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Prenatal and Postpartum Playbook

Purpose: The purpose of this document is to assist health centers with optimizing performance for the Prenatal and Postpartum CMS and HEDIS measures as well as to increase access and completion of this necessary health service for the patients they serve.

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Introduction: Prenatal and postpartum visits are essential to perinatal care for both the parent and the child. Getting early and regular prenatal care improves the chances of a healthy pregnancy [Cited]. Regular and timely prenatal care reduces the risk of pregnancy complications and the fetus's risk of complications, improves maternal health, provides an opportunity for education and support, and improves maternal mental health. The weeks following birth are a critical period for a birthing person and their infant, setting the stage for long-term health and

well-being [Cited]. In the Medicaid population that FQHCs serve, there are many known barriers to receiving care, and thus, primary care practices play an important role in helping patients receive this vital prenatal and postpartum care.

PRE-NATAL CARE

TIMELINESS OF PRENATAL CARE MEASURE (PPC-PRE)

Measure Definition

Timeliness of Prenatal Care - The percentage of deliveries that received a prenatal care visit in the first trimester on or before the enrollment start date or within 42 days of enrollment in the organization.

Measure Definition Break-Down

The denominator or eligible population is the number of deliveries of live births on or between October 8 of the year prior to the measurement year and October 7 of the measurement year. For these members, the measure assesses the following facets of prenatal and postpartum care:

1. Prenatal care visit in the first trimester or within 42 days of enrollment, where the practitioner type is an OB/GYN or other prenatal care practitioner or primary care physician (PCP).
2. First Trimester is defined as 280-176 days prior to delivery (or estimated delivery date [EDD]).

CODING FOR GAP CLOSURE

Data Collection

Below relevant coding information for compliance is outlined. Qualifying codes and value sets may change with the measurement year, so it is recommended that health centers verify and update these codes when establishing workflows.

Billing:

- Prenatal visit – When the practitioner is an OB/GYN, other prenatal care practitioner, or PCP, any of the following meet the criteria for a prenatal visit:
    - Bundled service – The date of service for the timely prenatal visit must be indicated on the claim.
    - Prenatal care visit – OB/GYN only.
    - Prenatal care visit – PCPs must include a pregnancy-related diagnosis code.
    - Telephone visits, online assessment, and pregnancy-related diagnosis code. National Provider Identifier (NPI) – The individual NPI must be used. Do not use the clinic NPI.

Below are codes recommended by Medicaid health plans for measure compliance. This table does not represent a comprehensive list of all qualifying codes. For a comprehensive list, please refer to the HEDIS measure technical specifications.

Description	Codes
Prenatal Visits	**CPT:** 99201–99205, 99211–99215, 99241–99245, 99483 **HCPCS:** G0463, T1015
Prenatal Bundled Services	**CPT:** 59400, 59425, 52426, 59510, 59610, 59618 **HCPCS:** H1005
Postpartum Visits	**CPT:** 57170, 58300, 59430, 99501 **CPT-CAT-II:** 0503F HCPCS: G0101 **ICD-10:** Z01.411, Z01.419, Z01.42, Z30.430, Z39.1, Z39.2

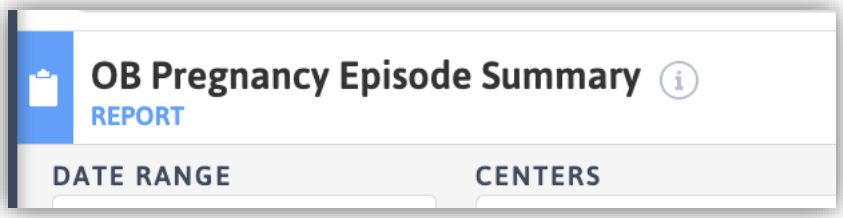
EMR Documentation:
Include one of the following data in the patient's medical record:

- Documentation indicating the person is pregnant, such as:
  - Use of a standardized prenatal flow sheet, or
  - Last menstrual period (LMP), estimated due date (EDD) or gestational age, or
  - A positive pregnancy test, or
  - Gravidity and parity, or
  - A complete OB history, or prenatal risk assessment and counseling/education.
  - A basic physical OB exam that uses a standardized prenatal flow sheet.
- Evidence that a prenatal care procedure was done, such as:
  - a complete OB panel,
  - TORCH antibody panel alone,
  - a rubella antibody test/titer with an Rh incompatibility (ABO/Rh) blood typing, or
  - an ultrasound of a pregnant uterus

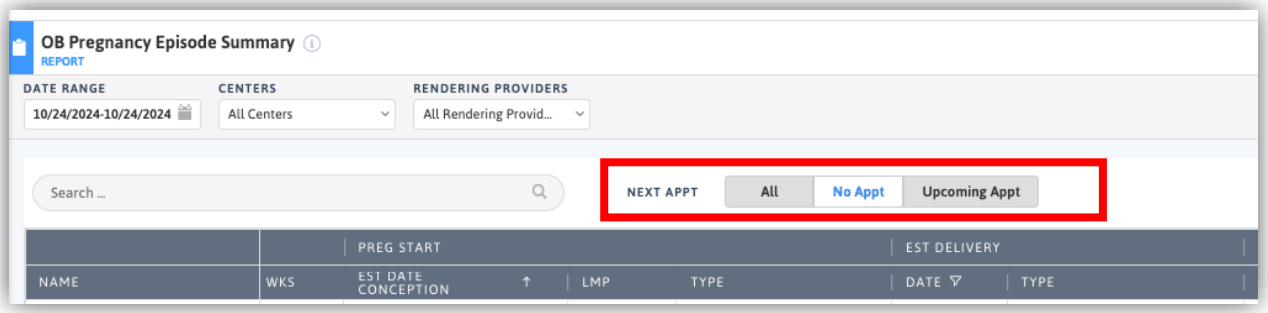
AZARA REPORTS

There are Claim and EMR-sourced reports in Azara that can be utilized for outreach purposes.

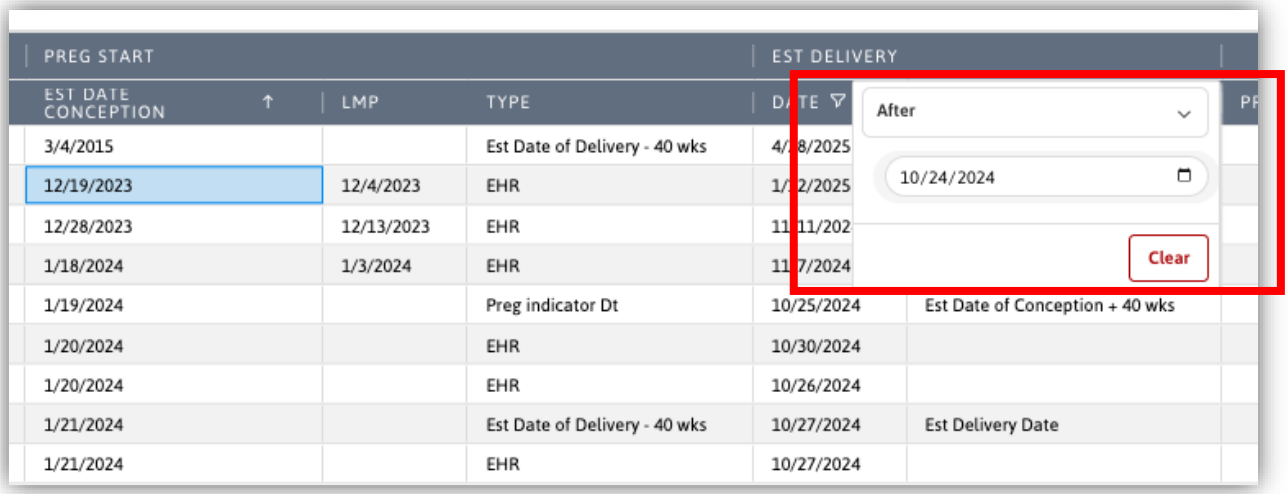
OB Pregnancy Episode Summary Report
The OB Pregnancy Episode Summary Report provides details about the estimated date of conception, delivery date, and more based on health center EMR data. To utilize this report for outreach, use the following steps:



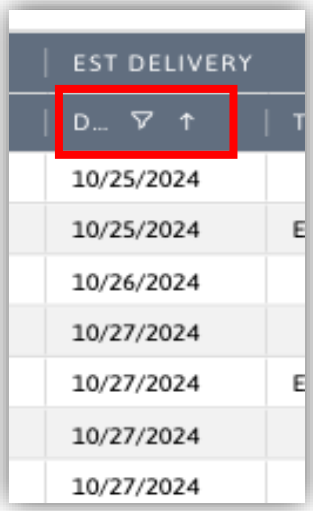
Step 1. Open the report by searching "OB Pregnancy Episode Summary."
Step 2. Filter by Health Center and Providers if applicable.
Step 3. Choose "No Appt" under the "Next Appt Filter" (red box below).



Step 4. Filter the Estimated Delivery Date to be **after** the date which you are searching. For example, if the day is October 24, 2024, filter the Est Delivery Date to be after October 24, 2024 (red box below).



Step 5. Filter the "Est Delivery Date" column to be ascending, displaying the soonest deliveries first. Outreach according to those with the highest priority based on the delivery date. Filter the column by clicking on the column header until the arrow is pointing up (red box below).

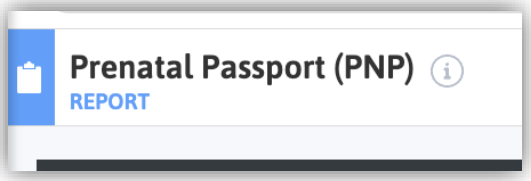


Step 6. Conduct outreach utilizing the scripts in the next section, "Outreach Scripts." Patients' providers may not be populated in Azara if no appointment is scheduled, so outreach staff may need to utilize the EHR to ensure the patient is scheduled with their established OB-GYN or connected to one at the health center.

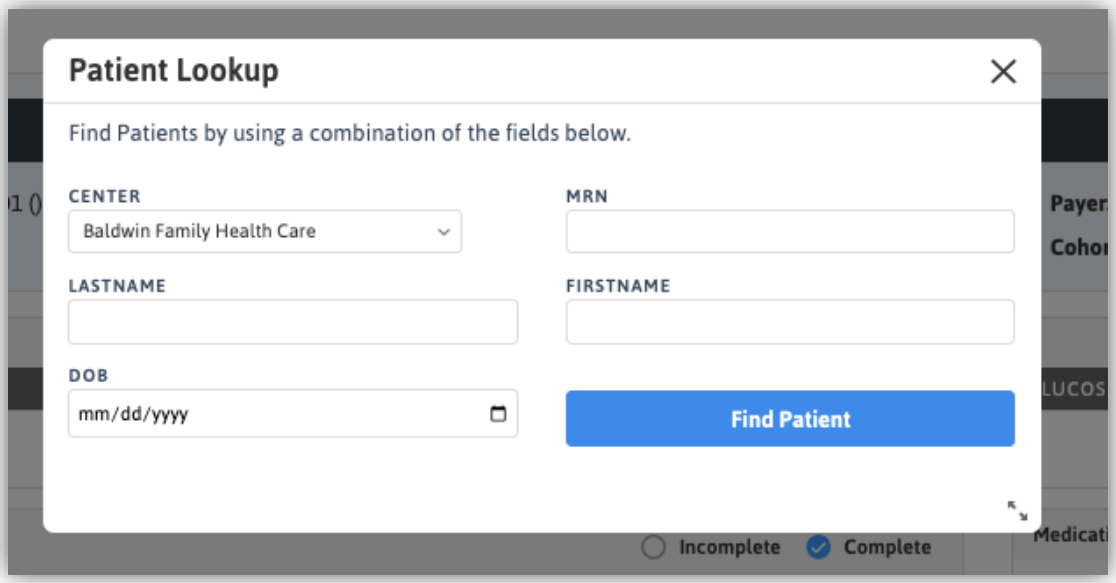
Prenatal Passport

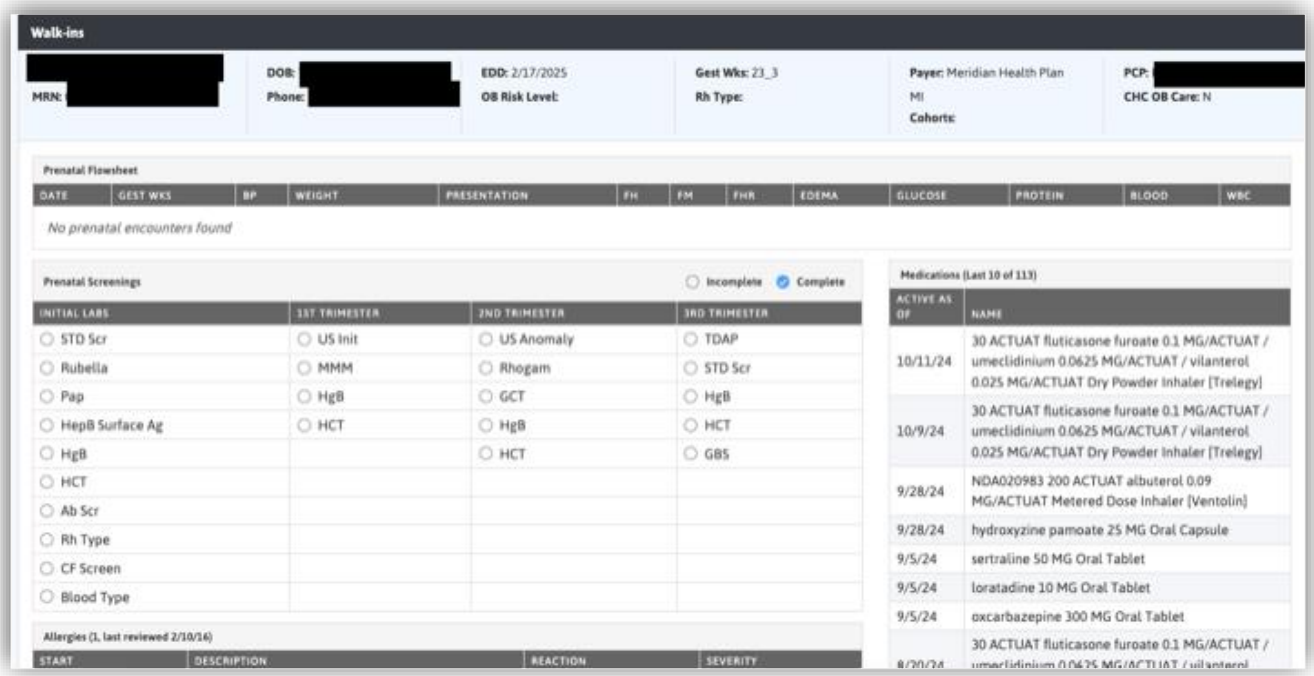
Once a patient has a scheduled appointment, the Prenatal Passport report may be useful for Pre-Visit Planning. The Passport contains information including an estimated delivery date, a summary of prenatal visits, prenatal labs, and medications.

Step 1. Search for the Prenatal Passport Report in the search bar.



Step 2. Search for the patient using identifying information such as their MRN, date of birth, and name. Click on the "Find Patient" button, and then click the patient's name/MRN to bring up their PNP chart.





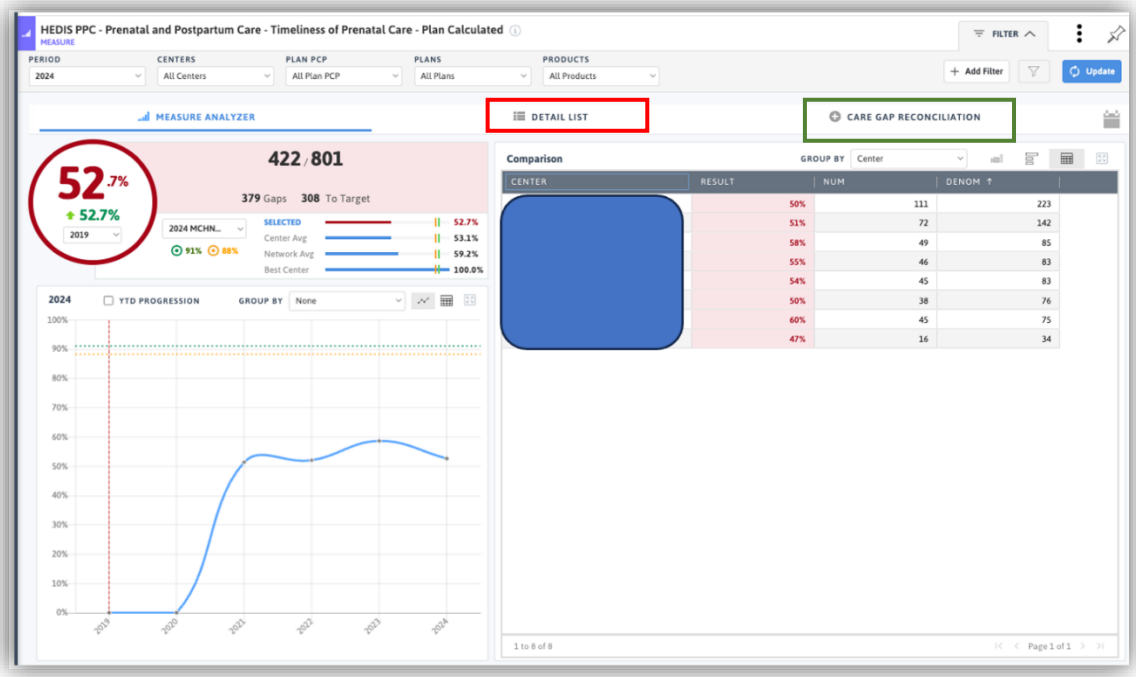
Step 3. The patient's Prenatal Passport will open. Providers can utilize this report as best fits their workflows prior to the patient's appointment, such as ensuring the patient is up to date on vaccines and screenings, has not had recent ED visits, etc.

Additional Measures

There are HEDIS-certified and Azara-certified reports that health centers can use to see gaps in Prenatal Care. However, it is recommended that the following reports are not used for outreach, as the reports are not actionable within the appropriate timeframe to meet gaps for prenatal care. Additionally, the HEDIS measure for PPC-Post limits eligible patients to those who have had a delivery, meaning the prenatal window has passed. These barriers are further explained as relates to each report identified below.

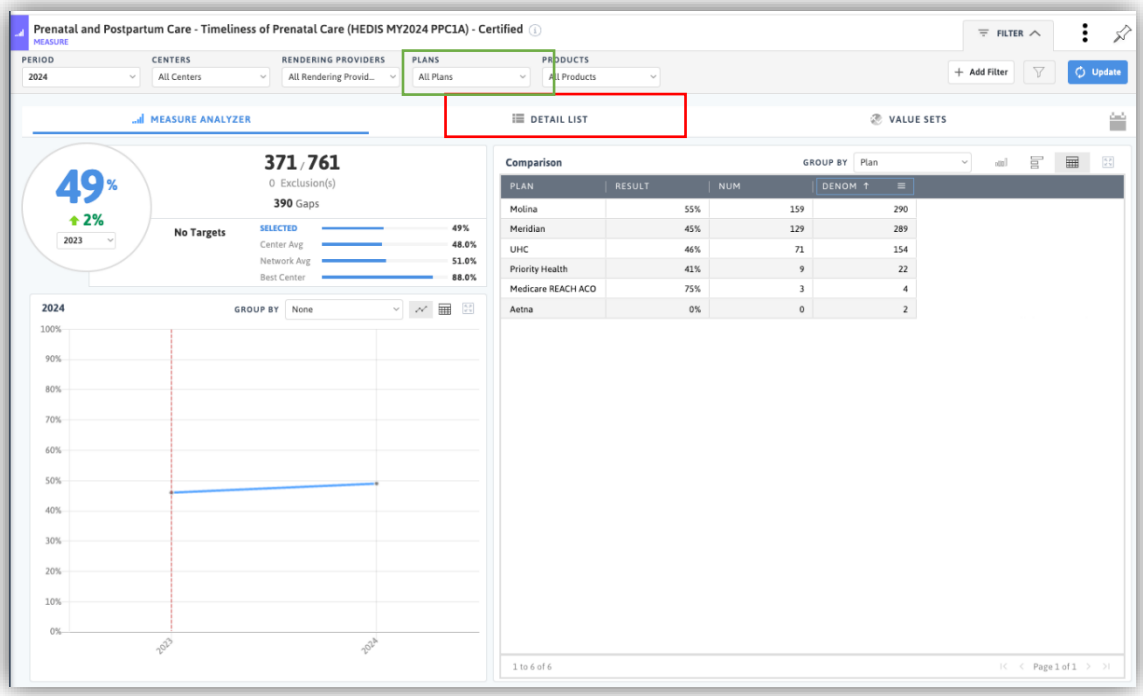
HEDIS-Certified Measure

The **"HEDIS PPC – Prenatal and Postpartum Care – Timeliness of Prenatal Care – Plan Calculated"** measure is a report that uses claims data from health plans. With any sourced claims data, there is a lag of about 90 days for the data to be processed and to be populated into Azara. To see detailed member-level reports for outreach, click the Detail List as depicted below (red box). To see a comparison of care gaps reported by claims versus by the EMR, click Care Gap Reconciliation (green box).



Azara-Certified Measure

The Azara Certified **"Prenatal and Postpartum Care – Timeliness of Prenatal Care (HEDIS MY2024 PPC1A)"** measure is a report that uses EMR-sourced data. To see detailed member-level reports, click the Detail List as depicted below (red box). To see care gaps for a specific health plan, filter by Plans and select desired health plan(s) (green box). Because a delivery is



required to put patients into this prenatal measure, it is a look-back measure and, therefore, cannot be used for prenatal outreach. It may be used for postpartum outreach and that is discussed in the postpartum section below.

OUTREACH SCRIPTS

Script Overview and Key

This script is for use during outreach to pregnant patients who have not had an initial prenatal care visit or who have not had a recent prenatal visit. Based on their usual outreach methods, each practice may have its own resources for transportation, SDOH, etc. that they would like to include in the script. Review and finalize the script for your practice before beginning outreach.

Live Phone Call

Introduction/Getting Patient Scheduled

"Hi, is this <patient name>? I am a <CHW, nurse, MA, etc.> calling from <practice>. My name is <name>. We're calling today about your health needs. Please know that this conversation is completely confidential. Are you in a location where you can speak privately? I am calling because I have on record that you have not had a prenatal visit OR recent follow-up prenatal visit within the past <number of weeks since the last visit>. Is this correct?" *If the patient cannot talk, leave contact information so they can call back.*

If the patient reports they have completed a recent prenatal visit: "That is great! I will make a note of that. Where and when did you get your prenatal visit done?" *Ask the patient when and where they completed this service and ask the patient to have their records sent over. Record in a tracker that the service was completed and note to populate records from the location into local records. Check to ensure that the patient's record release form is signed; if not, send the form during the call so you can gather records.*

If the patient says they have not gotten a recent prenatal visit: "Thank you for taking the time to talk with me today. According to our records, you are overdue for a follow-up prenatal visit **OR** we have never seen you for a prenatal visit. Can we get you scheduled for the prenatal visit that you are due for?" *Wait for the patient's response. If agreeable, then:* "We have on record that you typically see <provider name>. **OR** We do not have a provider on file for you. <Provider name> has appointment availability starting <date>. *Be sure to mention the location that the provider is at.* "What days/times of the week work best for you? We have an appointment available on <date> and <time>. Do you have availability to come in on <day> at <time>?" *Schedule the appointment and record in the tracker.*

Call closure

Always thank a patient for their time and make sure they know how to reach you again: "Thank you so much for your time today. If you need anything leading up to your appointment **OR** in the future, please feel free to reach out to me. Again, my name is <Name> and you can reach me at <phone number or preferred mode of contact>. Have a great day."

If the Patient Refuses To Schedule

If patient refuses: "I understand. You have important reasons which prevent this from being a priority right now. Do you mind if I share the importance of having a prenatal visit?" *Wait for an answer.*

Prenatal visit information

"Prenatal visits are essential to ensuring the health of both you and your growing child. The sooner we can assess your progress and overall health, the sooner we can catch any potential issues and can prepare for you to have a healthy pregnancy. This is why your insurance allows you to have prenatal visits at no cost to you. This visit is free, and we'd really like to see you come in. Can we get you scheduled for an appointment?"

Call closure

Always thank a patient for their time and make sure they know how to reach you again: "Thank you so much for your time today. If you need anything leading up to your appointment **OR** in the future, please feel free to reach out to me. Again, my name is <Name> and you can reach me at <phone number or preferred mode of contact>. Have a great day."

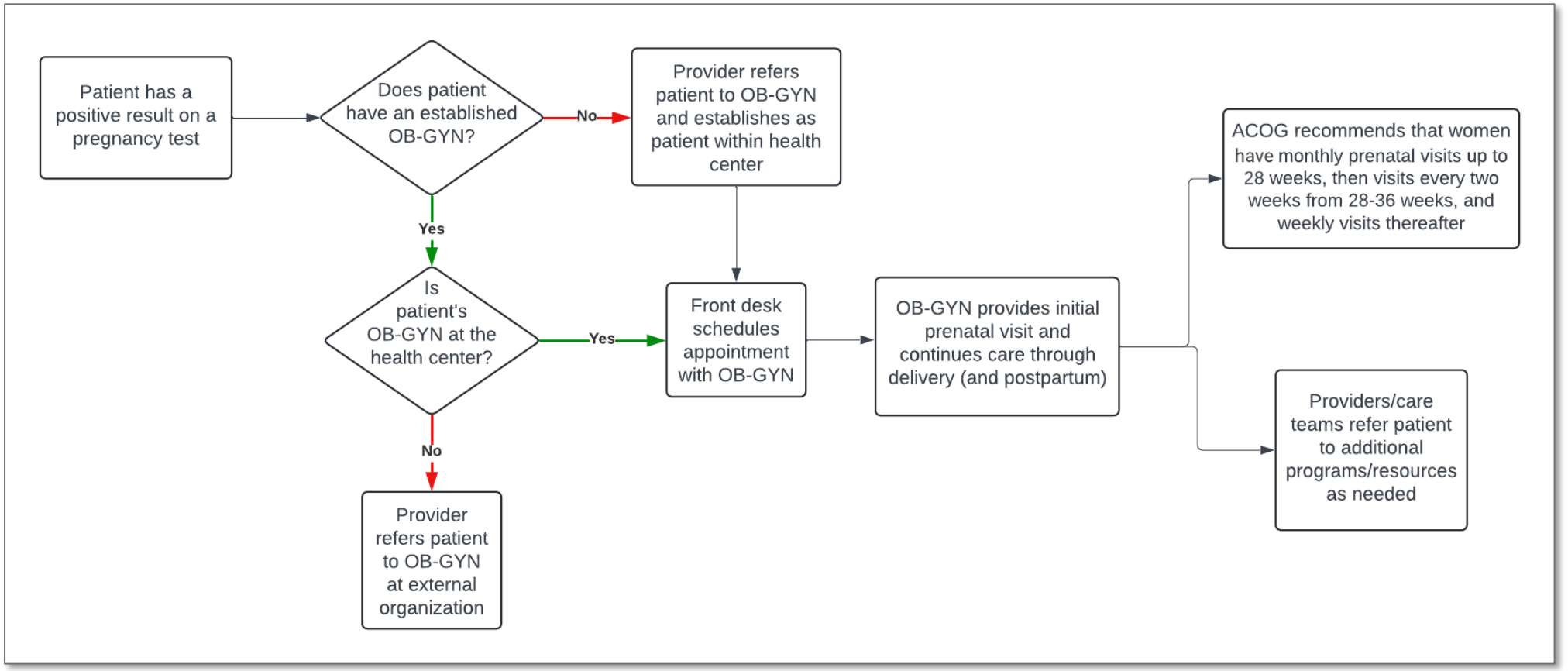
Script Sample – Leaving A Voicemail

If a patient doesn't answer, leave them a voicemail which is general and will incite a conversation the next time they call. This may be more effective than discussing appointment logistics via voicemail.

"Hi, this is <name> from <practice> and I'm calling to speak with [patient name] about a health care appointment. Please give me a call back at <phone number or preferred mode of contact>. Thank you and have a great day."

PRENATAL CARE WORKFLOW

Standardizing workflow for prenatal patient outreach is important for the long-term success of the clinic's team-based care. Standardization includes employees following through with established workflows every time the appropriate situation arises and should not differ by employee or employee's time for follow up. A general workflow diagram for health center prenatal appointments is depicted below. This workflow should be tailored according to your health center's needs:



INCENTIVES

There may be incentives available to members who complete visits, or to health centers for reaching quality improvement milestones with health plans, such as reaching the 75th percentile with a Medicaid health plan. It is recommended for health centers to work with health plans to assess what incentives may be available for both patients and providers. As of the creation of this playbook, the known 2024 health plan incentives related to prenatal and postpartum care are outlined below:

Meridian: Rewards Card is mailed to the patient to their address on file when the eligible service is completed, and the claim is processed (could take up to 90 days). Additional rewards are loaded to the same card that was mailed for their first reward. No application or attestation is required on the patient end. More information: Meridian Link

HEDIS Measure	Rewards Card Value	Meridian Eligibility
First Prenatal Visit	**$25**	Once per pregnancy. **Patient must notify Meridian they are pregnant prior to having their baby by submitting a completed Notification of Pregnancy (NOP) form**
Postpartum Visit	**$25**	One per pregnancy. **Must be completed 7-84 days after delivery.**
Well Child Visits	**$25**	Ages 0-15 months. Requires 6 visits for reward

Molina: To qualify, after receiving the service listed below, members must complete the online form at www.MIMolinaHealthyRewards.com and the gift card will be sent to the mailing address on file with Molina within 4-6 weeks. For more information on the Health Rewards program, email QualityGiftCardInquiry@molinahealthcare.com

HEDIS Measure	Gift Card Value	Molina Eligibility
Prenatal Care (PPC)	**$100**	Members must complete a prenatal visit in the first trimester or within 42 days of enrollment
Postpartum Care (PPC)	**$50**	Member must complete a virtual postpartum visit with a Nurse Practitioner from Care Connections which includes a postpartum depression screening between 7-84 days after delivery. Request a visit with Care Connections by calling: 844-847-9954
Well Child Visit (W30)	**$100**	Members ≤15 months. Complete 6 well-child visits before turning 15 months of age.

United: No patient incentives are known at the time of writing this playbook. Please reach out to your local United Healthcare representative for more information.

POST-PARTUM CARE

TIMELINESS OF POSTPARTUM CARE MEASURE (PPC-POST)

Measure Definition

Timeliness of Postpartum Care **-** The percentage of deliveries that had a postpartum visit on or between 7 and 84 days after delivery.

Measure Definition Break-Down

The denominator or eligible population is the number of deliveries of live births on or between October 8 of the year prior to the measurement year and October 7 of the measurement year. For these members, the measure assesses the following facets of prenatal and postpartum care:

- The percentage of deliveries that had a postpartum visit on or between 7 and 84 days after delivery.

CODING FOR GAP CLOSURE

Data Collection

Below is relevant coding information for compliance. Qualifying codes and value sets may change with the measurement year, so it is recommended that health centers verify and update these codes when establishing workflows.

Billing:

Postpartum care – Any of the following meet the criteria for postpartum care:

- Bundled service – Provide dates for postpartum visits. Bundled service codes are used on the date of delivery, not on the date of the postpartum visit. These codes may be used only if the claim form indicates when postpartum care was given.
- Postpartum visit.
- Cervical cytology.
- National Provider Identifier (NPI)—The individual NPI must be used; do not use the clinic NPI.

Below are codes recommended by Medicaid health plans for measure compliance. This table does not represent a comprehensive list of all qualifying codes. For a comprehensive list, please refer to the HEDIS measure technical specifications.

Description	Codes
Postpartum Bundled Services	**CPT:** 59400, 59410, 59510, 59515, 59610, 59614, 59618, 59622
Cervical Cytology	**CPT:** 88141-88143, 88147, 88148, 88150, 88152-88154, 88164-88167, 88174, 88175 **HCPCS:** G0123, G0124, G0141, G0143-G0145, G0147, G0148, P3000, P3001, Q0091
Postpartum Visits	**CPT:** 57170, 58300, 59430, 99501 **CPT-CAT-II:** 0503F HCPCS: G0101 **ICD-10:** Z01.411, Z01.419, Z01.42, Z30.430, Z39.1, Z39.2

EMR Documentation:
Enter the date of the postpartum visit in the patient's chart, and document one of the following:

- Pelvic exam.
- Evaluation of weight, blood pressure, breasts, and abdomen – note can include breastfeeding for the evaluation of breasts.
- Notation of postpartum care, such as "postpartum care," "PP care," "PP check," or "6-week check."
- A preprinted postpartum care form filled out during the visit.
- Perineal or cesarean incision/wound check.
- Screening for depression, anxiety, tobacco use, substance use disorder, or pre-existing behavioral health disorders.
- Glucose screening for women with gestational diabetes.
- Notes on topics about:
    - Infant care or breastfeeding.
    - Waiting period for intercourse, birth spacing, or family planning.
    - Sleep/fatigue.
    - When to start physical activity and reaching a healthy weight.

AZARA REPORTS

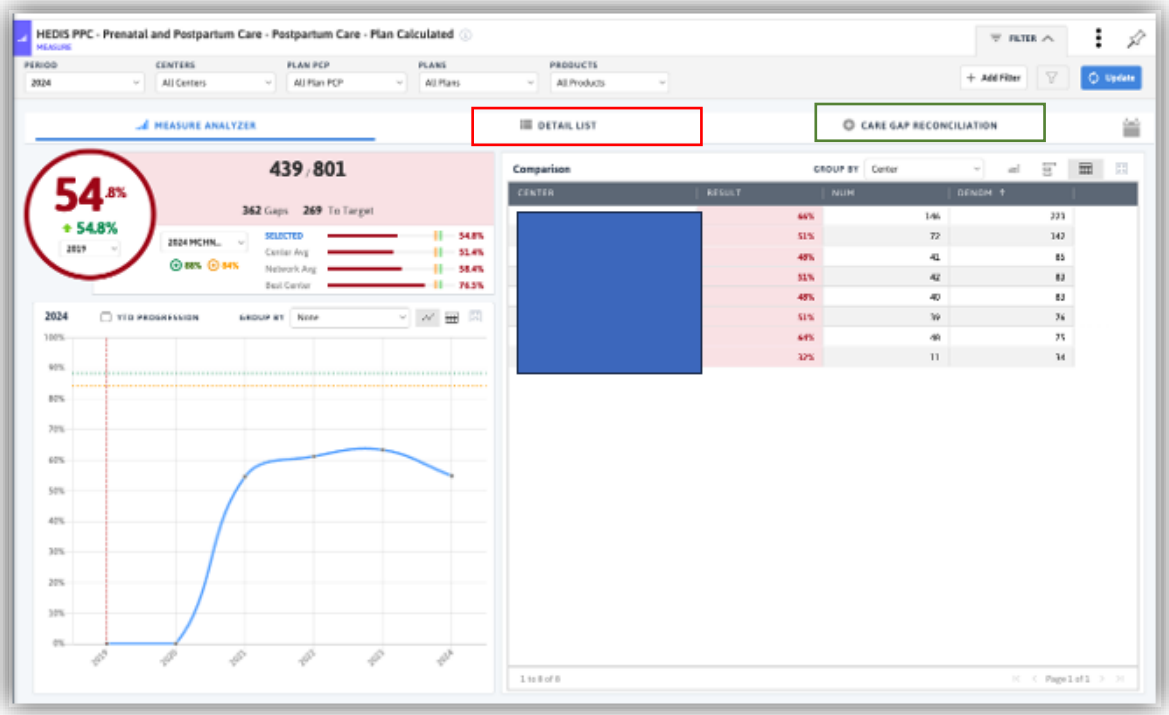
There are HEDIS-certified and Azara-certified reports that health centers can use to see gaps in Postpartum Care.

OB Pregnancy Episode Summary Report
The OB Pregnancy Episode Summary Report provides details about the estimated date of conception, delivery date, and more based on health center EMR data. To utilize this report for postpartum outreach, use the following steps:

Step 1. Open the report by searching "OB Pregnancy Episode Summary"
Step 2. Filter by Health Center and Providers if applicable
Step 3. Choose "No Appt" under the "Next Appt" filter (red box below)
Step 4. Filter "Trimester" to 3rd
Step 5. Filter "Est Delivery Date" to "After" 1 month ago. For example, if you are searching on October 25, 2024. You could filter to "After" September 25, 2024
Sort to have the most recent at the top
Step 6. Be aware that these are not necessarily confirmed deliveries but expected delivery dates based on your health center's knowledge of the patient's gestation. This list can be used to monitor patients for outreach and ensure up-to-date prenatal appointments and awareness of deliveries.

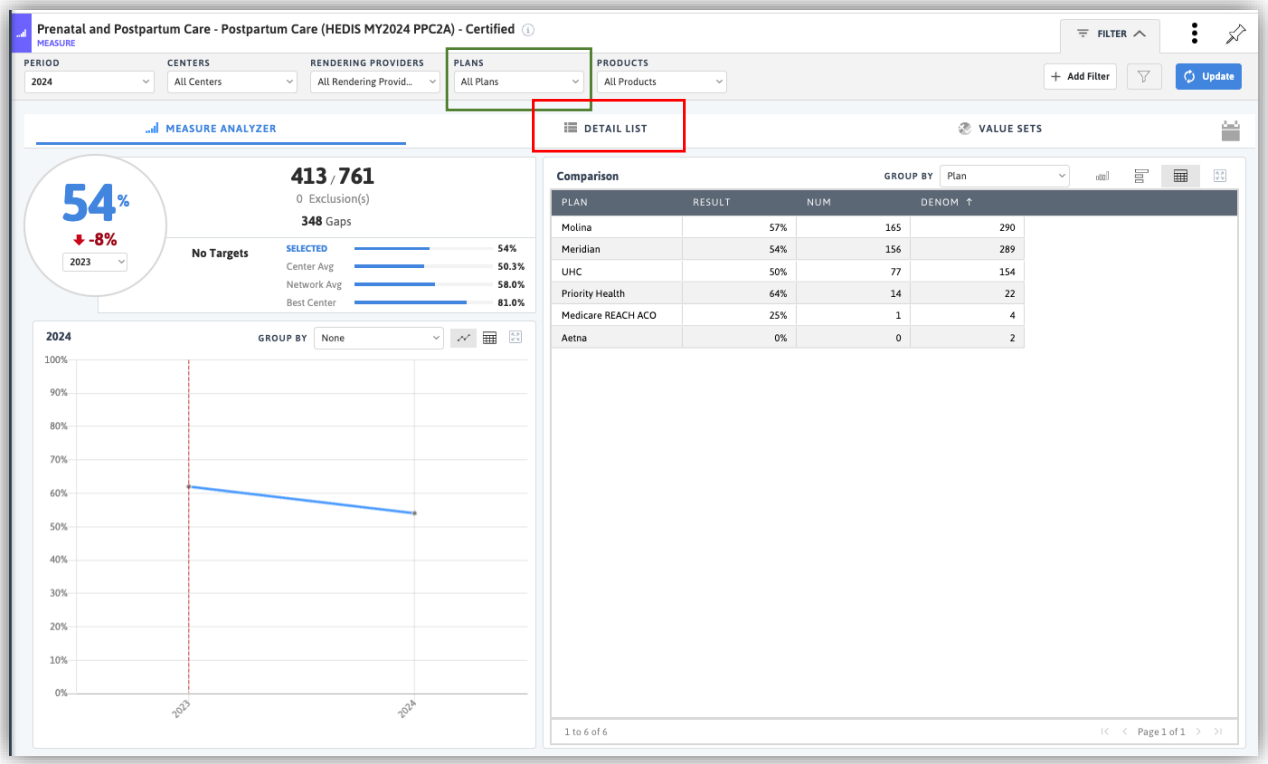
HEDIS-Certified Measure
The **"HEDIS PPC—Prenatal and Postpartum Care—Postpartum Care—Plan Calculated"** measure uses claims data from health plans. With any sourced claims data, there is a lag of

about 90 days for the data to be processed and populated into Azara. To see detailed member-level reports, click the Detail List (red box). To see a comparison of care gaps reported by claims versus by the EMR, click Care Gap Reconciliation (green box).



Azara-Certified Measure

The Azara Certified **"Prenatal and Postpartum Care – Postpartum Care (HEDIS MY2024 PPC2A)"** measure is a report that uses EMR-sourced data. To see detailed member-level reports, click the Detail List as depicted below (red box). To see care gaps for a specific health plan, filter by Plans and select desired health plan(s) (green box). Of note, this certified measure has deliveries that are based on claims, and the most recent deliveries occurred about one month ago. This is an important consideration when determining your health center's best practice workflow and which outreach lists to use.



OUTREACH SCRIPTS

Script Overview and Key

This script is for use during outreach to patients who have given birth and have not had an initial postpartum care visit (within 3 weeks of delivery) or who have not had a recent postpartum visit (up to 12 weeks postpartum as needed). Each practice may have its own resources for transportation, SDOH, etc., that it would like to include in the script based on its usual outreach methods. Review and finalize the script for your practice before beginning outreach.

Live Phone Call

Introduction/Getting Patient Scheduled

"Hi, is this <patient name>? I am a <CHW, nurse, MA, etc.> calling from <practice>. My name is <name>. We're calling today about your health needs. Please know that this conversation is completely confidential. Are you in a location where you can speak privately? I am calling because I have on record that you have not had a postpartum visit OR recent follow-up postpartum visit within the past <number of weeks since the last visit>. Is this correct?" *If the patient cannot talk, leave contact information so they can call back.*

If the patient reports they have completed an initial/recent postpartum visit: "That is great! I will make a note of that. Where and when did you have your postpartum visit?" *Ask the patient when and where they completed this service and ask the patient to have their records sent over. Record in a tracker that the service was completed and note to populate records from the location into local records. Check to ensure that the patient's record release form is signed; if not, send the form during the call so you can gather records.*

If the patient says they have not gotten an initial/recent postpartum visit: "Thank you for taking the time to talk with me today. According to our records, you are overdue for a follow-up postpartum visit **OR** we have never seen you for a postpartum visit. Can we get you scheduled for the postpartum visit that you are due for? " *Wait for the patient's response. If agreeable, then:* "We have on record that you typically see <provider name>. **OR** We do not have a provider on file for you. <Provider name> has appointment availability starting <date>. *Be sure to mention the location that the provider is at.* "What days/times of the week work best for you? We have an appointment available on <date> and <time>. Do you have availability to come in on <day> at <time>?" *Schedule the appointment and record it in a tracker.*

Call closure

Always thank a patient for their time and make sure they know how to reach you again: "Thank you so much for your time today. If you need anything leading up to your appointment **OR** in the future, please feel free to reach out to me. Again, my name is <Name> and you can reach me at <phone number or preferred mode of contact>. Have a great day."

If the Patient Refuses To Schedule

If the patient refuses: "I understand. You have important reasons which prevent this from being a priority right now. Do you mind if I share the importance of having a postpartum visit?" *Wait for an answer.*

Postpartum visit information

"Seeing your doctor after giving birth is so important to make sure that you are healthy and that you are recovering from pregnancy and delivery. It's so important for us to check in with you and make sure you're taken care of. The healthier you are, the better able you are to take care of your child. The sooner we can assess your progress and overall health, the sooner we can catch any potential issues after delivery. This is why your insurance allows you to have postpartum visits at no cost to you. This visit is free, and we'd really like to see you come in. Can we get you scheduled for an appointment?"

Call closure

Always thank a patient for their time and make sure they know how to reach you again: "Thank you so much for your time today. If you need anything leading up to your appointment **OR** in the future, please feel free to reach out to me. Again, my name is <Name> and you can reach me at <phone number or preferred mode of contact>. Have a great day."

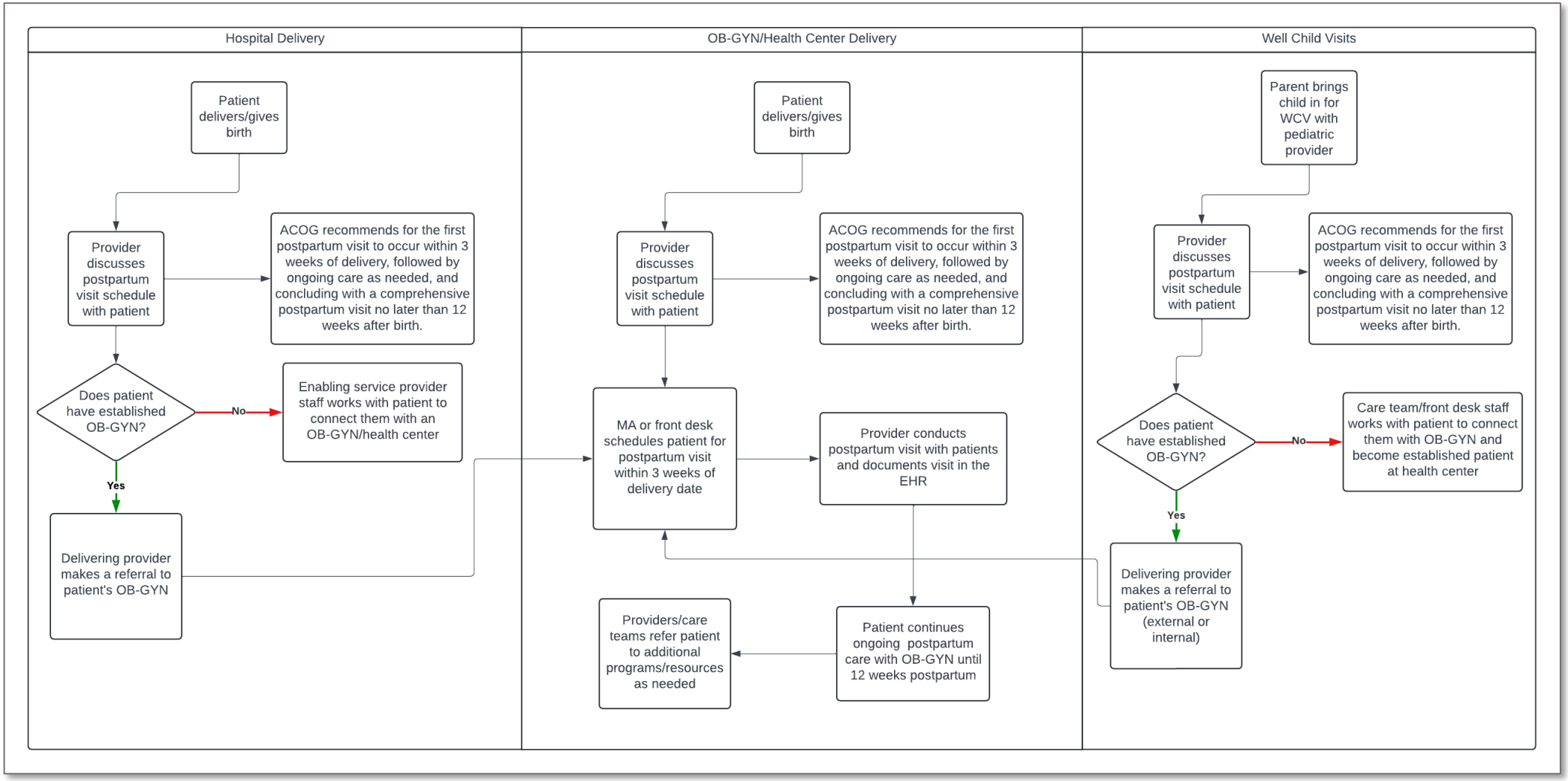
Script Sample – Leaving A Voicemail

If a patient doesn't answer, leave them a voicemail which is general and will incite a conversation the next time they call. This may be more effective than discussing appointment logistics via voicemail.

"Hi, this is <name> from <practice> and I'm calling to speak with [patient name] about an appointment. Please give me a call back at <phone number or preferred mode of contact>. Thank you and have a great day."

POSTPARTUM CARE WORKFLOW

A general workflow diagram for health center postpartum appointments is depicted below. This workflow should be tailored according to your health center's needs



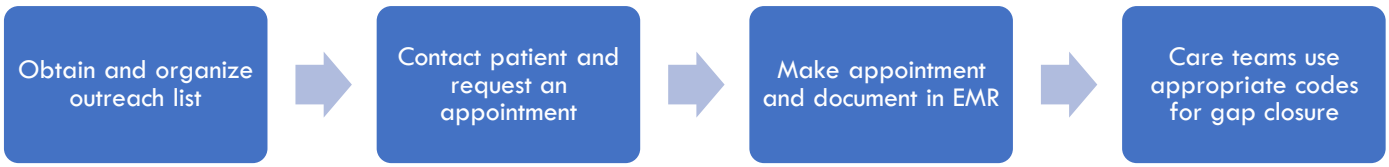
HEALTH CENTER STAFF ACTION SHEET

Prenatal

1. Obtain the outreach list from Azara and organize for prenatal outreach. The recommended Azara report to use to get patients scheduled in the appropriate timeframe is "OB Pregnancy Episode Summary."
2. Filter the report to a list of patients who have not had a prenatal appointment and have not delivered yet. ACOG recommends that women have monthly prenatal visits up to 28 weeks, then visits every two weeks from 28 to 36 weeks, and weekly visits thereafter. HEDIS requires one prenatal visit in the first trimester.
3. Outreach to patients using outreach scripts or health center-specific workflows to request the patient come in for a prenatal appointment.
4. If a patient is unable to be reached by phone, outreach using other modalities such as texting and letters.
5. Document outreach in the EMR as appropriate.
6. When patients arrive for their prenatal appointment, use recommended codes and documentation to qualify as a prenatal encounter.

Postpartum

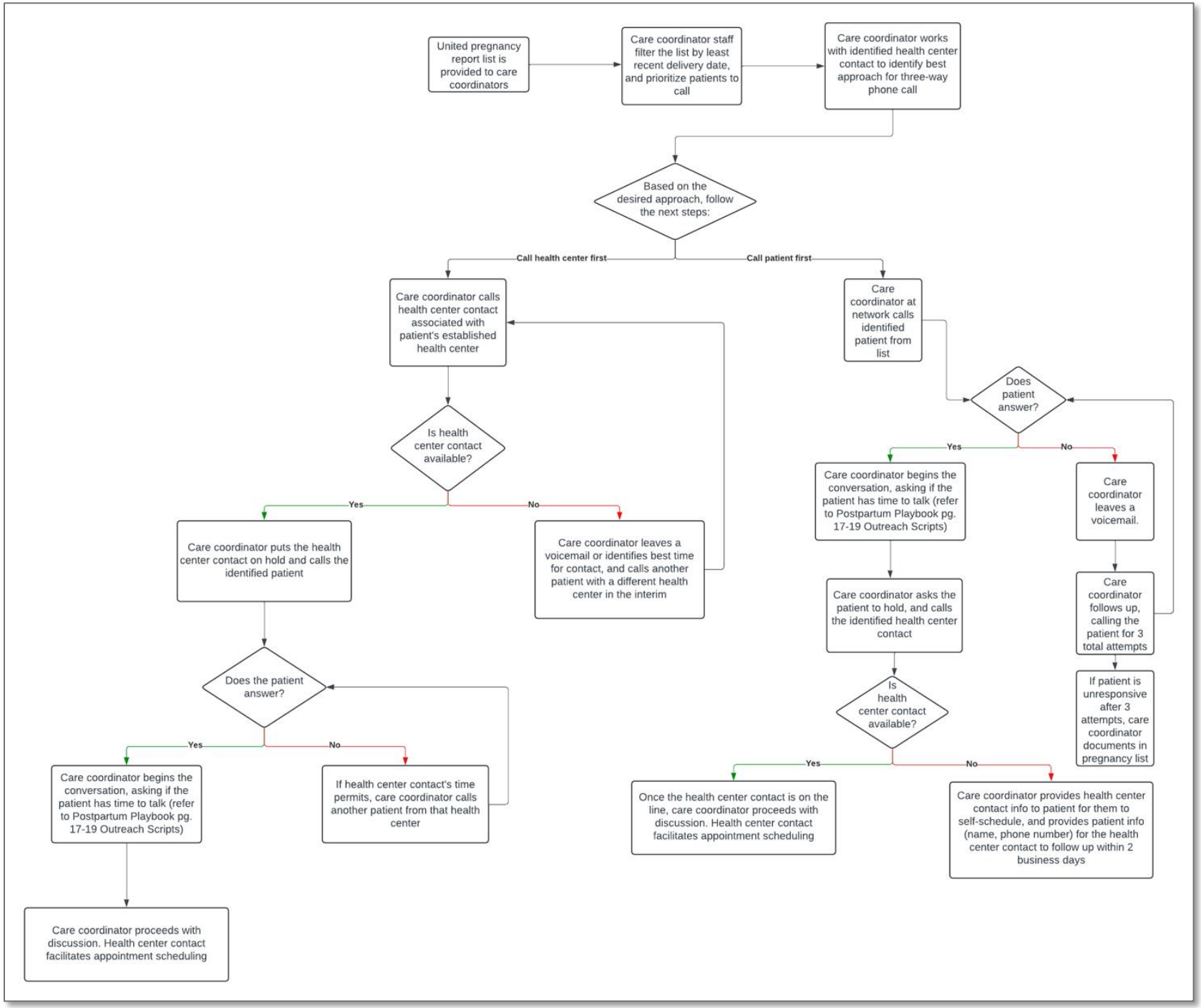
1. Obtain a list of recent deliveries based on your health center's workflow. Consider the TOC discharge report in Azara and filter for "delivery" as discharge description if no other best practice report exists.
2. Filter the report for recent deliveries and patients who have not had their postpartum appointment. ACOG recommends that the first postpartum visit occur within 3 weeks of delivery, followed by ongoing care as needed and concluding with a comprehensive postpartum visit no later than 12 weeks after birth. HEDIS requires a postpartum visit to occur between 7 and 84 days after delivery.
3. Outreach to patients using outreach scripts or health center-specific workflows to request the patient come in for a postpartum appointment.
4. If a patient is unable to be reached by phone, outreach using other modalities such as texting and letters.
5. Document outreach in the EMR as appropriate.
6. When patients arrive for their postpartum appointment, use recommended codes and documentation to qualify as a postpartum encounter.
7. Ensure the child is established with a provider and the parent understands the expected well-child visit frequency.



NETWORK-LEVEL CARE COORDINATOR OUTREACH

MCHN care coordinators will be conducting outreach calls to patients who are identified by United Health Plan who have given birth recently and who have not yet had a postpartum appointment. The care coordinators will receive a pregnancy report list from United, which will be used to conduct outreach. The recommended approach is to organize the list so that those with the least recent delivery date are prioritized and to attempt to schedule those patients in as soon as possible for a postpartum appointment. When calling a patient, use the script outlined in the "Outreach Scripts" section.

The workflow for network-level care coordinators to outreach to postpartum patients is outlined below. This is a general workflow, and it is recommended to adapt the workflow based on the needs and goals of the network. Identify a person at the health center who is the "contact" person who may be expecting these care coordinator calls


United pregnancy report list is provided to care coordinators
Care coordinator staff filter the list by least recent delivery date, and prioritize patients to call
Care coordinator works with identified health center contact to identify best approach for three-way phone call
Based on the desired approach, follow the next steps:
Call health center first
Call patient first
Care coordinator calls health center contact associated with patient's established health center
Is health center contact available?
Yes
No
Care coordinator puts the health center contact on hold and calls the identified patient
Care coordinator leaves a voicemail or identifies best time for contact, and calls another patient with a different health center in the interim
Does the patient answer?
Yes
No
Care coordinator begins the conversation, asking if the patient has time to talk (refer to Postpartum Playbook pg. 17-19 Outreach Scripts)
If health center contact's time permits, care coordinator calls another patient from that health center
Care coordinator proceeds with discussion. Health center contact facilitates appointment scheduling
Care coordinator at network calls identified patient from list
Does patient answer?
Yes
No
Care coordinator begins the conversation, asking if the patient has time to talk (refer to Postpartum Playbook pg. 17-19 Outreach Scripts)
Care coordinator leaves a voicemail.
Care coordinator asks the patient to hold, and calls the identified health center contact
Care coordinator follows up, calling the patient for 3 total attempts
Is health center contact available?
If patient is unresponsive after 3 attempts, care coordinator documents in pregnancy list
Yes
No
Once the health center contact is on the line, care coordinator proceeds with discussion. Health center contact facilitates appointment scheduling
Care coordinator provides health center contact info to patient for them to self-schedule, and provides patient info (name, phone number) for the health center contact to follow up within 2 business days

Potential Barriers:

There may be barriers to utilizing a network-level three-way call outreach workflow as outlined below:

- The network-level staff do not have access to directly schedule a patient for an appointment, requiring additional resources from the health center and network staff to schedule appointments.
- The plan-provided lists may have lag associated, meaning patients may be farther into their postpartum period than is feasible for meeting care gaps.
- The plan-provided lists are for one health plan, resulting in a narrowed population of targeted patients for outreach.
- By calling the patients first and then a representative from the health center for a three-way telephone call, there may be long wait times to reach the health center and a potential loss of opportunity to get the patient scheduled during the call. It is best practice to schedule a patient on the phone rather than having the patient schedule themselves. If a patient were to be unable to be scheduled as a result, there is a risk that the appointment scheduling may be foregone altogether.
- By calling a representative from the health center first and then calling the patient for a three-way telephone call, there will be a risk that a patient or several patients will not answer the phone and will require follow-up. In the workflow, there are steps for the network outreach staff to call back and follow up with patients who do not answer. However, this could be time consuming for the health center representative to participate in phone calls that are unanswered and would not be an optimal use of their time.

NETWORK CARE COORDINATOR ACTION SHEET

1. Obtain a bi-weekly outreach list from the United Health Plan and organize for outreach according to the prioritized population (prenatal or postpartum).
2. Filter report to a list of patients who have a gap in care.
3. Determine point of contact at each health center. Work with the contact to determine the best workflow – calling the patient first or calling the health center first.
4. Outreach to patients using outreach scripts or network-specific workflows to request the patient come in for a prenatal appointment.
5. If a patient cannot be reached by phone, coordinate with the health center point contact to reach out using other modalities, such as texting and letters.
6. Document outreach in the health plan list as appropriate.

Prenatal Timeline

The denominator or eligible population is the number of deliveries of live births on or between October 8 of the year prior to the measurement year and October 7 of the measurement year. For these members, the measure assesses the following facets of prenatal care:

1. Prenatal care visit in the first trimester or within 42 days of enrollment, where the practitioner type is an OB/GYN or other prenatal care practitioner or primary care physician (PCP).
2. First Trimester is defined as 280-176 days prior to delivery (or estimated delivery date [EDD]).

Members must have a delivery claim already submitted to the health plan to be on the United health plan list. Members who have already had a delivery are no longer eligible for a prenatal visit.

Postpartum Timeline

The denominator or eligible population is the number of live births delivered on or between October 8 of the year prior to the measurement year and October 7 of the measurement year.
Due to lag in claims data, it is recommended to prioritize members without a postpartum appointment, who are closest to 84 days postpartum, first, to ensure they have an appointment in the recommended timeframe.

APPENDIX

HEDIS MEASURE EXCLUSION/INCLUSION INFORMATION

PPC-Pre Measure

Key Exclusion/Inclusion Information

Eligible Population:

Live birth deliveries on or between October 8 of the year prior to the measurement year and October 7 of the measurement year. Include deliveries that occur in any setting.

Follow the steps below to identify the eligible population, which is the denominator for both rates.

Step 1: Identify deliveries. Identify all members with a delivery (Deliveries Value Set) on or between October 8 of the year prior to the measurement year and October 7 of the measurement year.

- Note: The intent is to identify the date of delivery (the date of the "procedure"). If the date of delivery cannot be interpreted on the claim, use the date of service or, for inpatient claims, the date of discharge.

Step 2: Remove non-live births (Non-live Births Value Set).

Step 3: Identify continuous enrollment. Determine if enrollment was continuous 43 days prior to delivery through 60 days after delivery, with no gaps.

Step 4: Remove multiple deliveries in a 180-day period. If a member has more than one delivery in a 180-day period, include only the first eligible delivery. Then, if applicable include the next delivery that occurs after the 180-day period. Identify deliveries chronologically, including only one per 180-day period.

- Note: The denominator for this measure is based on deliveries, not on members. All eligible deliveries that were not removed in steps 1–4 remain in the denominator.

Measure Criteria:

a) **Denominator:** The eligible population, outlined in steps 1-4 above.
b) **Numerator:** A prenatal visit during the required time frame. Follow the steps below to identify numerator compliance.

Step 5: Identify members who were continuously enrolled (with no gaps) from at least 219 days before delivery (or EDD) through 60 days after delivery. These members must have a prenatal visit during the first trimester.

Step 6: Identify members who were not continuously enrolled from at least 219 days before delivery (or EDD) through 60 days after delivery. These members must have a prenatal visit any time during the period that begins 280 days prior to delivery and ends 42 days after their enrollment start date.

- Note: Do not count visits that occur on or after the date of delivery. Visits that occur prior to the member's enrollment start date during the pregnancy meet criteria.

Step 7: Identify prenatal visits that occurred during the required timeframe (the time frame identified in step 5 or 6). Any of the following, where the practitioner type is an OB/GYN or other prenatal care practitioner or PCP, meet criteria for a prenatal visit:

- Note: A bundled service (Prenatal Bundled Services Value Set) where the organization can identify the date when prenatal care was initiated (because bundled service codes are used on the date of delivery, these codes may be used only if the claim form indicates when prenatal care was initiated).
- A visit for prenatal care (Stand Alone Prenatal Visits Value Set). Do not include codes with a modifier (CPT CAT II Modifier Value Set).
- A prenatal visit (Prenatal Visits Value Set) with a pregnancy-related diagnosis code (Pregnancy Diagnosis Value Set).

PPC-Post Measure

Key Exclusion/Inclusion Info

Eligible Population:
Live birth deliveries on or between October 8 of the year prior to the measurement year and October 7 of the measurement year. Include deliveries that occur in any setting.
Follow the steps below to identify the eligible population, which is the denominator:
Step 1: Identify deliveries. Identify all members with a delivery (Deliveries Value Set) on or between October 8 of the year prior to the measurement year and October 7 of the measurement year.

- Note: The intent is to identify the date of delivery (the date of the "procedure"). If the date of delivery cannot be interpreted on the claim, use the date of service or, for inpatient claims, the date of discharge.

Step 2: Remove non-live births (Non-live Births Value Set).
Step 3: Identify continuous enrollment. Determine if enrollment was continuous 43 days prior to delivery through 60 days after delivery, with no gaps.
Step 4: Remove multiple deliveries in a 180-day period. If a member has more than one delivery in a 180-day period, include only the first eligible delivery. Then, if applicable include the next delivery that occurs after the 180-day period. Identify deliveries chronologically, including only one per 180-day period.

- Note: The denominator for this measure is based on deliveries, not on members. All eligible deliveries that were not removed in steps 1–4 remain in the denominator.

Measure Criteria:

a) **Denominator:** The eligible population, outlined in steps 1-4 above
b) **Numerator:** A postpartum visit on or between 7 and 84 days after delivery. Any of the following meet criteria:
    - A postpartum visit (Postpartum Care Value Set). Do not include codes with a modifier (CPT CAT II Modifier Value Set).
    - An encounter for postpartum care (Encounter for Postpartum Care Value Set). Do not include laboratory claims (claims with POS code81).

- Cervical cytology (Cervical Cytology Lab Test Value Set; Cervical Cytology Result or Finding Value Set).
- A bundled service (Postpartum Bundled Services Value Set) where the organization can identify the date when postpartum care was rendered (because bundled service codes are used on the date of delivery, not on the date of the postpartum visit, these codes may be used only if the claim form indicates when postpartum care was rendered).

Exclude services provided in an acute inpatient setting (Acute Inpatient Value Set; Acute Inpatient POS Value Set).