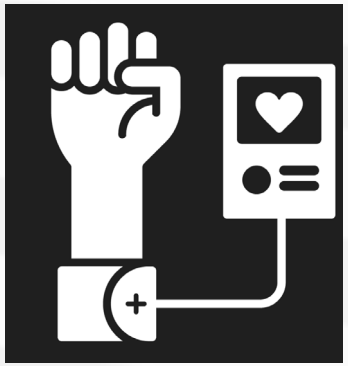

Improving Measure Outcomes:
Perinatal Care and Chlamydia Screening

Dr. Colleen Townsend
Regional Medical Director

Kimberly Robertello, Ph.D.
Improvement Advisor

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Learning Objectives

KR

- Define the clinical background, specifications, and performance threshold definitions of the 2024 Quality Improvement Program Specifications: 2024 Perinatal Quality Incentive Program Specifications: *Women* and *Timely Postpartum Care* screening measures.
- Identify barriers for timely prenatal and postpartum care and discuss best practices for implementing effective care practices.
- Understand clinical background and importance of the Sexually Transmitted Infection (STI) measure: Chlamydia Screening in Women.
- Evaluate the prevalence and risk factors for chlamydia and associated health inequities in the diagnosis and treatment of chlamydia.
- Identify best and promising practices including accessing care, successful clinical workflows, member/staff education, outreach, addressing social context which influence treatment decisions, referrals to local community resources, and technical tips to improve women's sexual and reproductive health.

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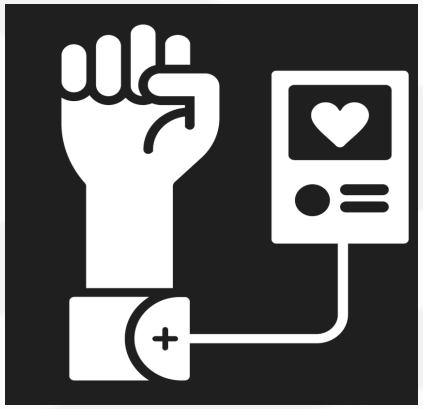

Overview of Measures

Timely Perinatal and Post-Partum Care

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Purpose of Prenatal and Post-Partum Care

CT

- Prenatal and post-partum care aims to support healthy outcomes for pregnant person and infants.
- Prioritizes screening for and management of complications including but not limited to:
  - Cardiovascular
  - Infections
  - Psychosocial factors
  - Normal development of fetus
- Not all practices offer prenatal care. Primary care provider practices are an important link for timely prenatal care and for providing services after pregnancy as well as infant care.

Recommendations for Perinatal Care

CT

Prenatal Visits

- First visit in first trimester
- Identify behavioral health and substance use disorders
- Screening for high risk medical conditions
- Breast feeding & family planning discussions
- Vaccinations: TDAP, Influenza and COVID19 and RSV
- Develop relationship with patient

Post-Partum Visits

- 2 visits: first within 3 weeks and follow up by 12 weeks
- Screening for post partum depression
- Lactation support
- Implement family planning
- Address conditions or risks identified in pregnancy
- Connection to healthcare systems

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Post-Partum Visits Components

CT

Two visits recommended post partum:

- <21 Days
- 22 – 84 days

Documentation to include:

- Weight and blood pressure
- Depression screening and follow up as indicated by results
- Lactation education/support
- Family planning discussion
- Examination of abdomen/breast as needed

Perinatal Mood Disorders: Bad for Mom and Bad for Baby

CT

Maternal Impacts

Pregnancy Effects

- Preterm delivery
- Small for gestational age
- Low birth weight infant

Post-Partum Effects

- Negatively impacts parenting and interactions with infant/children

Infant /Child Impacts

- Early cessation of breast feeding
- Fewer preventative visits
- Fewer vaccinations
- Increased behavioral and cognitive issues
- Increased risk for psychiatric disease

Screening for Mood Disorder Diagnosis

CT

Highly Predictive Factors

- Personal history
- Current symptoms but not meeting criteria
- Current intimate partner abuse
- Low socio-economic status
- Single or teen parent

Additional Associated Factors

- History of physical or sexual abuse
- Medical complications to pregnancy
- Family history of depression
- Poor social/financial support
- Current stressful life
- Unplanned/undesired pregnancy

Interventions to Stem Impact of Perinatal Depression and Risk for Depression

CT

At Risk or Moderate Depression

Behavioral Health Therapy and Supportive Services:

- Cognitive behavioral or interpersonal therapy
- Refer to Partnership Growing Together program
- Consider Partnership Care Coordination

Refer to: Carelon (Beacon) Perinatal Services phone number - (855) 765-9703

Severe Depression

Medication Management + Behavioral Therapy:

- SSRI and SSNRI safe and effective
- Reassess every 1-2 weeks after starting Rx, titrate if no change after 4-6 weeks
- Treat at least 6 months

Refer to: Carelon (Beacon) Perinatal Services, Partnership Care Coordination and Growing Together Programs

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Maternal and Infant Health Disparities

CT

- Disparities exist for preterm labor and birth, pregnancy-related deaths, stillbirth, low birthweight, gestational diabetes, and other clinical conditions, which impact overall health for women and infants.
- Increased barriers to abortion services for people of color widens existing disparities in maternal and infant health.
- Black and AI/AN persons have higher rates of pregnancy-related death compared to white women.
- Black and AI/AN infants have twice the rate of infant mortality than white/non Hispanic.

Disparity by Maternal and Infant Outcomes

CT

Infant Mortality

American Indian/Alaska Natives (AIAN)

- Twice the infant mortality rate as non-Hispanic whites
- 2.7 times more likely than to die from accidental deaths before the age of one year
- 50% more likely to die from complications related to low birthweight

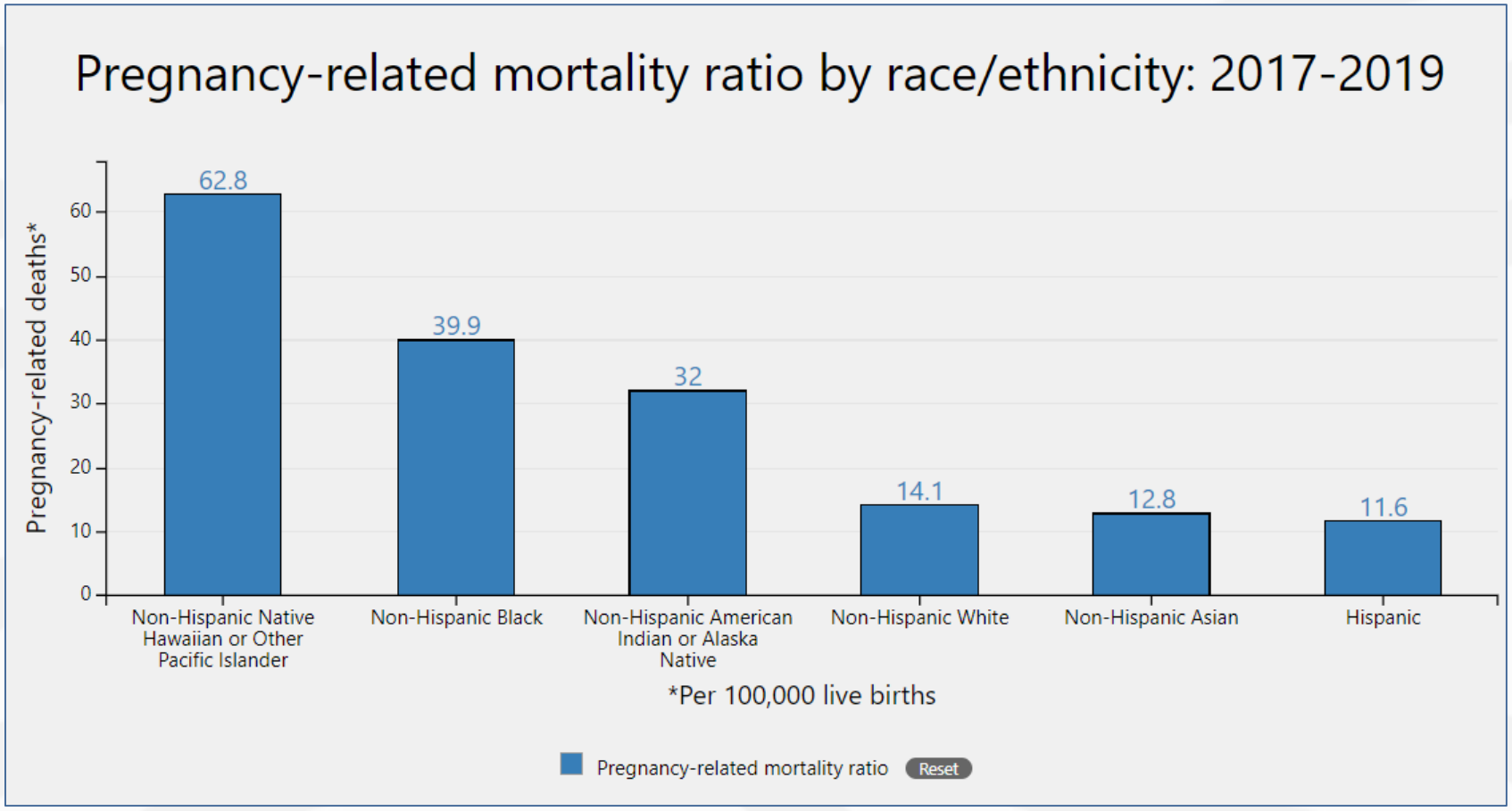
African American

- Twice that of white, non-Hispanic and Hispanic infants

Source: National Center for Health Statistic Data Brief No. 489, December 2023
https://www.cdc.gov/nchs/data/databriefs/db489.pdf

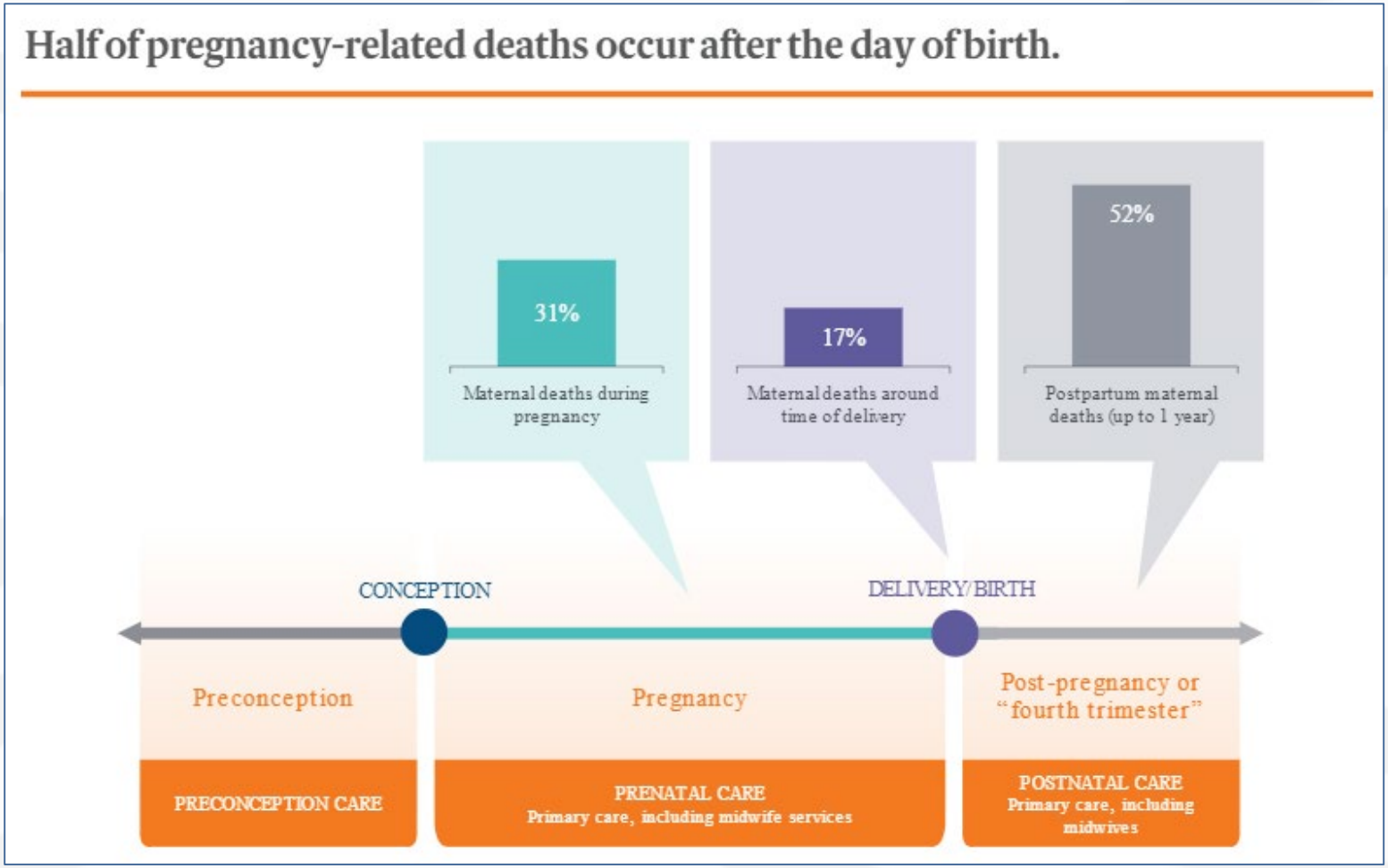
Disparities in Maternal Mortality

CT



Source: Pregnancy Mortality Surveillance System https://www.cdc.gov/reproductivehealth/maternal-mortality/pregnancy-mortality-surveillance-system.htm#:~:text=During%202017%E2%80%932019%2C%20the%20pregnancy,among%20non%2DHispanic%20Black%20persons

Continuum of Care and Pregnancy-Related Deaths



Source: https://www.commonwealthfund.org/publications/issue-brief-report/2020/dec/maternal-mortality-united-states-primer

Partnership Timely Prenatal Care Disparities 2022

Healthcare Effectiveness Data and Information Set (HEDIS®) Data

CT

NE	NW	SE	SW
90.49	86.27	83.09	94.56

NW

American Indian/Alaska Native	81.08
Asian/Pacific Islander	88.89
Black	50
Hispanic	88.71
Other/unknown	100
White	85.49

NE

American Indian/Alaska Native	100
Asian/Pacific Islander	92.86
Black	100
Hispanic	87.88
Other/unknown	75
White	91.12

75th%	88.86
50th%	85.4
25th%	81.27
below 25th%	

SW

American Indian/Alaska Native	100
Asian/Pacific Islander	66.67
Black	100
Hispanic	94.92
Other/unknown	94.87
White	95.12

SE

American Indian/Alaska Native	--
Asian/Pacific Islander	80
Black	70.59
Hispanic	86.05
Other/unknown	86.44
White	77.14

2023 Perinatal Post-Partum Care Health Equity

CT

NE	NW	SE	SW
79.02	85.67	88.41	90.48

NW

American Indian/Alask	81.10
Asian/Pacific Islander	100.00
Black	66.70
Hispanic	87.10
Other/unknown	92.90
White	85.00

NE

American Indian/Alask	92.90
Asian/Pacific Islander	71.40
Black	70.00
Hispanic	72.70
Other/unknown	70.00
White	80.80

75th%	84
50th%	77
below 50th%	

SW

American Indian/Alask	100.00
Asian/Pacific Islander	100.00
Black	100.00
Hispanic	91.50
Other/unknown	89.70
White	87.80

SE

American Indian/Alask	--
Asian/Pacific Islander	80.00
Black	82.40
Hispanic	88.40
Other/unknown	91.50
White	88.60

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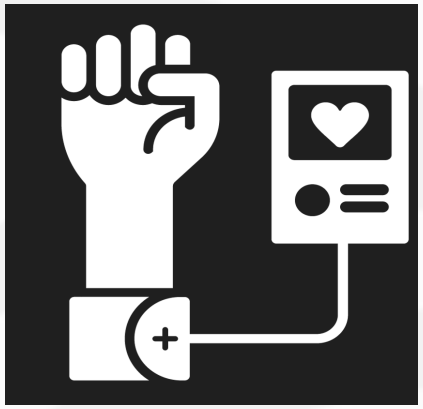

Overview of Measures

Chlamydia Screening

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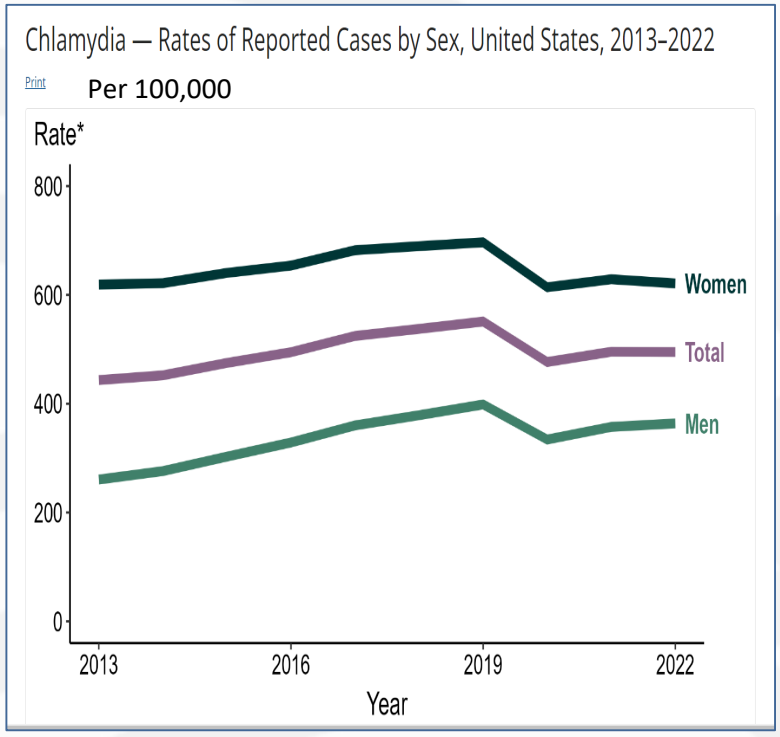
Chlamydia Rates and Impact

CT

Rates of Chlamydia Infection California



*Rates have been increasing since 1990 when the rate was 150/100,000

Chlamydia Counts

- Chlamydia is the most common STI
- May be without symptoms
- Has long term impact: Pelvic Inflammatory disease, Tubal pregnancies, infertility
- Untreated in pregnancy can cause neonatal blindness

Source: CDC STI Surveillance, 2022
https://www.cdc.gov/std/statistics/2022/overview.htm#:~:text=The%20rate%20of%20reported%20chlamydia,628.8%20to%20621.2%20per%20100%2C000
.

CDC Chlamydia Screening and Treatment Guidelines for Women

CT

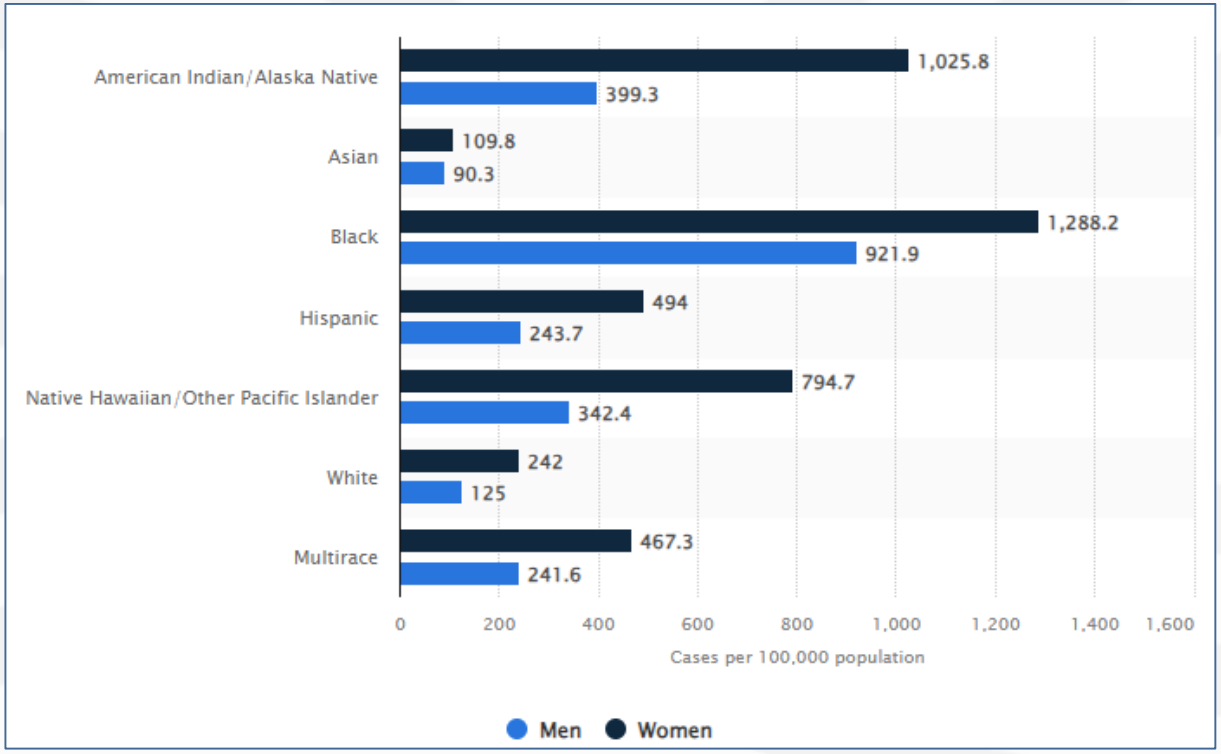
- Annually for sexually active women under 25 years of age
- Pregnant members
  - **ALL** members with risk factors; repeat in third trimester
  - Test of Cure 4 weeks after treatment and retest within 3 months after treatment
- Sexually active women 25 years of age and older if at increased risk:
  - New sex partner
  - More than one sex partner
  - Sex partner with concurrent partners
  - Sex partner who has an STI
- Treat with Antibiotics + Abstinence for 7 days from start of treatment
  - Treat Partners
  - Retest 3 months after treatment

Source:
https://www.cdph.ca.gov/Programs/CID/DCDC/Pages/California-STI-Screening-Recommendations.aspx

Chlamydia Health Disparities

CT

- Provider chlamydia testing differs by age, race/ethnicity, and insurance status when a person presents with STI symptoms and no prior medical history.
- This bias may contribute to a higher reported rate among younger, minority, and poor women.



Source: https://journals.lww.com/stdjournal/fulltext/2010/12000/Disparities_in_Chlamydia_Testing_Among_Young_Women.4.aspx

2023 Chlamydia Health Equity Data

CT

NE	NW	SE	SW
49.13	52.38	61.27	58.49

NW

American Indian/Alask	54.50
Asian/Pacific Islander	50.00
Black	50.00
Hispanic	57.10
Other/unknown	57.80
White	49.70

NE

American Indian/Alask	49.60
Asian/Pacific Islander	57.60
Black	50.80
Hispanic	49.90
Other/unknown	47.90
White	48.70

90th%	68
50th%	55
below 50th%	

SW

American Indian/Alask	50.60
Asian/Pacific Islander	53.00
Black	71.80
Hispanic	60.40
Other/unknown	63.20
White	51.90

SE

American Indian/Alask	52.90
Asian/Pacific Islander	55.50
Black	71.10
Hispanic	60.80
Other/unknown	64.00
White	55.40

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Perinatal Quality Incentive Programs and HEDIS®

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Perinatal Quality Improvement Program (PQIP)

CT

What is it?

- A value based program that focuses on financial incentives for Comprehensive Perinatal Services Program (CPSP) providers offering timely and high quality prenatal services to Partnership members.

Why does Partnership offer financial Incentives?

- Financial incentives offer enhanced reimbursement which encourages practices to provide high quality care and build systems that support this care.

Perinatal QIP Measure Sets

- Timely Prenatal and Post Partum Care
  - Includes depression screening
- Vaccinations in Pregnancy: TDaP and Influenza
- Electronic Clinical Data System (ECDS)

Detailed information can be found in the
2023-24 PQIP Measures Specifications Manual

Measure Specification - Timely Prenatal Care

CT

Measure Description

Timely prenatal care services are rendered to pregnant Partnership members in the first trimester, as defined as less than 14 weeks of gestation, or within 42 days of enrollment in the organization.

Measurement Period: July 1, 2023, to June 30, 2024

Documentation to include:

- Comprehensive physical exam
- Assessment of complete medical and social history including
  - History of GD
  - Use of drugs, alcohol or tobacco during pregnancy
  - C-section prior to the pregnancy
  - Issues with previous pregnancy
- Depression screening using validated tool and score reported

Measure Specification - Timely Postpartum Care

CT

Measure Description

Two timely postpartum care services rendered to PHC members with one occurring within 21 days after delivery and the other occurring between 22 and 84 days after delivery.

Measurement Period: April 8, 2023, to April 7, 2024 (index period by which women with live births are identified)

Documentation to include:

- Date of delivery and live birth confirmation
- A complete postpartum visit with notations
- Depression screening
- Provider attestation of lactation evaluation and discussion of family planning

More detailed information can be found in the
2023-24 PQIP Measures Specifications Manual

Chlamydia Healthcare Effectiveness Data and Information Set (HEDIS®) Measure

Measure Description

The percentage of women 16-24 years of age who were identified as sexually active and who had at least one test for chlamydia during the measurement year.

Best practices:

- Universal screening for all patients 16+ using family planning
- Consider screening all women 18+ regardless reported of sexual activity
- Standardized processed for taking sexual history
- Routine trainings for CDC/CDPH Guidelines for STI screening and treatment for providers and back office staff

Putting Quality Into Practice

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Perinatal Best and Promising Practices

KR

Timely Prenatal Care

- Train all reception / front office staff in “pregnancy dating” based on Last Menstrual Period to schedule in first trimester.
- Consider a variety of appointment options: after hours, same day appointments, and weekends, telehealth allowed for ONE post partum visit.
- Refer all pregnant patients to CPSP services for case management and system navigation.
- During pregnancy, inform patients of the importance of two post-partum visits.

Perinatal Best and Promising Practices

Post-Partum Visits

- Schedule first post partum visit **before** patient is discharged from hospital.
- Develop relationship with delivery hospital to view weekend discharges and contact patient to schedule post partum visit.
- For PCP pediatric providers, remind birthing parents of the importance of post partum appointments.
- Contact patients prior to post partum visit to asses if transportation needed.
- Ensure continued access to CPSP services.

New Doula Benefit Resource

Partnership Doula Benefit

Supportive pregnancy services to Partnership pregnant or post partum members.

- Prenatal, Intrapartum, and Post Partum Care
  - During Pregnancy labor and delivery, miscarriage, still birth, and abortion.
  - Physical, emotional, and non-medical care.
  - Services can be provided up to 12 months from the end of pregnancy.
  - Does not require supervision by a clinical provider nor a referral from a clinical provider.

Covered Doula Services

KR

Covered services include:

- One initial visit
- Eight additional visits (pre and/or post-partum)
- Labor support
- Up to two extended three-hour post-partum visits
- Addition visits (≤9) may be considered if needed

Contracted doulas will be added to the Provider Directory

Interested doulas can contact Partnership:
doulaservices@partnershiphp.org

Measure Best Practices

KR

Chlamydia Screening Best Practices

- Standardized process for including sexual history into the History and Physical and at regular intervals.
- Universal Screening: Develop work flows to screen all sexually active members assigned female at birth for chlamydia through age 25.
    - Consider CDC guidelines to include other at risk populations as well.
- Include chlamydia screening as part any visit women 25 years and younger.
    - Focus on those patients who are using Family Planning.
- Educate staff and patients about STIs including signs, symptoms and treatment and prevention.

Best and Promising Practices

Communication/Education for Staff

- Educate patients that women's preventive screening is a Partnership covered preventive service.
- Use approved tailored targeted education; can be done by MAs - should not be a one-time occurrence.
- Conduct outreach efforts that rely on several communication/touch points. Combined with clinician recommendations, can have a significant cumulative effect.
- Use already existing media (videos, printed materials, posters, newsletters) from national and state reputable sources.
- Ensure information is person-centered.
- Collaborate with community agencies for outreach.
- Highlight patient stories.

Measure Best Practices

KR

Strategies with a Health Equity Focus

- Incorporate train for staff to include Implicit Bias and Diversity, Equity, and Inclusion.
- Address transportation barriers.
- Review data by race, ethnicity, location (zip code), and preferred language to address potential barriers.
- Consider how member information is presented.

Voices from the Field

KR

Ann Soliday Bench
Associate Director, MCH and SRH Services
Karolina Soltero
SRH Services Manager

CommuniCare+OLE
Caring for Napa, Solano & Yolo Counties

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CHLAMYDIA SCREENING AT CCOLE

CommuniCare+OLE

Caring for Napa, Solano & Yolo Counties

Locations

CCOLE CLINICS - YOLO COUNTY

*Napa/Solano Counties coming soon

Safe Care Clinic Program offers free and confidential (private) sexual and reproductive health services to individuals ages 12+.

Hansen Family Health Center

Davis Community Clinic

Salud Clinic

Vida Family Health Center

safe care clinic

CommuniCare+OLE

Caring for Napa, Solano & Yolo Counties

Srh Team

TBD

TBD

He/Him/El

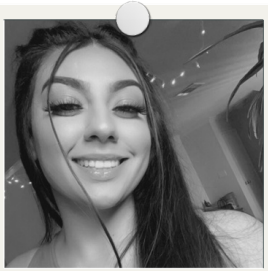
Jesus x3116

She/Her/Ella

Karolina x2837

Vanessa x2853

She/Her/Ella



Angelica x2913

She/Her/Ella

Ann x2925

She/Her

Office Visits

HEALTH COACH FLIPPED VISITS + WHOS

- Health coaches are…
- Their training includes…
- They offer the following services…
- Workflows include offering STI testing to all patients regardless of reason for visit.

safe care clinic

CommuniCare+OLE
Caring for Napa, Solano & Yolo Counties

Reducing Barriers

BY...

- Online + phone call scheduling
- Walk in appointments
- Collecting Sexual Health on ipads
- Outreach during schools lunch time
- Presentations to youth and community members
- Reaching community members where they are located (mobile medicine)

safe care clinic

CommuniCare+OLE

Caring for Napa, Solano & Yolo Counties

Coming Soon

TO CCOLE SITES

- Health Coach expansion to Solano/Napa Counties
- Explore CT/GC POCT
- Stock DoxyPEP

safe care clinic

CommuniCare+OLE
Caring for Napa, Solano & Yolo Counties

THANK YOU!

Any Questions?

Partnership Website Resources

KR

Perinatal QIP website

PERINATAL QIP

In 2018, the Perinatal Quality Improvement Program (Perinatal QIP) was introduced as a pilot program to include participation of the two largest practices in Partnership HealthPlan of California's major regions. The Perinatal QIP offers financial incentives to participating Comprehensive Perinatal Services Program (CPSP) and select non-CPSP providers providing quality and timely prenatal and postpartum care to Partnership members. Since inception, the Perinatal QIP has expanded to primary care and specialty providers within the fourteen counties we serve. As a result, it has been added as a permanent fiscal year offering in Partnership's value based payment programs starting on July 1, 2020.

Contact Us

Email: perinatalqip@partnershiphp.org (please allow two business days for a response)
Fax: (707) 863-4316

Perinatal QIP Overview

To help orient our hospitals to the Perinatal QIP year, we have provided measurement set documents as well as submission templates and resources.

Learn More about Perinatal QIP

Webinars and Events

View the current Perinatal QIP webinars:

2023-24 Perinatal QIP Kick-Off Webinar

Presentation
Recording

Referral Resources

KR

Carelon Services - (855) 765-9703 (24 hours a day/ 7 days a week)

- https://www.partnershiphp.org/Providers/BehavioralHealth/Pages/Mental-Health-Services.aspx

Partnership Care Coordination - (800) 809-1350

- Health Care Guides and Nurse Case Manager offer care management for high risk members and families.
- Refer patients with care coordination needs – issues with transportation, high risk conditions or other psycho-social or medical concern.

Post Partum Support International - (800) 944-4772

- www.postpartum.net

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Resources

KR

Growing Together Program (GTP)

- Prenatal and Post Partum Outreach from Partnership to members
- Focus: Health Education and Access to services for all members
- Refer ALL pregnant, postpartum members and members/families <5 years old

  Phone: (855) 798-8764

  Monday – Friday 8 am – 5 pm

  PopHealthOutreach@partnershiphp.org

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Upcoming Opportunities and Evaluation

Improving Measure Outcomes Series Feedback

KR

- We are requesting feedback for the Improving Measure Outcomes Webinar Series.
- For those who have attended **two or more** webinars in our series, you will be sent a ten question evaluation rating this series on April 29.
- Your candid feedback is appreciated.

For taking the time to complete, one lucky provider office will receive a gift from Edible Arrangements® to share with their staff!

Upcoming Trainings:
Incorporating Patient Experience in Quality Improvement Projects and Plans

KR

Incorporating Patient Experience in Quality Improvement Projects and Plans

Target Audience: Quality improvement staff, team leaders, managers, and front-line staff.

Presented by: The Health Alliance of Northern California (HANC) and North Coast Clinics Network (NCCN)

This webinar discusses the importance of incorporating patient experience measures in your quality improvement projects and plans. Topics for discussion and practice will include assessment of patient experience data, identifying opportunities to conduct PDSAs that address patient experience priorities, and strategies for collaborating with patients and families.

Planned session: Tuesday, May 7, 2024, Noon – 1 p.m.

Register: http://www.partnershiphp.org/Providers/Quality/Pages/Quality_Events.aspx

Contact: cackerman@partnershiphp.org

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Contact Us

KR

Colleen Townsend, MD
Ctownsend@partnershiphp.org

Partnership Perinatal QIP questions
PerinatalQIP@partnershiphp.org

QI/Performance Team
ImprovementAcademy@partnershiphp.org

Evaluation

KR

Please complete your evaluation. Your feedback is important to us!