POLICY AND PROCEDURE

DEPARTMENT: Population Health and Clinical Operations	**DOCUMENT NAME:** Start Smart for Baby® Care Management Program
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APPROVED DATE: 10/28/22	**RETIRED:**
EFFECTIVE DATE: 01/23	**REVIEWED/REVISED:** 10/22
PRODUCT TYPE: Medicaid	**REFERENCE NUMBER:** LA.SSFB.03

SCOPE:
Louisiana Healthcare Connection's Population Health and Clinical Operations Department (PHCO)

PURPOSE:
To provide an overview of LHCC's Geaux Baby and Me Case Management Program, anchored by Centene's Start Smart for Baby® (SSFB) Program.

The SSFB program incorporates the concepts of integrated care management, care coordination, and disease management in an effort to improve the health of mothers and their newborns with an enhanced focus on black maternal enrollees. The program's multi-faceted approach to improving prenatal and postpartum care includes enhanced enrollee outreach and incentives, wellness materials, intensive care management, provider incentives, and support of the appropriate use of medical resources to extend the gestational period and reduce the risks of pregnancy complications, premature delivery, and infant disease.

The program consists of identifying pregnant enrollees; stratifying them by risk level and impactability; providing care management, care coordination, disease management and intervention as appropriate; and health education for all enrolled pregnant enrollees. SSFB provides participants with the education and tools to reduce their risk of adverse pregnancy outcomes. Enrollees are also eligible to receive incentives, based on health plan and state approval. The program helps pregnant enrollees access medical care, educates them on their healthcare needs, assists with social needs and concerns, and coordinates referrals to appropriate specialists and nurse OB Care Managers as needed.

GOALS:
The Start Smart for Your Baby® (SSFB) program goals are to reduce rates of pregnancy complications, premature deliveries, low birth weight deliveries, and infant disease.

PROCEDURE:

I. ENROLLEE IDENTIFICATION
One of the essential components of the program is the NOP process, which identifies pregnant enrollees and their risk factors as early in pregnancy as possible to establish a relationship between the enrollee, provider, and health plan staff. Identifying enrollees early in pregnancy will enable Plan to help enrollees gain access to prenatal care, give education on healthcare needs, to assist with social needs and concerns, and to coordinate referrals to appropriate specialists. The SSFB program identifies pregnant enrollees through the notification of pregnancy (NOP) assessment, claims data, state eligibility data, and referrals. Receipt of an NOP screening assessment automatically enrolls a pregnant enrollee in the

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Start Smart for Your Baby® program (see LA.SSFB.02 Notification of Pregnancy Work Process for details).

Enrollees are identified as pregnant from multiple sources including, but not limited to:

1. **Claims and eligibility files**
2. **Community Events or Agencies i.e., WIC**
3. **Health plan staff i.e., Care Manager, Community Health Services, Enrollee Services**
4. **Inpatient and emergency department census reports**
5. **Enrollee or family enrollee**
6. **Nurse Advice Line**
7. **Other Providers or Practitioners**
8. **Pharmacy Data**
9. **Primary care provider (PCP) or OB/GYN**
10. **Specialists**
11. **Start Smart Microstrategy Reports:**
    a. **412 Currently Pregnant NOP Report**
    b. **413 Currently Pregnant No NOP Report**
12. **State Reports**
    a. **039 Report- Women with high-risk pregnancies (i.e.: pregnancies that have 1 or more risk factors) or who have had an adverse pregnancy outcome during the pregnancy including pre-term birth or less than 37 weeks.**

II. ENROLLEE STRATIFICATION

The Plan obtains general screening information from the NOP form which can be filled out and submitted by the Provider and/or Enrollee online or by mail. Telephonic NOP assessments are also completed to identify enrollees at risk for pregnancy complications. Once pregnant enrollees are identified and their risk factors collected in the NOP, enrollees are stratified into low, medium, and high-risk groups according to their NOP assessment results and claims data (see SSFB.01.01 Notification of Pregnancy Work Process for details). High-risk enrollees are prioritized for outreach by health plan staff. Particular attention is paid to enrollees with a history of prior preterm delivery.

III. ENROLLEE INTERVENTIONS

1. **Enrollees with a submitted NOP, are less than 34 weeks gestation, and haven't had a pregnancy mailing within the last 5 months receive a mailing packet that contains the following:**
    a. **The packet contains a 'Welcome to the Start Smart for Your Baby®" program letter and educational materials specifically educating them on the importance of prenatal care, staying healthy during pregnancy, signs of preterm labor, education on testing for STIs and a prenatal depression survey.**

   b. **The packet includes SSFB and My Health Pays Program which provides incentives for attending prenatal and postpartum appointments and accessing other services (see below for information on incentives).**
   c. **Also included is Plan's toll-free phone number and SSFB website address; enrollee rights and responsibilities; Plan's recommendation and process for changing PCP to an OB; information about Plan's 24/7 nurse advice line; and pregnancy-specific information.**
   d. **SSFB materials encourage enrollees to schedule (or contact Plan for assistance with scheduling) a prenatal care visit within the first trimester, or as soon as possible if the enrollee is past the first trimester (Model Contract 2.7.13). A journey booklet is also included to track prenatal and postpartum visits.**
   e. **Materials also encourage enrollees to choose a pediatrician during their 3rd trimester (60 days) prior to their expected due date along with a tool kit on how to interview and select a pediatrician for their baby**

2. **Using the 409 Start Smart Deliveries report, the enrollees are provided an additional mailing packet post-delivery containing a congratulations letter, a postpartum wellness survey to screen for postpartum depression, and The Mother's Guide to Life after Delivery book which contains newborn and postpartum care educational information. Enrollees whose birth event information indicates stillborn/expired or adopted/foster care will not receive this mailing.**
3. **The Text & Email program is an opt-in program that allows enrollees to receive texts and emails about pregnancy and postpartum tips starting at 27 weeks gestation through six months postpartum. Enrollees opt-in through completion of an NOP or through the SSFB Texting Note available in TruCare.**
4. **The SSFB Breastfeeding program coordinates interventions throughout pregnancy, birth, and infancy to increase breastfeeding initiation and duration. Interventions include enrollee education, optional additional breastfeeding texts and emails, providing a breast pump, and postpartum follow up and support. The Plan offers a free breast pump to enrollees who have a commitment to breastfeeding.**
5. **Enrollees identified as high-risk, based on the NOP risk score, are contacted by the MCH OB care manager (CM) who conducts a more in-depth case assessment. Enrollees identified as medium and low risk will be outreached by the MCH Program Coordinator and Community Health Service Representatives (CHSRs) to assess for additional needs regarding pregnancy, community resources, and/or social determinants of health. Upon outreach, a referral is entered in TruCare and a case is opened with the case type of "Start Smart Pregnancy." The following assessments/screenings will be conducted when outreaching an enrollee OB Care Management:**
   a. **SSFB Member OB Screening (Medium or Low Risk)**
   b. **SSFB OB Case Management Assessment (High Risk)**

c. **Complex Case Management Assessment (Complex cases only- Enrollees with high-risk conditions that will not resolve with pregnancy)**
d. **Edinburgh Scale Tool (All Enrollees)**
e. **COVID Screening (All Enrollees)**
f. **HRS Addendum (All Enrollees)**
g. **Perinatal SUD Journal (Enrollees Enrolled in SUD program)**

6. **Once enrolled in CM, the OB care manager along with the enrollee and family will develop an enrollee specific care plan. The OB care manager will request a treatment plan from the provider to incorporate into the care plan. The OB care manager will continue to follow-up with the enrollees throughout the pregnancy and up to 60 days postpartum.**
    - **OB care managers will follow-up with high-risk enrollees at a minimum of monthly, in- person in the enrollees preferred setting or more as required within the enrollee's plan of care with monthly updates to the plan of care and formal in person reassessment quarterly (Model Contract 2.7.5.1)**
    - **Pregnant enrollees identified with substance use disorders will be referred to LHCC Perinatal Substance Use Program (See LA.CM.31)**
    - **Pregnant enrollees with perinatal depression can be referred to the Perinatal Depression Program (See LA.DM.258)**
    - **Pregnant enrollees with other behavioral health diagnoses shall be co-managed by the OB CM and a Behavioral Health Care Manager.**
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7. **Enrollees enrolled in Plan's MCH Program are reminded and encouraged, to designate a Pediatrician for their baby (60) calendar days before the expected date of delivery. If a Pediatrician is not selected, one will be auto-assigned after fourteen (14) days post-delivery. (If Plan was not informed of the pregnancy at delivery and a Pediatrician had not been selected, one will be auto-assigned within one business day of delivery (Model Contract 2.3.12.4.1)**
8. **Enrollees enrolled in CM and those that are indicated as high-risk pregnancy or with an adverse pregnancy outcome receive postpartum outreach assessments (SSFB Postpartum Assessment) which encourage follow up postpartum care with their providers within 21-56 days and continue to receive annual gynecological care.**
9. **As part of the NOP and assessment process, enrollees who are at risk for repeat pregnancy and births less than 18 months apart. Upon identification, the MCH staff engage the enrollee in preconceptual planning, explain the risks of rapid repeat births, and provide contraceptive education and referrals (including long-acting reversible contraceptive), all incorporated into their plan of care.**
10. **The Plan's MCH Program also consists of a Preterm Birth Prevention Program which includes, but is not limited to:**

a. **Enrollee and Provider education regarding routine cervical length assessments and provision of 17P for all eligible pregnant enrollees with history of preterm birth or short cervix in the current pregnancy.**
b. **The Plan partners with Delegated Vendors to make home visits to high-risk enrollees and provide education and/or administer injectable progesterone to eligible enrollees**
c. **Enrollees are educated on risks of unnecessary C-sections and how to avoid them, such as vaginal delivery after cesarean (VBAC).**
d. **Focus on disparities throughout the state to improve outcomes related to Black Maternal Health**

11. **Enrollees are also referred to delegated vendors that make home visits for enrollees with the following conditions:**
    - **Pre-Eclampsia**
    - **Insulin Dependent Diabetes**
    - **Severe nausea and vomiting**
12. **MCH staff will refer enrollees to community partners mentioned in LA.SSFB.01 as needed based on enrollee's needs**

IV. MONITORING OUTCOMES

Outcomes and success of Start Smart for Your Baby® will be monitored through various avenues including executive summary reports and dashboards. The 464 SSFB Executive Dashboard contains an overview of program outcomes with trending for state reporting and serves as the main overview for the SSFB program outcomes. The Clinical Initiatives Dashboard (CID) contains key clinical program outcomes, including SSFB outcomes. The CID also allows comparison across health plans. The main goals of the program are to improve outcomes by showing improvement in the following measures:

Metric Group Name	Metric Name	Numerator	Denominator
StartSmart 2.0	No NOP - High-Risk - Outreach for Risk Assessment Attempted	High-Risk Pregnant No-NOP Enrollees with outreach with an SSFB NOP V% note	Total High-Risk Pregnant No-NOP Enrollees identified in a given month
StartSmart 2.0	No NOP - High-Risk Outreach Timeliness	High-Risk Pregnant No-NOP Enrollees with an SSFB NOP V% outreach note within 7	Total High-Risk Pregnant No-NOP Enrollees

		days of first becoming high risk on the 413	**identified in a given month**
StartSmart 2.0	**No NOP - Pregnant Enrollees with Outreach for Risk Assessment**	**Pregnant No-NOP Enrollees with outreach with an SSFB NOP V% note**	**Total Pregnant No-NOP Enrollees identified in a given month**
StartSmart 2.0	**NOP - High-Risk - CM Engagement**	**High-Risk Pregnant NOP Enrollees with a Start Smart Pregnancy case type and active CM during their pregnancy span**	**Total High-Risk Pregnant NOP Enrollees identified in given anchor month**
StartSmart 2.0	**NOP - High-Risk - Outreach for CM Attempted**	**High-Risk Pregnant NOP Enrollees with outreach with an SSFB OB Outreach V% note**	**Total High-Risk Pregnant NOP Enrollees identified in a given month**
StartSmart 2.0	**NOP - High-Risk Outreach Timeliness**	**High-Risk Pregnant NOP Enrollees with an SSFB OB Outreach V% note within 7 days of first becoming high-risk on the 412**	**Total High-Risk Pregnant NOP Enrollees identified in a given month**
StartSmart 2.0	**Total Deliveries with an NOP**	**Count of unique NOP enrollees with a delivery claim and at least one NOP in their pregnancy span**	**Total delivery count for enrollees identified in given anchor month**

REFERENCES:

RFP
Louisiana Department of Health MCO Manual
LA.SSFB.01

ATTACHMENTS:

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DEFINITIONS:

REVISIONS:	**DATE**
New policy	**10/2022**

POLICY AND PROCEDURE APPROVAL

The electronic approval retained in RSA Archer, Centene's P&P management software, is considered equivalent to a physical signature.