Provider Toolkit
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February 21, 2012

Dear Obstetrical Provider:

We are pleased to invite you to participate in a new state-wide quality initiative called “40 Weeks of Pregnancy, Every Week Counts”. This initiative was created to address the concerning 41% increase in late preterm births in Indiana, due to elective inductions and cesarean sections over the past 16 years. The Indiana Medicaid Hoosier Healthwise health plans (Anthem, MDwise, and Managed Health Services) are supporting and endorsing this initiative.

- The Indiana Chapter of the American College of Obstetrics and Gynecology
- The Indiana Chapter of the Association of Family Physicians
- The Indiana Chapter of the American Academy of Pediatrics
- The Indiana University School of Medicine
- The Indiana Hospital Association
- The Indiana Perinatal Network
- The March of Dimes, Indiana Chapter
- The Indiana State Department of Health
- The Office of Medicaid Policy and Planning

The goal of the quality initiative is to reduce the number of elective inductions and cesarean deliveries prior to 39 weeks of gestation. Elective deliveries prior to 39 weeks of gestation are associated with increased admission to the NICU and ventilator use. A retrospective analysis of 179,701 births showed that the incidence of severe respiratory distress syndrome was 22.5-fold higher for infants born at 37 weeks gestation and 7.5-fold higher for infants born at 38 weeks of gestation compared to those born at 39 to 41 weeks of gestation.²


The Joint Commission has added early elective deliveries to its Core Measure set for maternity care, and the Leapfrog Group has adopted this measure as its primary measure of quality for maternity care. Many Indiana hospitals and their medical staffs have responded to these national initiatives by adopting policies that assure that early inductions and caesarean deliveries meet ACOG guidelines for medical necessity.

As a physician with privileges at Indiana hospitals, we know you are well aware of the national concern and of the local efforts to reduce the trend. We also know that as a physician on the front line, you are often put in the difficult position of communicating these risks to your patients. A recent survey by UnitedHealthcare of first-time mothers found more than half the respondents believe it is safe to deliver their baby before 37 weeks’ gestation even if not required because of a medical complication.3

In recognition of the critical role that physicians providing obstetric services play in communicating the risks of early induction or caesarean section, the Indiana Medicaid Hoosier Healthwise health plans have developed a 40 Weeks of Pregnancy toolkit for their participating providers. The toolkit includes both clinical resources including an early induction bibliography and compelling patient education resources for physicians to use in discussions with their patients. The Hoosier Healthwise Plans will also be providing their contracted providers with information on specific obstetric care management and health education services offered to their providers and members.

We hope that you will accept our invitation to participate in “40 Weeks of Pregnancy”. Your participation would include:

- Displaying the “Healthy Babies Are Worth the Wait” educational poster in your office waiting and/or exam rooms, and
- Sharing and discussing patient education materials with your patients.

The Hoosier Healthwise health plan representatives will be making personal visits to physician offices in the next few weeks to hand deliver the “40 Weeks of Pregnancy” toolkits and to discuss any additional needs that offices might have for improving birth outcomes.

We believe that by working together to impact patient understanding of healthy pregnancy, we can improve birth outcomes in our communities and our state. Thank you in advance for your participation and support of improved birth outcomes for Indiana’s babies.

Sincerely,

Patricia Casanova
Director of Medicaid

Provider Resources


Elimination of Non-medically Indicated (Elective) Deliveries Before 39 Weeks Gestational Age. Presentation for clinicians developed by the March of Dimes and the California Maternal Quality Care Collaborative. ........................................7–11

Bibliography for Elective Delivery Prior to 39 Weeks.
Compiled by the IU National Center of Excellence in Women’s Health Best Practices Committee ........................................12
Decreasing Elective Deliveries Before 39 Weeks of Gestation in an Integrated Health Care System

Oshiro, Bryan T. MD1,3; Henry, Erick MPH1; Wilson, Janie RN1; Branch, D Ware MD1,2; Varner, Michael W. MD1,2; for the Women and Newborn Clinical Integration Program

Abstract

OBJECTIVE: The American College of Obstetricians and Gynecologists has recommended that elective deliveries not be performed before 39 weeks of gestation, to minimize prematurity-related neonatal complications. Because a worrisome number of elective deliveries were occurring before 39 weeks of gestation in our system, we developed and implemented a program to decrease the number of these early term elective deliveries. Secondary objectives were to monitor relevant clinical outcomes.

METHODS: The electronic medical records of an integrated health care system involving nine labor and delivery units in Utah were queried to establish the incidence of patients admitted for elective induction of labor or planned elective cesarean delivery. These facilities have open staff models with obstetricians, family practitioners, and certified nurse midwives. Guidelines were developed and implemented to discourage early term elective deliveries. The prevalence of early term elective deliveries was tracked and reported back regularly to the obstetric leadership and obstetric departments at each facility.

RESULTS: The baseline prevalence of early term elective deliveries was 28% of all elective deliveries before the initiation of the program. Within 6 months of initiating the program, the incidence of near-term elective deliveries decreased to less than 10% and after 6 years continues to be less than 3%. A reduced length of stay in labor and delivery occurred with the introduction of the program, and there were no adverse effects on secondary clinical outcomes.

CONCLUSION: With institutional commitment, it is possible to substantially reduce and sustain a decline in the incidence of elective deliveries before 39 weeks of gestation.

LEVEL OF EVIDENCE: III

Link to full article

Elimination of Non-medically Indicated (Elective) Deliveries Before 39 Weeks Gestational Age

Funding for the development of this toolkit was provided by:
Federal Title V block grant funding from the California Department of Public Health; Maternal, Child and Adolescent Health Division was used by the California Maternal Quality Care Collaborative to develop the toolkit; and March of Dimes.
This study by Goldenberg et al. addresses the potential impact of the patient on initiating the elective delivery process due to a lack of understanding of the risks of an early delivery. A national sample of 650 insured women was commissioned by a large health care insurance company. The purpose of the study was to understand women’s beliefs related to the meaning of full term and the safety of delivery at various gestational ages. The study was anonymous and voluntary and included women who had given birth within the last 18 months; were first-time mothers of singleton infants; currently had health insurance coverage either through their employer or spouse’s employer; had completed at least some high school education; and delivered their child at a hospital or medical facility. Those who had diabetes, hypertension/preclampsia, or obesity or had any other medical condition that would put them at high risk for a cesarean delivery were excluded from the study. The online survey was conducted August 18–29, 2008, while the telephone portion of the survey was conducted August 18–29, 2008. 58% were white, 93% were married or partnered, and 77% had a yearly family income of at least $50,000. Nearly 50% were employed full-time and nearly 69% held a college degree.
When participants were asked “At what gestational age do you believe the baby is considered full term?” nearly 25% chose 34–36 weeks. Another 50% chose 37–38 weeks and only 25% chose 39–40 weeks.
When women were asked “What is the earliest point in the pregnancy that it is safe to deliver the baby, should there be no other medical complications requiring early delivery?” more than half of the mothers chose 34–36 weeks. Only 7.6% chose 39–40 weeks.
Timing of Fetal Brain Development

• Cortex volume increases by 50% between 34 and 40 weeks gestation. (Adams Chapman, 2008)
• Brain volume increases at rate of 15 mL/week between 29 and 41 weeks gestation.
• A 5-fold increase in myelinated white matter occurs between 35-41 wks gestation.
• Frontal lobes are the last to develop, therefore the most vulnerable.
Evidence that “early term” delivery is associated with neonatal adverse effects


ACOG bulletins/committee opinions

1. Cesarean delivery on maternal request. ACOG Committee Opinion No. 394
2. Induction of labor. ACOG Practice Bulletin No. 107

General articles


March of Dimes Less Than 39 Weeks Toolkit

The March of Dimes, in collaboration with the California Maternal Quality Care Collaborative and the California Department of Health, Maternal Child and Adolescent Health Division, created a quality improvement toolkit.

“Elimination of Non-medically Indicated (Elective) Deliveries Before 39 Weeks Gestational Age” was developed to support hospitals and contains a step-by-step guide to assist hospital leaders with implementing policies and a guide for measuring quality improvement over time. The appendix includes educational tools for clinicians and staff and sample forms and hospital case studies. Download or purchase a copy at www.prematurityprevention.org.
Patient Resources

Provider Office Poster (English & Spanish) .................................................................14–15

What You Should Know About a Scheduled Delivery FAQs
(For use when counseling patients) ...........................................................................16–17
Babies aren’t fully developed until at least 39 weeks in the womb. Important development of their brains, lungs and eyes occurs in the last few weeks of pregnancy. If your pregnancy is healthy, wait for labor to begin on its own.
Los bebés no están desarrollados por completo hasta no haber cumplido al menos 39 semanas en el vientre. El desarrollo importante del cerebro, los pulmones y los ojos ocurre en las últimas semanas del embarazo. Si su embarazo es sano, espere que el parto comience por sí solo.

nacersano.org/39semanas
What is a scheduled delivery?
A scheduled delivery is when you and your healthcare provider pick the day to deliver, either by Cesarean delivery or by giving you medications to start your labor – a process called induction. Scheduled deliveries occur before you go into natural labor.

Why are deliveries scheduled?
Most of the time a scheduled delivery is due to a medical reason involving either the mother or the baby. Recently, more scheduled deliveries are occurring without a medical reason.

Why do women choose a scheduled delivery?
A scheduled delivery may appeal to both a woman and the healthcare provider because it helps them plan their schedules. Many women have backaches, swollen feet, are very tired and just want to have the baby.

Are there medical risks to my baby?
Babies born between 36 – 38 weeks are more likely to:
- Be admitted to the intensive care unit, not go home at the same time as their mothers and need IV and other needle sticks
- Have trouble breathing and be connected to a ventilator
- Have trouble keeping their body temperature at a healthy level and spend time in an incubator

Are there medical risks for me?
If labor is induced before your body is ready to deliver, there is an increased chance of having a Cesarean delivery.

What is a full term pregnancy?
In reality, a full term pregnancy is a range of time and only 4.5% of women go into labor on their actual due date.* Most women deliver up to a week before or after their due date.

Sources: *www.familyresource.com  **www.whattoexpect.com
What do health care providers recommend?

- If there is no medical reason for you to be delivered before your due date, it’s best for you and your baby to wait for natural labor.
- The American College of Obstetricians and Gynecologists recommends that scheduled deliveries without a medical reason should not occur before 39 weeks of pregnancy.
- If you must schedule your delivery, talk with your health care provider and make sure you are at least 39 weeks into your pregnancy.
- If you are planning a vaginal delivery, make sure your cervix is beginning to open and ready for delivery.

The closer your baby is born to his or her due date - the healthier he or she is!

A baby’s brain at 35 weeks weighs only two-thirds of what it will weigh at 39 to 40 weeks.*

35 weeks 39 to 40 weeks

Source: *March of Dimes; © Bonnie Hofkin, 2007
Managed Care Resources
Anthem Blue Cross and Blue Shield
Hoosier Healthwise Program

*Future Moms*
Prenatal Program Description
2011
I. BACKGROUND

At Anthem, we believe that Medicaid-funded prenatal programs are well-positioned to help increase healthy birth outcomes by helping to improve the overall quality of care pregnant women receive.

Anthem has a demonstrated commitment to promoting healthy birth outcomes and helping to improve the health of pregnant members by seeking to increase member access to prenatal care, a commitment strengthened by our Future Moms prenatal program (hereafter referred to as the “prenatal program”). Designed to provide pregnant members with a comprehensive program of prenatal care from conception through 30 days postpartum, the prenatal program strives to:

- identify members who are pregnant
- encourage early and on-going prenatal and postpartum care
- provide pregnant members with information on how to manage their pregnancies

All members are screened to determine pregnancy risk and are referred to high risk obstetrics as appropriate. Anthem works in collaboration with members, obstetrician/gynecologist(s) and/or primary care providers to help meet the goals of the prenatal program.

Guidelines for the prenatal program are based upon the American Congress of Obstetricians and Gynecologists Guidelines for Perinatal Care and the Institute for Clinical Systems Improvement Guidelines for Routine Prenatal Care.

II. OBJECTIVES

A. The qualitative goals of the prenatal program are:

- Increase access to appropriate prenatal and postpartum care
- Increase identification of potential moderate- and high-risk pregnancies

B. The quantitative measures of the prenatal program are:

- The Healthcare Effectiveness Data and Information Set (HEDIS®) measure for timeliness of Prenatal Care within the first trimester or within 42 days of enrollment
- The HEDIS measure for Postpartum Care 21-56 days after delivery

III. DEFINED POPULATION

A. Target Population

Any Anthem member identified as pregnant may enroll in the prenatal program.

If a member:
- requests confidentiality
- is under the age of 18 and did not directly request enrollment, or
- is over 36.6 weeks of pregnancy at the time of program enrollment,

the Member Interventions set forth in Section IV below will not be implemented. However, we attempt to reach all members, except those over 36.6 weeks of pregnancy, to ask if the member would like to receive the Member Interventions.

B. Population Identification

All members who are identified as both 1) pregnant and 2) whose due date is known are automatically enrolled in the prenatal program. However, to continually communicate and educate about the prenatal program, we inform members of the prenatal program through:

- New member enrollment package
- Program notification letter
- Member newsletter
- Member website
Members are enrolled in the prenatal program through a variety of methods:

- Membership files with pregnancy indicator (automatic enrollment if due date provided)
- Provider referrals (automatic enrollment if due date provided)
  - Notification of Pregnancy (NOP)
    - Pregnancy Notification Report (PNR)
    - Utilization Management (UM) calls
- Health Management and Education (HME) Call Center calls
- Claims Data
- Membership files received from the state with pregnancy indicator
- Customer Care Center (CCC) calls
- Self referral calls

IV. MEMBER INTERVENTIONS

A. Prenatal Member Education Book

Members enrolled in the prenatal program receive an educational book that includes information on pregnancy related topics, breastfeeding and postpartum care.

B. Care Management

In this vital function of the program, we screen all prenatal program members to determine the need for more intense intervention, and nurse care managers (“Nurse Coach”) work closely with members and their physicians to facilitate an appropriate care plan complete with goals and interventions. Here is a more complete description:

- **Assessment:** The Nurse Coach completes a telephonic maternity health assessment on the participant, which helps determine the participant’s risk for pregnancy complications. She/he then establishes and prioritizes individualized intervention goals based on the participant’s current medical status, history of and current pregnancy complications, and the maternity care provider’s plan of care.

  As assigned, the Nurse Coach is available for ongoing one-on-one telephonic management and education for each participant. This consistency in relationship with an assigned nurse is an essential component of creating genuine change. Recognizing how vital our participants’ family support is to reaching successful outcomes, staff include family members of participants, per our established HIPAA protocols, according to the participants’ wishes. At the start of this process, a participant-specific profile is created with all available data, and a system-driven intervention plan with goals to facilitate adherence and readiness for change is also created at that time.

  - **Personalized Interventions:** The Nurse Coaches determine the confidence and conviction levels of their assigned members through an ongoing question and answer process. The most appropriate interventions are then implemented, to help facilitate the necessary changes to achieve the desired health goals.

- **Stratification:** Our program stratifies program participants into low-, moderate- and high-risk management categories. We assess low-risk participants initially and again at the 28-week gestational age mark and at any time the participant calls with health concerns and/or questions. The assigned Nurse Coach closely monitors those participants determined to be at moderate or high risk, and helps them adhere to the treating maternity care provider’s plan of care. If warranted, such as when a participant has special medical needs, the nurse verifies the plan of care with the maternity care provider.

  The Nurse Coach also acts as a coordinator in cases requiring home care, home infusion therapy, durable medical equipment and other services that support the plan of care. They coordinate access to benefits for services per approved protocol, regularly inform health plan case managers of participant progress, and maintain contact with the maternity care provider and health services vendor(s). At a minimum, the Nurse Coach contacts the high-risk participants on a monthly basis, but as often as daily if deemed necessary.
C. Postpartum Visit Reminder Card
   Prenatal program members receive a mailing to remind them of the importance of scheduling and attending their postpartum visit after delivery.

D. Postpartum Visit Reminder Live Call
   Prenatal program members receive a live call from Anthem to remind them of the importance of scheduling and attending their postpartum visit after delivery. This call includes a reminder on the importance of newborn exams and immunizations.

E. Postpartum Visit Reward
   Prenatal program members that Anthem identifies as completing their postpartum visit will receive a reward.

F. Prenatal Education Classes
   We refer prenatal program members to local health education classes by request or via a physician’s PNR that indicates a request for health education. Prenatal classes include topics such as early prenatal care, childbirth education, breastfeeding and baby care.

G. Breastfeeding Support Line
   The Breastfeeding Support Line is a nurse information line available 24 hours a day, 7 days a week. We encourage prenatal program members to call during their pregnancy and/or after childbirth for information on breastfeeding.

V. ANCILLARY HEALTH ASSOCIATES (SUCH AS SOCIAL WORKER, PHARMACIST, DIETICIAN, LACTATION CONSULTANTS)
   A. Work in collaboration with Nurse Coaches to provide participant assistance as applicable in helping with identified medical or psychosocial needs/issues such as community referrals, financial resources and dietary support.
   B. Provide direct participant assistance as applicable in helping with identified medical or psychosocial needs/issues such as community referrals, financial resources and dietary support.

IMPORTANT CONTACT INFORMATION

Future Moms Prenatal Program.................................................................877-337-5640
   TTY line for members with hearing or speech loss.........................866-408-7188
24/7 NurseLine..........................................................................................866-800-8789
   TTY line for members with hearing or speech loss.........................800-368-4424
Anthem Blue Cross and Blue Shield (Anthem) Breastfeeding Support Line...800-231-2999
   TTY line for members with hearing or speech loss.........................800-368-4424
Anthem Customer Care Center.................................................................866-408-6131
   TTY line for members with hearing or speech loss.........................866-408-7188
Hoosier Healthwise Helpline.................................................................800-889-9949
National Tobacco Quitline.................................................................800-QUITNOW or 800-784-8669