Interconception Care and Health Centers

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Community Health Centers: Post-Hurricane Katrina

- Greater New Orleans Community Health Connection
  - September 2010 approval of Louisiana 1115 Medicaid Waiver – Greater New Orleans Community Health Connection (GNOCHC)
  - This Waiver ensures that uninsured adults (19 – 64 years) who fall <200% FPL can continue to access services through the Primary Care Access Stabilization Grant (PCASG) network funded by CMS post Hurricane Katrina to restore and expand outpatient primary care services.

Interconception Care Enhancement to GNOCHC 1115 Waiver

- June 2012, CMS approved an enhancement to the 1115 primary and behavioral health care in federally qualified health centers demonstration
  - Added Interconception Care (ICC) case management to GNOCHC Waiver, delivered by Healthy Start New Orleans
  - Eligible population: women with recent low birth weight and/or preterm birth, fetal death > 20 weeks gestation, or infant death

Engaged Community Health Centers in Interconception Care

- Louisiana Public Health Institute (LPHI) was grantee of 1 of 17 funded Beacon Community Grant Programs of the Office of the National Coordinator for Health Information Technology
- Implemented HIT and quality improvement in cardiovascular disease and diabetes management
- Baptist Community Ministeries, the largest foundation in state, funded LPHI to conduct an interconception care initiative in Greater New Orleans area Community Health Centers, building on Beacon infrastructure

Beacon Grant Successes

- Care transition: region's first real-time automatic notification system from emergency department to patient-centered medical homes
- Clinical transformation practice coaching program by Primary Care Development Corporation in16 clinics
- Quality improvement efforts in 4 hospital systems and more than 20 primary care practices
- Clinical seminar series for community providers to share best practices

www.**crescentcitybeacon**.org/.../ccbc-3rd-annual-**report**.original.pdf

Interconception Care: Greater New Orleans Community Health Centers

- Adapted Grady Memorial Hospital's Interpregnancy Care Study's components
  - Anne Dunlop of Grady contracted as trainer/consultant for Interconception Care Learning Collaborative with quarterly seminars:
    - ICC care; family/reproductive planning and STI's; behavioral health; chronic disease management; care coordination
- Primary Care Development Corporation conducts quarterly learning sessions and practice transformation monthly coaching calls
- All GNOCHC FQHC's are invited to learning sessions

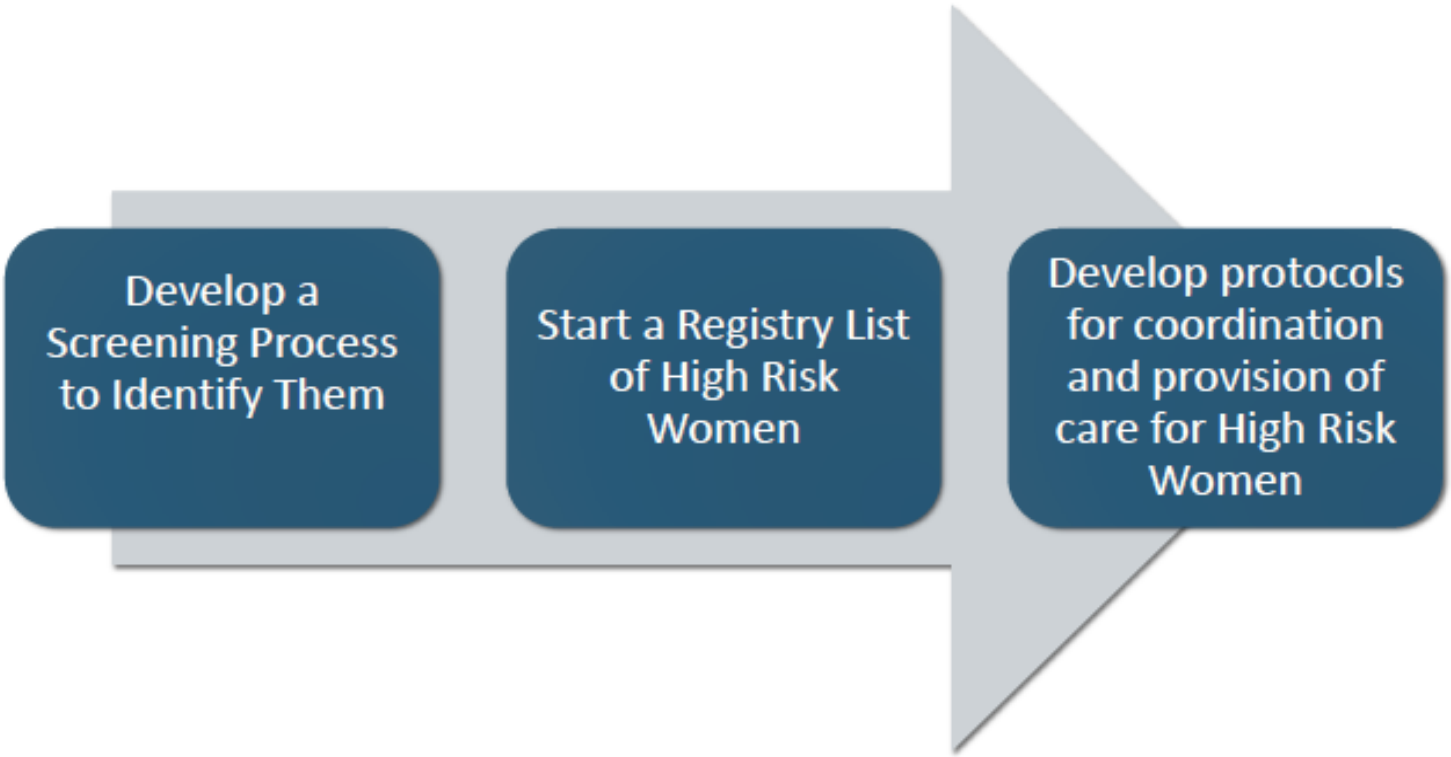
LPHI and 4 FQHCs Signed Charter:

Interconception Care Center for Excellence

To test and carefully build ICC system:

- Establish change team including clinical champion, nurse, behavioral health provider, care coordinator, and health information technology staff
- Develop and implement processes in the community health centers for identifying women at risk for future poor birth outcomes & set up processes for tracking women identified
- Create systematic care transition with hospitals, payers, OB providers
- Process and outcome data reporting in EMR

1.Targeting High Risk Women



LPHI
Louisiana Public Health Institute
Bringing People, Ideas and Resources Together

PRIMARY CARE DEVELOPMENT CORPORATION

Recommended Criteria for Women who are High Risk for Future Poor Birth Outcomes

1. Hx of low birth weight or pre-term delivery

- < 2500 grams
- Born before 37 weeks
- Fetal death or stillbirth

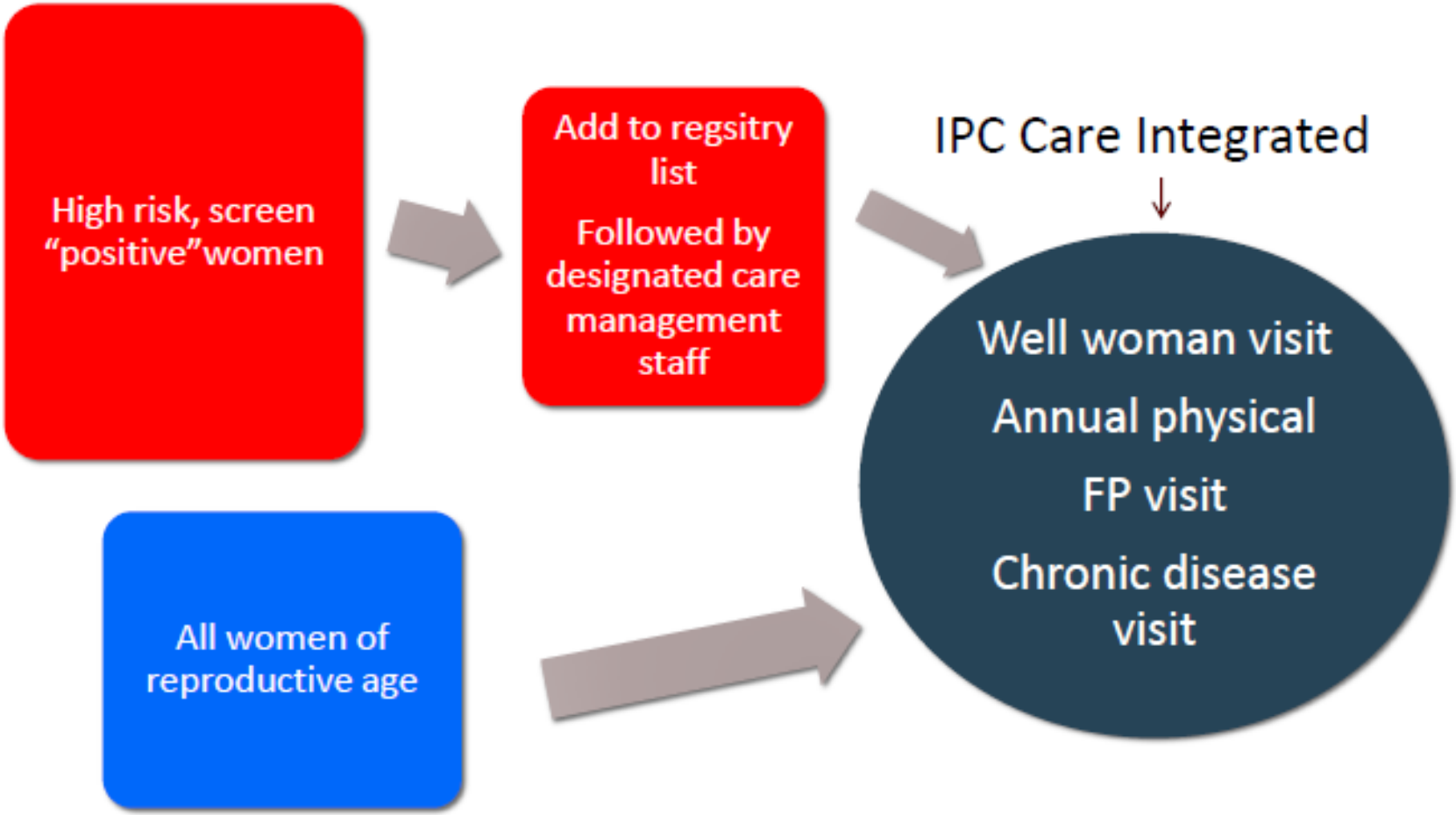
2. Hx of high risk pregnancy

- gestational diabetes, pregnancy induced hypertension
- pre-eclampsia, eclampsia

3. Current chronic disease or medical condition

- Hypertension
- Cardiovascular disease
- Diabetes
- Seizure Disorder

High Risk Women Get Care Management/Care Coordination



Coaching T/A Calls with Centers of Excellence

- Discuss how to integrate ICC into routine visits
  - New patient visit
  - Well-woman
  - Family planning,
  - Chronic disease visits
- Which tools/forms from Grady Memorial Hospital IPC Project would best fit into the clinic system?
  - Reproductive Life Plan?
  - Risk Assessment?

Complete Risk Assessment

- **Reproductive life plan**
  - Have they made one?
- **Risk for unintended pregnancy or short pregnancy interval**
  - Are they at risk and have they been counselled?
- **OB and Contraceptive history**
  - Did you ask? What did you ask?
- **Chronic health conditions and medications:**
  - Would they affect a pregnancy? Patient counselled?
- **Tobacco , alcohol and substance abuse**
  - Are they using these? Counselled on effects on reproductive health and future pregnancy? Receiving help?
- **Depression, social stressors, and IPV**
  - Are these conditions present? Are they receiving help?
- **Nutritional status**
  - Have you assessed it?

Centers for Excellence: Process Data & Reporting Results

- Each of the centers collect and report on:
  - Chronic conditions and associated test results
  - Contraceptives by type
  - Substance use screening and treatment
  - Depression screening
  - Domestic Violence screening

Centers for Excellence: Process Data & Reporting Results

- Few centers conduct/collect and/or report on:
  - Reproductive life plan
  - Child spacing counseling
  - How chronic conditions and substance use affect a pregnancy
  - Folic acid supplementation

Measures

# of clients with reproductive plans assessment

# of clients counseled about child-spacing

Next Steps

- EMR changes for gaps in essential ICC components such as Reproductive Life Plan and Birth Spacing Counseling
- ICC Manual to include: educational materials developed for this model, case studies, and other tools to assist in planning, implementation, and sustainability
- Referral system from hospital obstetric and neonatal departments, Medicaid MCOs, obstetricians