine IUD insertions/removals, including for women who are nulliparous, adolescents, or who have yet to engage in sexual activity, offered onsite.
 - 2 = Manage both routine and complicated IUD insertions and removals onsite.

- b. Implant insertions/removals.
 - 0 = Implant insertions/removals not offered onsite.
 - 1 = Routine implant insertions/removals offered onsite.
 - 2 = Manage both routine and complicated implant insertions and removals onsite.

Preconception domains

- Access
- Service Provision
 - Chronic disease
 - Nutrition, exercise, weight
 - Immunizations
 - Genetic counseling
 - Preparation for parenting
 - Behavioral health
- Community collaborations
 - Referrals and linkages

Samaritan Health Services

- “We implemented OKQ in 2015 and used surveys to assess patient acceptance of being asked One Key Question at every visit (where appropriate). The initial response was unfavorable, with fewer than 30% of women wanting to be asked at every visit. This was a surprise to us so we added a preamble to the survey explaining the public health consequences of unintentional pregnancy and that our organization was attempting to ensure that every pregnancy was healthy and wanted. After adding the preamble the acceptance rate leapt to greater than 80% regardless of socio-economic status or education level. We feel it is valuable to explain to the public that we screen everyone so that we can help some.”
- Robert Hughes, MD

Facilitated Group Discussion



Preconception
Health+Health Care Initiative
A National Public-Private Partnership

Before, Between
& Beyond Pregnancy

For the Group

- Thinking about advancing preconception wellness on a health system level:
 - What needs to be measured?
 - What actually can be measured, or is being measured already?
 - Where is the data?
 - What is it going to take to get the data?
 - What is it going to take to report the data to effect change?
- What programs do you need to implement change?
- Who are the stakeholders that need to be at the table?
- Are there any incentives?
- What are the barriers – specifically...

Collaborative Timeline:

Suggested site groupings and dates for future webinars

- **July 28, 2016 at 4PM EST: State Organizations**
 - *Ohio State Hospital Association and Ohio Perinatal Quality Collaborative*
 - *Washington State Hospital Association*
 - *Alabama State Department of Health, Title V*
 - *NY State Department of Health*
- **September 15, 2016 at 4PM EST: ACOs and CCOs**
 - *Samaritan Health Services (CCO)*
 - *Health Share of Oregon (CCO)*
 - *Mission Health Partners (ACO)*

Collaborative Timeline:

Suggested site groupings and dates for future webinars

- **November 10, 2016 at 4PM EST: MCO and Insurers**
 - *County Care Health + Cook County Health System*
 - *UC Davis*

- **January 12, 2017 at 4PM EST: FQHCs, VA, and IHS**
 - *The Providence Community Health Centers*
 - *The VA Health System*
 - *Shiprock Service Unit (Navajo)*

INVITATION: National Maternal Health Summit

- Sponsored by HRSA-MCHB
- Key leaders in field will be present
- We will use the day before for this collaborative
 - Opportunity for PCHHC Clinical and Consumer workgroups to cross-pollinate
- **Purpose:** Compile strategies for integrating system measurement of PCW and implementing PCC into routine clinical care, develop a research agenda and share 'out-of-the box' ideas
- **Dates:** Dec 5-7 (tentative...)
- **Location:** Washington, DC
- Funding is available for our collaborative partners



Next steps

- Cancel the Jan 12 Webinar session
- Should we try and find another date in October to replace?
- Is it possible for those groups to present on Nov 10?
- Comments?
- Feedback?