Pennsylvania Department of Public Welfare
DRAFT Obstetrics Care and Delivery EQUIP

Focus Area	Lead Agency	2011 Objectives	Provider Goals
OB Care and Delivery	**OMAP**	**Acceptance, Metric and Clinical Rates**	
Improve Quality, Cost Containment and Efficiency	1. Predictive Modeling: Stratify low, medium and high risk pregnancies 2. Develop clinical decision support for Providers (Pop-ups for providers for pregnant women: ACOG guidelines, etc.) 3. Early identification of pregnant women: establishing requirements for pharmacy claims, labs and enrollment 4. Pharmacy utilization rates (ability of Department to track medication usage, adherence and abuse 5. Physician access to pharmacy data 6. Healthy Beginnings Plus (?) 7. Pregnancy indicator on CIS 8. Medical Case Manager for co-existing medical conditions: diabetes, hypertension (all EQUIPS)	**Acceptance Rate:** 1. Twenty percent of ARRA OB/GYN providers are using certified EHR/EMR **Metric Rate:** 1. Monitor HEDIS rates for: a. Timeliness of prenatal care b. Frequency of ongoing prenatal care c. Post-partum care 2. Monitor depression rates **Clinical Rate:** 1. Increase adherence to maternal vitamins 2. Screen mother for: a. Drug/alcohol abuse b. Psychiatric medications/conditions c. Social issues (DV, homelessness, etc.) 3. Monitor appropriate utilization of 17H-P	1. Automatic Order Sets 2. Depression screening[1] 3. Needs assessment completed through common OBNA form submitted electronically by trimester and post-partum 4. Use of care plans with HEDIS measures; 5. E-prescribing (all EQUIPS) 6. ACOG guidelines being used for pregnancy 7. Labs 8. Smoking assessment and cessation counseling 9. Vitamin adherence 10. PDL Adherence (all EQUIPS)

[1] Validated tool used and submitted. Use ACOG Conduct a two question screening: 1) Over the past two weeks, have you ever felt down, depressed or hopeless? 2) Over the past two weeks, have you felt little interest or pleasure in doing things? If positive, complete a full depression assessment. (Edinburgh Postnatal Depression Scales)

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Engage Patients and Families	1. Identify race/ethnicity for review of treatment disparities 2. Develop pop-up alerts for providers that signify needed care (all EQUIPS) 3. Develop pop-up alerts for consumers that signify needed care (all EQUIPS) 4. Ability to send/receive text/ email messages to provider (all EQUIPS) 5. Peer support/coaching (all EQUIPS)	**Clinical Rates:** 1. Increase outreach efforts in WIC programs and shelters to identify pregnant women 2. Improve patient engagement through counseling of the mother and family members 3. Begin expanding HealthChoices and ACCESS Plus member services by developing programs that allow consumers to access records (all EQUIPS) 4. Increase enrollment of pregnant women in WIC 5. Computer kiosks in FQHCs and RHCs for consumers to access their: a. Health information, including current medication list for reconciliation b. Current care plan c. Upcoming appointments d. Review care gaps e. Offer to pay for partial cell phone coverage each month so contact with consumers can be maintained	1. Patient education on importance of prenatal and post-partum visits 2. Referrals to WIC programs/shelters 3. Text messages to remind them of appointments/reminder calls (all EQUIPS) 4. Website for health information, including the same hyperlinks to MA Guidelines that are available via the ACCESS Plus website (all EQUIPS) 5. Ability to send/receive text/email messages to consumers (all EQUIPS) 6. Availability of appointments (Appointment standards), and ability to schedule and re-schedule appointments 7. Comprehensive patient-centered care plan, and provider collaboration with the consumer or caregiver in the development of electronic care plan 8. Physician and Case Manager educating patients about illness prevention, disease management and treatment options 9. Group support: 10-12 women who stay together for their whole pregnancy

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Improve Coordination of Care	1. Case management that focuses on identifying care gaps and increasing referrals for specific categories 2. Improve coordination of care for behavioral health issues, physical health issues, substance abuse and depression 3. Links for providers to patient specific data (all EQUIPS)	**Metric Rate:** 1. Develop a common statewide OBNA form **Clinical Rates:** 1. Establish Medical/Dental home assignments 2. Increase screening, prenatal and post-partum, and referrals in these areas: a. Drug and Alcohol b. Depression c. Smoking d. Use of electronic care plans	1. Certification and referral to Medical/ Dental home 2. Completion of OBNA at various stages of pregnancy 3. Medication reconciliation and adherence: prescription and alternative medications (Medication possession ratios)
Reduce Cycle Time between "New" Evidence-based Healthcare and Community Practice	1. Provider education, training and support on the use of technology in the practice. Hyperlinks to best practices 2. Long term: Question ability to get a license for "up-to-date" (non-personal use) and provide a link for providers to access 3. Question cost	**Metric Rates:** 1. Integrate HEDIS guidelines into the certified EHR/ patient care plan 2. Begin to analyze HEDIS measures that lead to proposed changes in clinical care **Clinical Rate:** 1. Create provider links to current treatment guidelines	1. Statewide adoption of OBNA form 2. Participation of providers in tracking trends and performance measures in clinical care (P4P, HEDIS)