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.
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
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
SMG Strong Start Components

• Social Worker
  – Home based assessment
  – Resource referral and coordination

• Nutrition support
  – New prenatal class
  – Mid pregnancy nutrition class
  – Individualized counseling
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

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