Our Partnership With You in Promoting Quality Maternity Health

BlueCross BlueShield of South Carolina and BlueChoice HealthPlan were created with a vision to give the average citizen access to health care.

While most families have healthy childbirths, poor birth outcomes are emotionally devastating for many families. One of the most important factors in improving birth outcomes is prenatal care that is consistent, effective and engaging. This also requires commitment and collaboration among the health care community and expectant mothers.

Through joint efforts with the South Carolina Department of Health and Human Services (SCDHHS) and other organizations, we have aligned incentives and programs to support healthy pregnancies and reduce health disparities.

Within this publication, we will explain our maternity managed care programs, inform you of helpful tools to engage your patients and provide you with resources to integrate your patient care with our services. We will also share articles about the Birth Outcomes Initiative (BOI), using Screening Brief Intervention and Referral to Treatment (SBIRT) in your practice, benefits of Centering Pregnancy and more.

BlueCross BlueShield of South Carolina and BlueChoice HealthPlan offer maternity managed care programs you can incorporate as part of your patients’ overall health. We include these programs as part of your patients’ health insurance benefit with the purpose of supporting a healthy lifestyle. We’ve shared program details explaining what makes these programs ideal for obstetricians and gynecologists to encourage their patients – our members – to use.
Working Together to Encourage Overall Maternity Health

• BlueChoice® created the Great Expectations® Before Baby program to help your patients of childbearing age prepare for pregnancy. Members who enroll in this program receive telephone counseling sessions covering general preconception information and information about their specific conditions. We also provide referrals to other Great Expectations programs that can help with other health issues, such as asthma, diabetes or quitting smoking.

• Great Expectations Maternity helps members take the right steps toward having a healthy baby. We provide free educational materials, including a list of helpful community resources, and ongoing support and monitoring by our nursing staff. Your patients receive telephone counseling sessions covering general maternity information and facts about the member’s specific condition. The number of calls we make depends on the member’s risk level and her individual pregnancy. Referrals to other Great Expectations programs, a telephone call and/or follow-up letter after delivery and helpful information about postpartum blues and postpartum depression are other services BlueChoice provides.

• Companion Benefit Alternatives, Inc. (CBA) offers Health Coaching for Moms, a program designed to give mothers early treatment for depression through use of a coach. CBA is a separate company that administers mental health and substance abuse benefits on behalf of BlueCross and BlueChoice. To help get patients’ lives back to normal, the health coach provides guidance and support through scheduled phone calls, sets short- and long-term goals in the recovery process and identifies facilities and providers.

• Be sure to complete the Pregnancy Notification form for BlueCross and BlueChoice members. This easy-to-use form ensures members receive support early during pregnancy. This form is not a request for prior authorization but is simply a notification that our member is expecting. The form also gives us information, such as the expected delivery date.

Did You Know?

We send members an invitation to join BlueChoice’s Great Expectations Maternity program when we receive a maternity authorization from you.

CBA has an online tool – Beating the Blues™ – that is an effective, clinically proven treatment for stress, depression and anxiety.

We allow two breast pumps, the Ameda Purely Yours electric pump and the Ameda One Hand manual pump, for members who qualify with no cost sharing.

Source:http://BlueChoiceSC.com/healthwellness/greatexpectationsforhealthprograms/maternity.aspx
By now, you may have heard about our work with SCDHHS to improve health outcomes for newborns throughout the state’s population. You may already know the core objectives of this initiative are to:

1. End elective inductions for non-medically indicated deliveries before to 39 weeks.
2. Reduce the average length of stay in neonatal intensive care units (NICUs) and pediatric intensive care units (PICUs).
3. Lower health disparities among newborns.
4. Make 17P – the health compound that helps prevent pre-term births – available to all at-risk expectant women without difficulty.
5. Implement a universal screening and referral tool for physicians to screen pregnant women for tobacco use, substance abuse, alcohol, depression and domestic violence.

What does this mean for your practice? Here you can find how to turn a statewide initiative into a fully adopted realization for your staff and patients.

**Ending Elective Inductions for Deliveries After 39 Weeks or Less**

According to the American Congress of Obstetricians and Gynecologists (ACOG), health care professionals recommend that unless there is a valid health reason or labor starts on its own, delivery should not occur before at least 39 weeks. ACOG is an independent organization that provides health information on behalf of BlueCross and BlueChoice. If you schedule your patients for a cesarean delivery or labor induction for a medical reason, it means that the benefits of having the baby early outweigh the potential risks. But when you perform them for a nonmedical reason, the risks – both to the mother and to the baby – may outweigh the benefits. The efforts to push the BOI campaign statewide have successfully reduced non-medically necessary early-elective inductions by 50 percent from 2011 to 2013. Sixty percent of all birthing hospitals in our state boast a rate of 0 percent for early elective inductions between 37 and 38 weeks. Practitioners can continue to focus on prevention of first cesarean and support vaginal births, including vaginal births after cesarean (VBAC), to uphold this aspect of the initiative.
Decreasing NICU Admission Rates and Average Length of Stay

An NICU length of stay can average up to four days for 30-35 percent of NICU admissions. The remaining 65-70 percent of NICU admissions have an average length of stay of about 20 days. The NICU patients who stay more than four days are a source of large expenditures, typically $40,000 to $80,000 in costs. The cost associated with late preterm infants is what BOI aims to eradicate. You cannot think of infants between 34 and 37 weeks gestational age as just “small-term infants.” They have increased medical risks, including a higher risk for NICU admission, a hospital length of stay four to five times as high as uncomplicated full-term infants and increased short-term morbidities.

Providers caring for expectant women can impact this initiative by using evidence-based practices with regard to advanced maternal age, use of assisted reproductive technologies that often result in multiple gestation births, safeties of vaginal deliveries after cesarean births and incidence of diabetes and/or excessive weight gain.

Lowering Health Disparities Among South Carolina Newborns

The Palmetto State’s infant mortality rate hit an all-time low last year, but that achievement largely bypassed its rural corners, where infants, white and black, still die at Third-World rates. South Carolina has long ranked among the deadliest states for newborns. Since 2000, 6,696 South Carolina babies have died before their first birthday.

Eight of South Carolina’s 46 counties don’t have an obstetrician. Two other counties have only one part-time specialist. This leaves patients with little or no ability to get vital health care needed during their pregnancies. The system set up to train physicians in South Carolina and throughout the United States does little to encourage medical school graduates to practice in rural areas, where the need for health care is most acute. The vast majority of more than 500 OB/GYNs in South Carolina practice in the state’s three main metropolitan areas — Charleston, Columbia and Greenville — making it extremely difficult for many women to get specialized care during their pregnancies.

Being able to afford medical care and get to medical offices is critical in preventing infant mortality, because a baby’s fate lies with the mother’s health before and during the pregnancy. Without a healthy diet and regular health care during pregnancy, serious problems can develop, and babies will die or survive with deformities.

The most effective way to lower health disparities – and thereby reduce infant mortality – is to educate patients on improving their health.

Making 17-Hydroxyprogesterone Carproate (17P) Easily Accessible

Administration of the 17P drug is another primary goal of the initiative to improve health outcomes for newborns in our state. The partnership aims to make the drug “available to all at-risk pregnant women with no ‘hassle factor.’” These injections, sold under the brand name Makena, may be given to pregnant women who previously gave birth to premature infants. The shots are considered an effective way to prevent the mother’s next baby from being born too early. We consider this therapy beneficial for a patient who meets all these requirements:

- Is between 16 and 36 weeks gestation
- Has a history of preterm singleton delivery before 37 weeks gestation
- Has no preterm labor in the current pregnancy
- Has no allergies to components of progesterone treatment
Applying SBIRT in Your Practice

Your expectant patients who need help with such issues as alcoholism, substance abuse and domestic violence can benefit greatly from this program. SBIRT is a universal tool designed so doctors can identify pregnant women who need help with these issues and refer them to treatment.

The state pays providers a small fee for each SBIRT test they administer, but the industry has been slow to catch on. Recent data from the state shows Medicaid paid for 31,038 deliveries in 2013, but only 7,953 SBIRT screenings. That means providers did not refer pregnant women who may be harming their unborn babies to treatment.

Let your medical practice be a model of change for implementing SBIRT. Consistently ask your patients about their personal problems. It will not annoy your patients. An Oregon SBIRT Primary Care Residency Initiative survey found more than 92 percent of patients were open to discussing their substance use to help their health. When you find risky or problematic behavior, employ brief motivational and awareness-raising intervention, culminating in an agreement to follow up with specialty treatment services.

Now it’s up to you. Lend your support to improving the health of newborns in the Palmetto State. You can do this by taking steps to align your practice with the key goals of BOI. As stated by Gov. Nikki Haley, “The Birth Outcomes Initiative is a wonderful example of leaders in the health community working together as a team in South Carolina’s fight against premature birth.”

ACOG source: http://acog.org/Patients/FAQs/Elective-Delivery-Before-39-Weeks
Source: http://bcbs.com/blog/better-starts-mean-better.html
Source: http://postandcourier.com/infant-mortality/
Source: http://fda.gov/downloads/drugs/developmentapprovalprocess/developmentresources/ucm252976.pdf
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Did You Know?

• The Agency for Healthcare Research and Quality reports that medical costs for the average very-low-birthweight infant are $79,000, compared to $1,000 for a normal newborn. The Agency for Healthcare Research and Quality is an independent organization that provides health information on behalf of BlueCross and BlueChoice.

• Eight South Carolina counties do not have a single OB/GYN: Allendale, Barnwell, Fairfield, Hampton, Lee, McCormick, Saluda, Williamsburg

• 92 percent - The percentage of patients who strongly agree with survey response, “If my doctor asked me how much I drink, I would give an honest answer.”
What is SBIRT?

It has been proven that substance use, depression and domestic violence during pregnancy can have negative implications for maternal and child health. Appropriate screening using the universal SBIRT tool is necessary to identify women at risk and reduce the likelihood of continued risky actions.

SBIRT is an evidenced-based, integrated and comprehensive public health approach for identifying at-risk patients, intervening and referring them to treatment. Providers use SBIRT to screen for tobacco use, substance and alcohol use, depression and domestic violence by incorporating a simple questionnaire into maternity care.

Benefits of SBIRT

SBIRT provides a consistent structure for early intervention and referral. By incorporating the use of this referral tool into your maternity and treatment plan, you are engaging in open and honest communication with patients and partnering with other medical professionals to reduce health disparities.

The SBIRT referral process consists of four components:

1. **Screening** – very brief process of identifying substance use, behavioral health issues, domestic violence and tobacco use
2. **Brief Intervention** – a five- to 10-minute conversation with the goal to raise awareness of risks and motivate the patient toward acknowledgement of the problem
3. **Referral** – when you identify a risk, referring the patient for further treatment
4. **Treatment** – cognitive behavioral work for the patient to prevent complications and reduce or eliminate existing risk factors

Making Motivational Interviewing Work in a 15-minute Office Visit

Motivational interviewing (MI) is an excellent technique to achieve success during an intervention. The MI approach is a way of communicating concerns with patients by asking permission to discuss risky behavior. MI focuses on the spirit of collaboration in an autonomous, respectful and compassionate manner. Using MI allows you to elicit reasons for change from patients by enhancing the patients’ own motivation to change and aid in resolving ambivalence. MI assumes you can influence motivation in the context of a supportive relationship between you and the patient, with the goal of influencing change.

Coordination of Care: Working With Other Providers You Know

Help build a network of support and care coordination for your patients by referring those with a positive screening (identified as at-risk) to network participating providers for further assessment and treatment. Consider professionals you know and trust to support the goals and objectives of your patients.

Also, consider referring patients to well-known state agencies:

- South Carolina Department of Mental Health (SCDMH)
- Department of Alcohol and Other Drug Abuse Services (DAODAS)
- Department of Health and Environmental Control (DHEC) Tobacco Quitline
- South Carolina Coalition Against Domestic Violence and Sexual Assault (SCCADVASA) Domestic Violence Hotline

For more information about the SBIRT program, including participating plans and the referral process, please refer to www.SouthCarolinaBlues.com or www.BlueChoiceSC.com.

Source: http://www.nova.edu/gsc/forms/mi_rationale_techniques.pdf
Centering Pregnancy

BlueCross and BlueChoice introduced the Centering Pregnancy program July 1, 2014. Centering Pregnancy involves care between providers and pregnant women to improve health outcomes. The program is a model of group health care, which integrates the three major components of care into a unified program:

1. Health assessment
2. Education
3. Support

This program operates with approved practices or those under contract with the Centering® Healthcare Institute. The Centering Healthcare Institute is an independent company that provides wellness education information on behalf of BlueCross and BlueChoice HealthPlan:

- GHS OB/GYN Center
- Mountain View OB/GYN – Easley
- University Specialty Clinic, USC – Columbia
- MUSC Department of OB/GYN – Charleston
- Sumter OB/GYN
- Anmed Anderson OB/GYN
- Carolina OB/GYN – Georgetown and Murrells Inlet
- Montgomery Center for Family Medicine – Greenwood
- Carolina Women’s Center – Clinton
- University Medical Group – Greenville

Women with similar gestational ages meet with their providers. During this time, they learn care skills, participate in facilitated discussions and develop a support network. As part of the program, eight to 12 women meet as a group for a total of 10 sessions. This will occur throughout their pregnancy and early postpartum care. The sessions include:

30-40 minutes
- Check-in and individual assessments with the provider

60-75 minutes
- Formal “circle-up” for facilitated discussion time
- Informal time for socializing
- Closing and follow-up as needed

The program promotes self-care skills, increased time with the provider, increased patient knowledge and satisfaction. The program also promotes better health outcomes, including an increase in breastfeeding, increased birth weight, decreased preterm labor and reduced NICU admission rates.

There are steps you will need to take to become a Centering provider. From the Centering Healthcare Institute’s website, complete a readiness assessment to help you understand how Centering will fit with your practice setting. A Centering representative will contact you and give you a Centering implementation plan that equips you with the tools you need to become a sustained Centering practice. Centering Healthcare Institute requires your practice to have a steering committee to inform and engage other members of the staff, providers and leadership to make the changes needed. Centering Healthcare Institute will pair a Centering consultant with you to guide your steering committee through the process of getting your site ready for Centering groups. For more detailed information about becoming a Centering Pregnancy provider or about the Centering Healthcare Institute, please visit www.centeringhealthcare.org.

Source: http://centeringhealthcare.org/pages/centering-model/group-start-up.php

(This link leads to a third party site. That company is solely responsible for the contents and privacy policies on its site.)
BlueCross and BlueChoice participate in many national quality efforts that advocate for better health care for women and infants, including the Healthcare Effectiveness Data and Information Set (HEDIS®). HEDIS is a tool that measures performance in the delivery of medical care and preventive health services. The National Committee for Quality Assurance (NCQA) administers HEDIS yearly. Our voluntary participation in the NCQA accreditation process reflects the company’s commitment to the transformation and improvement of the health care system.

NCQA is an independent, not-for-profit organization dedicated to assessing and reporting on the quality of health plans, managed behavioral health organizations, preferred provider organizations, physician organizations and physicians. It also credentials verification organizations, disease management programs and other health-related programs.

The accreditation process involves NCQA sending a team of trained health care experts, including physicians, to perform a rigorous on-site survey of the health plan. NCQA uses information from health plan records, consumer surveys, interviews with plan staff and performance on selected HEDIS (performance) measures. NCQA purposely sets the standards high to encourage health plans to continuously enhance their quality. The intention is to help organizations achieve the highest level of performance possible, reduce patient risk for untoward outcomes and create an environment of continuous improvement.

We use HEDIS to assess the overall performance of the medical care our providers deliver. We use the results to identify areas for improvement, develop quality initiatives and provide educational programs for our providers and members.

HEDIS assesses multiple areas of medical care, including maternity and postpartum care. The measures for maternity ask:

1. **Timeliness of prenatal care** – the percentage of deliveries during which the patient received a prenatal care visit during the first trimester or within 42 days of enrollment in the health plan.

2. **Postpartum care** – the percentage of deliveries during which the patient had a postpartum visit on or between the 21st and 56th day following the delivery.

ACOG is another national advocacy group of professionals providing health care for women to which we align our quality goals. ACOG aims to foster and stimulate improvements in all aspects of the health care of women. It establishes and promotes policy positions on issues affecting the specialty of obstetrics and gynecology. Its high standard of clinical practice and commitment to increasing awareness of the public to the changing issues facing women’s health care make it a great resource to further educate your patients on the importance of becoming healthier moms.

BlueCross will continue to work in collaboration with leading authorities and professional organizations at the state and national levels to improve the quality of life for our members. Our voluntary participation in several maternity quality initiatives makes a difference in the health of our members. It also demonstrates our support for our provider community, which plays a major role in this effort.

Source: [http://BlueChoiceSC.com/UserFiles/bluechoice/Documents/Agents/NCQA_Accreditation.pdf](http://BlueChoiceSC.com/UserFiles/bluechoice/Documents/Agents/NCQA_Accreditation.pdf)

Source: [http://acog.org/About-ACOG/Leadership-and-Governance](http://acog.org/About-ACOG/Leadership-and-Governance) (This link leads to a third party website. That company is solely responsible for the contents and privacy contents on its site.)
Want to know how your practice is performing when it comes to HEDIS maternity measures?

Ask us for a copy of your BlueCross OB/GYN Report Card by emailing provider.education@bcbssc.com or by calling 803-264-4730. We make this report available to our participating obstetricians and gynecologists to increase awareness of our maternity quality initiatives and how your patient care impacts this effort.