Strong Start for Mothers and Newborns

Introduction to Signature Medical Group

- Physician-owned, multispecialty physician group
  - Serving Greater St. Louis, Greater Kansas City and southwestern Missouri
  - Over 100 Board-certified or Board-eligible physicians
  - 450,000+ annual patient visits
  - On staff at 20+ hospitals
- Organized to improve health care outcomes, quality and efficiency:
  - Among the first to create standardized clinical guidelines and pathways
  - Episode of care for orthopedic surgeries contract yielded savings of over 20% while improving patient care, quality and outcomes
  - Standardized OB/GYN clinical guidelines

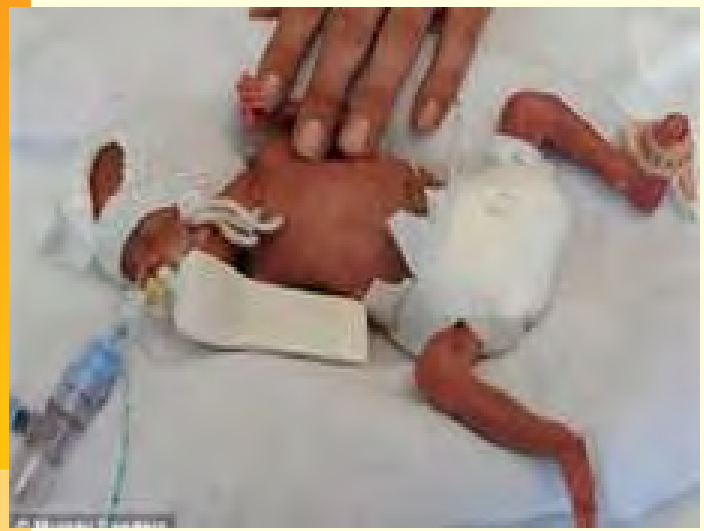
What is “Strong Start”?

- Four year initiative funded by the Centers for Medicare and Medicaid Services Innovations Center (CMMI)
- Goal: Test the impact of three enhanced prenatal care interventions to Medicaid/CHIPS beneficiaries at risk for preterm births in improving gestational age and reducing medical costs over the first year of life:
  - Specific, comprehensive, non-medical interventions to improve prenatal care delivery;
  - Not reimbursable services under current Medicaid/CHIPS
  - Address clinical, behavioral and psychosocial contributors to preterm-related poor outcomes

What is Strong Start?

- Three models of enhanced prenatal care:
  - Centering Pregnancy
  - Maternity Medical Home
  - Birthing Center
- Funding
  - 27 awardees funded nationally
  - Approximately 182 sites
  - SMG appears to be the only private medical group

Why Strong Start?



- Over 500,000 babies born prematurely each year
- Cost at least $26 billion annually
- ~12.5% babies are preterm
- Significant health and development issues.

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What Places Mothers at Risk for Preterm Births?

- Medical: Prior preterm birth, multiple gestations, gynecologic factors, medical conditions such as diabetes or preeclampsia
- Demographics: Poverty, maternal age, single mother, employment related physical activity, occupational or environmental exposures
- Psychosocial: Inadequate/no prenatal care, tobacco, alcohol or other drug use, inadequate nutrition, weight gain

IOM (2006) Preterm Births: Causes, Consequences and Prevention (Selected Examples)

Key Outcome Measures: Selected Examples

- Overall cost of medical care during the first year of life for babies born to high risk women
- Medicaid Maternity Core Measures: Gestational age, birth weight, frequency of prenatal visits, elective delivery < 39 weeks, antenatal steroids, maternal complications
- PCPI Measures: Prenatal screening, accuracy of gestational age, behavioral health assessment
- Utilization
- Health improvement activities
- Patient Satisfaction

SMG Strong Start Expectations

- Enroll a minimum of 500 Medicaid/CHIP beneficiaries per year
- Provide physician directed, team-based prenatal care
- Coordinate care across the perinatal continuum
- Enhance access through improved office processes
- Utilize real time metrics to guide clinical improvements

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SMG Strong Start Components

- Risk assessment and stratification to identify most at risk patients
- Nurse navigator will:
  - Collaborate with your offices
  - Follow patient between visits
  - Coordinate care

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SMG Strong Start Components

- Social Worker
  - Home based assessment
  - Resource referral and coordination
- Nutrition support
  - New prenatal class
  - Mid pregnancy nutrition class
  - Individualized counseling

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SMG Strong Start Overview

- Help accessing Medicaid
- Coordinated risk assessment by OB provider, nurse navigator and social worker
- Home visits
- Team-based care coordination and support
- Data collection and reporting for quality improvement

SMG Strong Start

SMG Strong Start	Traditional Prenatal Care
Initial appointment request triggers case coordination	No contact until initial appointment
Patient telephones office for problem; nurse navigator assists in coordinating care transitions	Traditional office, L& D or ER visit
Nurse navigator or social worker contact between visits guided by metrics and standardized care plan	Traditional prenatal care visits
Entry to care and mid-pregnancy social worker home visit	Office based care only
Strong Start team coordinates antepartum discharge planning and patient disposition to appropriate level of care	Patient discharged to home. Limited referral for community support
Coordinated post partum follow up and interconception health promotion	Scheduled for routine post partum visit

Next Steps

- Launch May 15, 2013 – patient enrollment
- Initiate IT based communication processes
- Refine risk stratification process
- Refine data collection and reporting plan

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